REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 1-A-19

Subject: Extreme Risk Protection Orders and Gun Violence, Resolution 314-A-18

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Science and Public Health

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The 2018 House of Delegates considered Resolution 314 from the Texas Pediatric Society that called for TMA to advocate for legislation permitting extreme risk protection orders in Texas. Resolution 314 identified gun violence as a public health threat – noting that mental illness, domestic violence, and substance abuse often are factors in gun violence. Testimony at the hearing of the Reference Committee on Science and Public Health revealed both support for the proposal and concerns about the consequences of such legislation. Acknowledging the complexities and challenges of firearm safety legislation and the recent mass shootings in Texas, the reference committee recommended the resolution be referred for study. The recommendation was approved, and the Board of Trustees referred Resolution 314 to the Council on Science and Public Health and the Council on Legislation. As part of the councils' review of Resolution 314, TMA President Doug Curran, MD, appointed a TMA Workgroup on Firearms and selected 13 physician experts to review, discuss, and advise both councils with recommendations for consideration. At Dr. Curran's request, TMA Board of Trustees member Gary Floyd, MD, chaired this workgroup. Two meetings (during 2018 TMA Fall Conference and 2018 Advocacy Retreat) were held to work up recommendations on Resolution 314 as well as Resolution 313 (Raising the Minimum Purchase Age for All Guns to 21), which also was referred for study. Additionally, the workgroup evaluated gaps in TMA firearm policy to offer a set of additional principles for consideration by both councils for a report back at 2019 TMA Winter Conference.

John Carlo, MD, member of the American Medical Association Council on Science and Public Health and TMA Council on Legislation, brought to the discussion the newly adopted 2018 AMA report, "The Physician's Role in Firearm Safety." The AMA council report focused on the presupposition that 38,000 U.S. deaths from firearms in 2016 is unacceptable and that firearm violence is a public health threat. Racial and ethnic disparities make nonwhites 2.5 times more likely to die from firearms than whites. The report called on the need for more scientifically based research for effective measures to address the public health issues with firearm violence.

Gun Violence and Behavioral Health

The United States has the highest violent death rates among high-income countries; this includes the highest firearm homicide rates and firearm suicide rates — both at least twice that of other high-income countries. The Centers for Disease Control and Prevention (CDC) does not use the term "gun violence," but in its role as national surveillant of violent deaths, CDC recently identified firearm-related deaths as a public health concern. Comparing data on firearm deaths in the 50 largest U.S. metropolitan statistical areas from 2012-13 and 2015-16, CDC reports that firearm-related death rates now have risen to the high rates of more than 10 years ago (2006-07).

CDC identifies suicides as "self-directed violence" and as a top 10 leading cause of death in the United States and one of only four causes of death with significant rate increases. There were more than 44,000 suicides in the United States in 2016, and 50 percent, or more than 22,000 deaths, were suicides by firearm. The rates of suicide by firearm vary by age group, but males consistently have the highest rates

(more than 80 percent of all firearm suicides), with the rates rising among older age groups. The U.S. suicide rate by firearm increased 21 percent from 2006 to 2016 (for people more than 10 years old).

In 2016, Louisiana, Alabama, and Alaska had the highest rates of firearm mortality in the country (21.3 to 23.3 per 100,000). With 3,353 firearm-related deaths in this period, Texas had more deaths than any other state and a firearm-death rate of 12.1 (per 100,000). Like the rest of the country, Texas' suicide rate increased from 2000 to 2016, and Texas' suicide-by-firearm rate of 7.3 (per 100,000) is higher than the U.S. rate of 6.5.

Contrary to news reports that associate firearm violence and mass shootings with a mental illness, most of the people who carry out a mass shooting do not have a diagnosis of a mental illness. A very small proportion of those with a severe mental illness and a history of violence may be more likely to become violent when experiencing a high-risk event. The American Psychiatric Association notes that less than 1 percent of gun-related homicides in a mass shooting each year involved a person with a serious mental illness, and about 3 percent of individuals with a serious mental illness were involved in a violent crime. A report of the Federal Bureau of Investigation (FBI) also confirms that only 25 percent of 63 active shooters in the United States (2000-13) had been diagnosed with a mental illness, and three of these were diagnosed with a psychotic disorder. The FBI reports that most of those involved in a mass shooting were known to have demonstrated concerning behaviors or to have experienced one or more severe stressors before they engaged in firearm violence. Firearm violence has been more commonly associated with compulsive, angry behavior. A recent analysis of the National Comorbidity Study Replication found that about 10 percent of U.S. residents both report pathological anger and possess firearms and/or carry firearms outside the home. In many cases, these people already have a history of misdemeanor violence (e.g., controlled substance misuse, physical altercations). These traits and access to firearms appear to increase the risk for violent behaviors.

Red Flag Laws and Protective Orders

Extreme risk protection orders, also known as "gun violence restraining orders" or "red flag" laws, are intended to remove firearms from individuals who are reported to be an extreme risk to themselves or to another person. While five states already have some type of red flag statute, an additional eight states recently have adopted red flag legislation. Legislation has been considered in many more states — including Texas — but has not been approved. Additionally, concerns have been raised about the complexity of these orders and their enforcement.

The United States has extensive statutory law that addresses firearm commerce, such as the Gun Control Act 1968, which limits the purchase of firearms by specific people such as those who are convicted of a felony or domestic violence, subject to a restraining order or involuntary commitment, or declared mentally incompetent. The 1968 legislation also raised the age for handgun purchase to 21 years. The Brady Handgun Violence Prevention Act established the National Instant Criminal Background Check System, and the National Crime Information Center was created for reporting required criminal justice information such as people identified under a protective restraining order.

Domestic protective orders and red flag laws are associated with federal laws on the purchase or possession of a firearm and the reporting of those not qualified to purchase or possess a firearm. While almost all states have protective orders, their scope varies by state. However, these orders generally are based on the type of risk presented — such as an association with family violence, a history of a felony conviction, or a diagnosed mental illness. The process for obtaining a protective order addresses who is at risk of harm and the mental status and history of firearm violence of the person identified as the offender. The petitioner for a protective order typically presents in court and must report direct threats or warning signs of a potential threat to family, household members, or law enforcement. The removal of firearms from the person identified as the offender is not automatic, but the petition can lead to removal if requested by the petitioner.

A protective order is not the same as a red flag law. Red flag laws do not focus on the domestic setting, nor do they relate to violence that already has occurred. Red flag laws are intended to prevent the future violent conduct of people who may have access to firearms and if there is evidence of direct threats to themselves, other individuals, or groups (e.g., in a home, school, or work setting), and/or there are other concerning behaviors. Red flag laws allow for the preemptive removal of a firearm based on potential risk.

Red Flag Law Effectiveness

Several states have had red flag laws for a few years, but red flag law requirements vary by state, and implementation of these laws still appears to be in an early stage in some states. Connecticut has the longest history, with its red flag law adopted in 1999, followed by Indiana's red flag law authorized in 2005. No studies could be found on the impact of red flag laws in most of the states that already have implemented them. It may be that differences in these state laws and implementation status make them complex to assess.

A few studies have assessed the impact of these laws in Connecticut and Indiana. Key findings include:

- From 2005 to 2015, Indiana saw a 7.5-percent reduction in firearm-related suicides.
- Connecticut initially saw a 1.6-percent reduction in firearm-related suicides in the earliest years of implementation, but the rate of firearm-related suicides decreased most significantly after 2007. The study authors attribute this to more rigorous implementation of red flag laws following the 2007 mass shooting at the Virginia Polytechnic Institute and State University.
- Another study on Connecticut's experience with its red flag law (1999-2012) found that while the number of suicides declined among those who had one or more firearms removed, suicides and suicide attempts that did not involve firearms increased. Suicidality was the key issue identified for almost two-thirds of the more than 760 people who were subject to a risk warrant petition. The study also found that some may seek and obtain mental health care, as 29 percent were in contact with the public mental health system in the year following their crisis. However, the removal of firearms from those at risk of suicide is viewed as a significant impact in Connecticut.

Several studies note significant inconsistencies in how red flag laws are implemented, and implementation can even vary by jurisdiction within a state. Interviews with legal counsel and judicial representatives associated with Connecticut's red flag legislation revealed an interest in clarifying Connecticut's process for approving risk-based warrants and also concern about the assurance of due process for people subject to firearm removal.

While there is a limited body of study on red flag laws, there is broader study on the effectiveness of domestic protective laws in reducing intimate partner violence, including reducing rates of homicide with firearms. Family and domestic protective orders are implemented in almost every state as a tool to prevent a personal assault or other violence.

Texas Statutes, Legislation, and Recent Action on Firearms

Unlike several other states, Texas does not require a permit to purchase a handgun, rifle, or shotgun, nor is registration or licensure required to possess these firearms. A permit is required to carry a handgun (open or concealed), although some facilities can restrict or prohibit the carry of a handgun. More than 1 million Texans have concealed handgun permits, and a recent national survey found that more than a third (35.7 percent) of Texas adults own a firearm. Texas' safe storage law creates a misdemeanor if a firearm is accessible to a child, and the misdemeanor can be raised to a Class A misdemeanor if a child's use of the firearm leads to death or serious injury to the child or another person. And while neither a municipality nor a county can adopt regulations on the possession, registration, or licensure of firearms or ammunition, municipalities can regulate the discharge of firearms within the city or the carry of a firearm at a public facility or certain events.

Texas does not have a red flag law, but like most states, Texas' protective orders are for domestic or family violence and emergency protective orders. Texas' protective orders statute is more expansive than most other states as it can refer not only to a spouse, family member, or other resident of the household but also to an intimate or "dating" partner and allows for a protective order against domestic or family violence or for a victim of sexual assault. Emergency protective orders also can be approved by a magistrate for a person who already has been arrested for family violence or assault — but may not allow for taking possession of a firearm. Texas' statute also extends to the possession of ammunition. A Texas resident under a restraining order must be reported by courts to the Texas Department of Public Safety, which in turn reports to the federal National Crime Information Center.

Recent legislation (2017) filed to expand protective orders in Texas includes House Bill 866 by Rep. Joe Moody and Senate Bill 434 by Sen. José Rodriguez to allow law enforcement to remove firearms with the issuance of a lethal violence protective order if family members or law enforcement can provide evidence that the individual or others are in immediate danger. HB 866 was left pending in committee. House Bill 131 by Rep. Joe Moody on extreme risk protection orders was the first bill to be filed on red flag legislation in the 2019 legislative session.

In response to the school shooting in Santa Fe High School and the November 2017 mass shooting in Sutherland Springs, Texas Gov. Greg Abbott convened three roundtables across the state on the safety of students and teachers in Texas schools. The Governor's School and Firearm Safety Plan made recommendations on school safety and on the reduction of firearm-related threats. One recommendation calls on Texas legislative leadership to consider the merits of red flag legislation in Texas.

The Texas Senate appointed the Select Committee on Violence in Schools and School Security, whose charge includes a review of red flag orders. Testimony at the committee's July 2018 hearing on red flag laws provided both support and opposition to the consideration of a red flag statute in Texas. Supporters suggested allowing family members and law enforcement to initiate an order to remove a firearm from someone they perceive as presenting harm to themselves or others, and in particular, someone who is recognized as being in a crisis situation. It was also noted that current statute could be broadened to address the person who has a history of violent behavior or reckless use of a firearm or other deadly weapons, or someone who has been released from a mental health hospital who also may present a risk. Others spoke on the ability to apply Health and Safety Code Chapter 573 in the Texas Mental Health Code that allows a peace officer to take into custody and restrain a person without a warrant if the officer believes the person has a mental illness and presents a substantial risk to himself or herself or to another person.

The Senate committee's August 2018 report made several recommendations but none in support of legislation on red flag orders. The recommendations called for legislation to clarify current statute on whether and when an individual convicted of domestic violence may possess a firearm legally and on the return of firearms to individuals who have been detained and declared no longer to be a risk to themselves or others.

Discussion

Gun violence often is associated with mental illness, and both matters are of significant concern to physicians. Yet studies indicate physicians are not screening routinely or counseling even high-risk patients on firearm safety. And when screening is done, it is more likely done by primary care physicians, psychiatrists, or emergency medicine physicians. This suggests there may be a need to increase physician awareness of screening tools and interventions, especially for patients who may be at risk for violence to themselves or others.

Violence is indeed a concern, and domestic and family violence is a significant problem in Texas. Texas has broad protective order procedures intended to prevent domestic and family violence, but almost 200,000 incidents of family violence were reported in 2015, with 97 percent of these categorized as involving a physical assault. Physical force was used in 80 percent of assaults, and a firearm was involved in 1.7 percent of reported family violence cases. The Texas Council on Family Violence reports that male partners killed 146 women in 2016, and there were more than 170,000 hotline calls to Texas family violence programs in this period. Yet data on current violence in Texas and firearm violence in particular could not readily be found. Active surveillance of firearm-related injuries and deaths in Texas and access to these data would help physicians better understand the circumstances contributing to injuries and deaths associated with firearms. Texas remains one of the few states that does not participate in CDC's National Violent Death Reporting System (NVDRS). CDC notes that the NVDRS helps communities understand the "who, when, where, and how" associated with violent deaths to enable communities to take action to save lives.

But physicians have important tools to support firearm violence prevention, and this begins with the patient-physician relationship that includes confidential communications on the care and personal safety of the patient. There is substantial evidence that patients depend on and trust the free exchange of information and personal guidance they receive from their physician. Patients are more likely to act upon direction from their physician than they are from other sources. This can and should include discussions on potential risks in the home such as firearm access by the patient or family members. Texas has clear statute on the duty to ensure firearm safety in the home, and physicians can inquire and readily share information on firearm risk in their communications with patients.

The public and physicians also can readily access state and volunteer resources on family and domestic violence. The Office of the Attorney General, the Texas Council on Family Violence, and many local community organizations offer information and assistance to those at risk of domestic violence. Patients also may be unaware of current protective order laws. In addition, Texas statute allows a physician and licensed or certified mental health professionals to disclose confidential patient information if a patient appears to be at imminent risk of self-harm or harm to another. Physicians do not have a duty to share information, but this presents an important option for physicians.

Conclusion

Background checks and age-based requirements for the possession and purchase of firearms have been the mainstay of federal and state management of firearms. Keeping firearms away from people who present a risk of harm or who are unable to make sound decisions provides a strong base for managing firearm safety. But with an estimated more than 400 million firearms in the United States, clearly purchase and possession laws are not providing adequate protection to prevent firearm access by those at high risk of harm to self or to others.

About 40 percent of U.S. adults own one or more firearms or live in a home where a firearm is present. Most of these firearms were purchased or otherwise obtained legally outside the federally regulated system for licensed firearm vendors. For a large proportion of U.S. adults, gun ownership is associated with an individual's personal freedom, and protection is a key reason why many own one or more firearms.

With dozens of significant events involving firearm violence and mortality, the country remains divided on what actions are needed to prevent firearm-related violence. But firearm violence is not a new concern for medicine. The American Medical Association, the American Academy of Pediatrics, and the American College of Physicians have taken a firm stand on the physician role in addressing gun violence as a public health issue. Other medical associations also have agreed upon the urgency for identifying public health prevention strategies to reduce firearm mortality and morbidity.

CDC defines public health as the science of protecting and improving the health of people in their communities. Historically this has focused on preventing and responding to infectious disease outbreaks, but as public health science and medicine have evolved, it has become increasingly important to direct research to better understand the factors that contribute to preventable diseases and injuries such as firearm violence. State legislation to allow extreme risk protection laws may have an impact in reducing suicide rates, but such legislation alone may not fully address other factors associated with mass shootings and domestic violence. Thus physicians must continue to advocate for and seek evidence so they can be directly engaged in identifying how to reduce firearm morbidity and mortality.

Texas has a history and culture of independence, which for about a third of Texas adults includes the freedom to possess and use firearms as permitted by the U.S. Constitution. TMA does not take a position on firearm possession or purchase, but recognizes that physicians have a role in helping identify and support their patients at risk of harm, particularly if a patient has access to firearms or lives in an unsafe environment. Further, there is an urgent need to improve Texas' understanding of firearm violence and of the outreach and public awareness that may be needed in some communities. Therefore, in lieu of adopting Resolution 314, the council makes the following recommendations:

Recommendation 1: Amend TMA Policy 260.015, Firearms, as follows:

> The Texas Medical Association recognizes gun violence as a public health issue requiring the promotion of evidence-based strategies in Texas. Medical professional organizations should speak out about the prevention of firearm-related injuries and deaths, and TMA calls on physicians to support:
>
> 1. The primary prevention of firearm morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership, recognizing that physicians have an unencumbered right to inquire of and inform patients and their families about the risks of firearms and in particular the risk to children;
> 2. Promotion of ~~T~~the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife;
> 3. ~~Physicians in the clinical setting p~~Providing anticipatory guidance in the clinical setting on the dangers of firearm ownership in an informational, nonjudgmental manner, encouraging firearm owners to adhere to best practices for reducing the risk of accidental or intentional injuries or deaths by ensuring firearms are not accessible to children; adolescents; or people with mental, behavioral, or substance use disorders;
> 4. Strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession;
> 5. The use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and
> 6. Unfettered study of issues involving firearms and public health and safety, and Texas' participation in national surveillance studies on violence in the United States, ensuring the state has timely, accurate data on firearm-related mortality and morbidity to guide Texas' public health prevention activities (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08; amended CSPH Rep. 5-A-18).

Recommendation 2: That the Task Force on Behavioral Health develop information for physicians on the prevention and assessment of suicide risk and promote awareness of mental health first-aid training for physicians and office staff, and of state statute on the sharing of information on patients at risk.

Recommendation 3: That TMA advocate for a protective order process to allow for the implementation of risk-based protective orders to ~~support t~~deal with those reported to be at high risk of violence to others or self-harm.

Recommendation 4: Amend TMA Policy 325.002, Family Violence, as follows:

> **325.002 Family Violence:** The Texas Medical Association believes that physicians should ~~learn~~ be aware of the ~~what~~ resources ~~are~~ available in their community such as information provided by the Texas Family Violence Council and information on family protective orders developed by the Office of the Attorney General to inform and support ~~to help~~ victims of domestic violence. Physicians should ~~and~~ make this information available in their waiting rooms or have their office staff provide it~~,~~ ~~that t~~The association should provide physicians with information on the symptoms of domestic violence and abuse, and ~~that~~ physicians should record information on domestic violence in the patient's medical file (CPH, p 129, A-92; amended CPH Rep. 3-A-10).

Related TMA policy:
245.021 Patient-Doctor Privileged Communication: The Texas Medical Association (1) opposes efforts by the Texas Legislature to insert itself into the patient-physician relationship in any way that interferes with the free and full disclosure of health care information in the best interests of the patient, and (2) reaffirms its support of the free exchange of professional information in the patient-physician relationship as privileged and worthy of the highest professional protection (Amended Res. 108-A-13).

325.002 Family Violence: The Texas Medical Association believes that physicians should learn what resources are available in the community to help victims of domestic violence and make this information available in their waiting rooms or have their office staff provide it, that the association should provide physicians with information on the symptoms of domestic violence and abuse, and that physicians should record information on domestic violence in the patient's medical file (CPH, p 129, A-92; amended CPH Rep. 3-A-10).

Related AMA policy:
H-145.997 Firearms as a Public Health Problem in the United States – Injuries and Death
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:

> (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
> (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
> (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
> (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns;
> (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
> (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
> (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
> (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

H-145.990 Prevention of Firearm Accidents in Children
Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care
1. Our AMA supports:

a) federal and state research on firearm-related injuries and deaths;
b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy;
c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety;
d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes;
e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes;
f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and
g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

H-145.972 Firearms and High-Risk Individuals
Our AMA supports:

(1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence;
(2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms;
(3) expanding domestic violence restraining orders to include dating partners;
(4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons;

(5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and
(6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care

1. Our AMA supports:

a) federal and state research on firearm-related injuries and deaths;
b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy;
c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety;
d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes;
e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes;
f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and
g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

H-145.976 Firearm Safety Counseling in Physician-Led Health Care Teams

1. Our AMA:

(a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients;
(b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and
(c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

H-145.996 Firearm Availability
1. Our AMA:

(a) advocates a waiting period and background check for all firearm purchasers;
(b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and
(c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored**.**

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REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

C-SPH Report 3-A-19

Subject: Raising the Minimum Purchase Age for Guns, Resolution 313-A-18

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Science and Public Health

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Background

The 2018 House of Delegates considered Resolution 313 submitted by the Texas Pediatric Society that called for TMA to support federal and state legislation to raise the age for the purchase of all firearms to 21 years. Testimony at the reference committee hearing was overwhelmingly in favor of the resolution, and the reference committee recommended adoption. However, there was extended discussion at the House of Delegates with members speaking in support of the resolution while others called for referral. Issues raised ranged from the association between mental illness and firearm violence, brain development and the decisionmaking capacity of adolescents, and a lack of information on the evidence that raising the age of purchase would reduce gun violence.

The House of Delegates supported the referral of the resolution, and the Board of Trustees referred Resolution 313 to the Council on Science and Public Health and the Council on Legislation. As part of the councils' review of Resolution 313, TMA President Doug Curran, MD, appointed a TMA Workgroup on Firearms and selected 13 physician experts to review, discuss, and advise both councils with recommendations for consideration. At Dr. Curran's request, TMA Board of Trustees member Gary Floyd, MD, chaired this workgroup. Additionally, the workgroup evaluated gaps in TMA firearm policy to offer a set of additional principles for considerations by both councils for a report back at 2019 TMA Winter Conference.

John Carlo, MD, member of the American Medical Association Council on Science and Public Health and of the TMA Council on Legislation, brought to the discussion the newly adopted 2018 AMA report, "The Physician's Role in Firearm Safety." The AMA council report focused on the presupposition that 38,000 U.S. deaths in 2016 from firearms is unacceptable and that firearm violence is a public health threat. Racial and ethnic disparities make nonwhites 2.5 times more likely to die from firearms than whites. The report called on the need for more scientifically based research for effective measures to address the public health issues of firearm violence.

Federal and State Laws on Firearm Purchase and Possession

Resolution 313 noted that gun violence is a threat to the health and safety of children, who are at high risk of firearm suicide, homicide, and unintentional injury, and that raising the age of purchase for long guns would align with federal and state law and would reduce child exposure to gun violence.

Federal law regulates firearm interstate commerce including purchase and possession. The 1968 federal Gun Control Act limits the purchase of firearms for certain people such as those who are convicted of a felony or domestic violence, subject to a restraining order or involuntary commitment, or declared mentally incompetent; however, federal law applies only to federally licensed firearm dealers. Federal law also sets the age of 18 years as the minimum legal age for *possessing* a handgun. While handguns can be *purchased* at the age of 21, the legal age for purchase of a rifle or a shotgun (long gun) is 18 years. There are no age prohibitions for the possession of long guns, but federal law prohibits an unlicensed private owner or firearm dealer from selling or transferring a handgun to anyone under the age of 18.

Texas does not require a permit to purchase a handgun or a rifle or shotgun, nor is registration or licensure required to possess these firearms. A permit is required to carry a handgun (open or concealed), and Texas' safe storage law makes it unlawful to have an unsecured firearm where a child is likely to be or where the child can obtain access. A recent national survey found that more than a third (35.7 percent) of Texas adults own a firearm.

Firearm Violence and Children

Firearms are second only to motor vehicle accidents as a cause of death among minors in the United States, and about 19 children are injured or die each day because of a firearm. More than half of the 1,300 child firearm deaths each year (2012-14) are a homicide, almost 40 percent are suicides, and about 6 percent are unintentional deaths. Older children aged 13 to 17 years are more than 12 times likely to die from a firearm than are younger children. The rate of firearm suicide is about 11 times higher for those 13 to 17 years than for 10- to 12-year-olds (suicide tracking starts at age 10). The highest rates of firearm mortality are among African-American children while annual firearm suicide rates are highest in American Indian children. More than 90 percent of child firearm deaths (in children aged 0 to 14 years) in high-income countries occur in the United States.

In 2015, 609 Texas children were injured or died because of a firearm. This includes 233 deaths from suicide, assault or homicide, or accidental firearm discharge or with an undetermined intent. More than half of these child deaths were homicides, and most deaths were in children aged 15 to 19 years.

Texas Child Firearm-Related Deaths, Age 1 to 19 years, 2015

Firearm related deaths	1-4 yrs	5-9 yrs	10-14 yrs	15-19 yrs	Total
Self-harm/suicide	N/A	N/A	12	80	92
Assault/homicide	2	9	8	107	126
Discharge of firearm, undetermined intent	1	0	0	3	4
Accidental discharge	4	1	1	5	11

Source: DSHS

In a 2015 study that assessed data from 16 states participating in the Centers for Disease Control and Prevention's (CDC's) National Violent Death Reporting System (2005 to 2012), the authors estimate that more than 100 children aged 0 to 14 years die each year from an unintentional discharge of a firearm. For those children under the age of 10 years, almost 40 percent died from a self-inflicted discharge, while in most other cases a family member was the shooter. Hunting was a factor in some cases, but most unintentional firearm deaths took place in the child's home or in the home of a friend. Of the children aged 11 to 14 years, 39 percent were killed in the home of a friend. And while some surveys indicate parents believe their children do not know how to access the firearms in the home, it appears that a lack of supervision for older children may be a factor in unintentional fatalities.

Age Restrictions in Texas

One of the issues raised during the House of Delegates' discussion on raising the age for the purchase of firearms was on understanding the rationale for a specific age. A comprehensive study could not be found that described or explained the relevance of age for some federal and state laws. Both the federal and state governments have designated a minimum age for a range of activities of importance to government and as allowed under their constitutional powers. Setting an age in a statute establishes a minimum age when a person becomes legally responsible for a right or activity regulated by the government. Almost all states including Texas have designated 18 years as the age of majority. A minor in Texas is a person under the age of 18 years who has not been married and not sought emancipation. But there are many well-recognized laws in Texas with varying age limits. These either directly or generally address health and/or personal or public safety:

- Minors are directly prohibited from buying tobacco products, and it is illegal to sell tobacco products to a person under the age of 18, including e-cigarettes. A minor in violation of state law can be fined, and both the minor and his or her parents may be required to participate in community service or attend a tobacco awareness program. The City of San Antonio recently raised the age for legal purchase of tobacco to 21 years.
- Minors cannot consent to their own health care, but they have limited ability to consent for care in certain circumstances such as for a pregnancy, for treatment of a reportable infectious disease, or if seeking diagnosis or treatment for a mental health condition. Minor parents can consent to the health care of their child.
- Texas' Alcoholic Beverage Code identifies a minor as someone who is under the age of 21 years. A person under the age of 21 is prohibited from buying, attempting to buy, or consuming alcohol, although a person aged 18 or older can serve alcohol. All state liquor age laws align with the federal minimum age as it appears that only states that observe the minimum age of 21 years can qualify for federal transportation funding.
- A minor can obtain a driver's license at the age of 16 with graduated driving restrictions until the age of 18.
- A person under the age of 18 can be employed with the minimum age of work set at 14 years, although there are exceptions for even younger ages for certain types of work (e.g., working for a parent, agriculture). Employed minors aged 14 to 15 years are limited in the number of hours and the time of day they can work, and minors may not perform work hazardous to their safety or health.
- Minors cannot marry nor can they can enlist in the United States military without the consent of a parent.
- A minor cannot get a tattoo.

Finally, 18-year-olds can vote and hold almost any local public office (e.g., sheriff, constable, county commissioner, justice of the peace, tax assessor). They cannot be elected to serve as a U.S. senator or a member of Congress until the age of 25, although a Texas state senator must be at least 26 years and a Texas state representative must be at least 21 years of age.

While several states have adopted the age of 21 for the purchase of all firearms, the majority of states including Texas, have not done so.

Child Decisionmaking

TMA members offered testimony that some of those who are 18 years old still lack the executive function abilities needed to make reasoned, adult decisions such as the purchase of a firearm. There is a growing body of research on child brain development including the development of executive function.

Executive function of the brain refers to the brain's organization of information from different parts of the brain needed for decisionmaking. The genes in our brains are continually expressed in the development of

millions of neural connections in different areas of the brain. Brain development starts while we are still in utero, and early neural development supports key sensory abilities such as vision and hearing, which allow an infant to build other abilities. The frontal lobe is where the integration of information occurs for executive function; the last stages of pruning or myelination in the brain occur in the frontal lobe, where these rapid developments will continue well into the mid- to late 20s for most.

By the time children are teenagers, many already have physically developed so that they appear to be an adult. But parents and educators may note that some – at the age of 18 or older – are not yet making informed adult decisions and often are receptive to activities that raise the risk of harm to themselves or others. Brain development and executive function capacity do not follow a regular schedule or pattern. There is evidence that adolescent and teenage brain development may be harmed or less developed based on a child's experiences. For some, adverse experiences can hamper a child's ability to access or process critical information from some parts of the brain. Unable to rapidly process memory or other information on a potentially harmful activity, a teenager may defer to his or her immediate emotional response. Poor decisionmaking can be exacerbated when a teen is regularly exposed to stress from school and peer pressure, financial concerns, family adversity, or even a lack of sleep or hormonal developments. Thus, while a teenager may be able to drive a car or understand the details of every new technology product, the brain of every 18-year-old is still in a process of maturation that will continue for several years. And while this process varies for every child, growing up in a stable, safe environment appears to contribute to improved ability to prioritize information and to manage emotions. This is particularly important for early brain development when daily, ongoing "serve and return" or back-and-forth interaction with parents and other adult caregivers supports neural development that connects different parts of a child's brain.

Discussion and Conclusion

The United States and most states have an inconsistent method for determining the age at which a person can be held responsible for an activity that can have an impact on personal or public health, such as firearm purchase. In most cases, decisions on age-related public policy appear to be based on tradition rather than on evidence of an ability to manage a regulated activity.

In a November 2018 CDC, the nation's public health agency identified firearm-related deaths as a public health concern and a leading cause of death in the United States. Firearm mortality is the second most common cause of death among U.S. children. Firearm homicide, suicide, and unintentional discharge are the major factors in both child injury and fatality. From 1994 to 2014, there were more than 180 million applications through the federal system for permits to purchase a firearm or to transfer firearms. The United States has a robust process for managing the sale of firearms by licensed vendors, but unlicensed firearm vendors can legally sell firearms at hundreds of gun show events held each year in Texas alone. Family members also can legally transfer firearms to other family members.

CDC has developed a framework for addressing child maltreatment and nurturing children that calls for bringing together those with shared interests in developing and supporting environments where children can grow healthy and be productive. This includes children being continually in an environment where they are secure and free of harm. As reported by the American Academy of Pediatrics, many parents believe their children will not touch a firearm or do not know where firearms are kept or can be accessed in the home. Most parents with firearms will talk to their children about firearm safety, but in homes where children are not taught, there is an increased risk, especially with children who are prone to make an impulsive decision. And the public health data tell us that children who are with untrained or otherwise careless adults or a friend that has access to a firearm are most likely to be injured or killed in an unintentional discharge.

There is extensive study on the development and role of executive function in teenagers, but it is not yet determined if brain imaging studies fully explain how we make decisions, particularly as we all are

continually exposed to different environments and experiences that can affect behavior and on the decisions an adult makes on a daily basis. Neuroscience and behavioral science are helping us better understand child maturation and development, but it does not appear the research is being applied for public policy development such as setting an age for the purchase of a firearm or other regulated activities. However, the rates of child injury and death from firearms indicate a need to reinforce and promote awareness of evidence-based harm reduction strategies for reducing firearm morbidity and mortality. Therefore, in recognition of the physician role in promoting evidence-based prevention, the council makes the following recommendations:

Recommendation 1: That resolution 313-A-18 not be adopted.

Recommendation 2: Adopt language from AMA policy H-145.990 as new TMA policy as follows:

Parental Education on Prevention of Firearm Accidents in Children: Texas Medical Association supports physician efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to: (1) inquire as to the presence of household firearms as a routine part of childproofing the home; and (2) share information materials to educate parents on the dangers of firearms to children; (3) encourage patients to educate their children and neighbors as to the dangers of child access to firearms; and (4) routinely remind patients to obtain firearm safety locks, store firearms under lock and key, and store ammunition separately from firearms.

Recommendation 3: Reaffirm TMA Policy 245.021, Patient-Doctor Privileged Communication:

245.021 **Patient-Doctor Privileged Communication:** The Texas Medical Association (1) opposes efforts by the Texas Legislature to insert itself into the patient-physician relationship in any way that interferes with the free and full disclosure of health care information in the best interests of the patient, and (2) reaffirms its support of the free exchange of professional information in the patient-physician relationship as privileged and worthy of the highest professional protection (Amended Res. 108-A-13).

Related TMA policy:
260.015 Firearms: The Texas Medical Association supports: 1. The primary prevention of firearm morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership; 2. The Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife; 3. Physicians in the clinical setting providing anticipatory guidance on the dangers of firearm ownership in an informational, nonjudgmental manner; 4. Strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession; 5. The use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and 6. Unfettered study of issues involving firearms and public health and safety (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08; amended CSPH Rep. 5-A-18).

55.033 Children's Mental and Behavioral Health: Texas has a relatively young population, with about 28 percent of Texans under the age of 18. TMA recognizes that many mental health disorders of childhood are the basis of both physical and mental disease throughout an entire lifespan. Childhood and adolescence are critical times for brain development; consequently, many mental disorders develop during these periods.

Managing mental health disorders among children requires multiple strategies.

Physician Education. All physicians should have adequate information that enables them to recognize common mental disorders. Primary care physicians should be provided educational tools regarding the screening, diagnosis, and current available treatment modalities for mental disorders such as attention deficit disorder, mild depression, and mild anxiety. TMA can provide resources for physicians on national screening and treatment guidelines, and billing and coding information.

Practice. Access to care remains a critical issue for children and adolescents with mental health disorders, especially underserved children. A physician-led medical home, therefore, can play an important role in recognizing, consulting, and treating children with mental health disorders by following the United States Preventive Services Task Force (USPSTF) recommendations for screening children and adolescents for mental health disorders.

All physicians who see and treat children should be able to recognize and either treat or refer children with obvious mental illness including substance abuse disorder.

Because school is the "workplace of the child," primary care physicians should have knowledge of the demands and resources of their local school districts.

Advocacy. TMA should facilitate and advocate for:

a. Continuing mental health education programs for physicians and mental health care providers regarding child and adolescent mental health and substance abuse,

b. Medical schools and graduate medical education programs that recognize the role of primary care physicians and provide effective training and research in all aspects of child and adolescent mental health and substance abuse,

c. Continuing dialogue and networking with the public mental health community on these issues,

d. Minimizing youth exposure to advertisements for legal addicting substances,

e. Positive mental health messages that counteract tobacco and alcohol advertisements,

f. Strong children's mental health networks throughout the state,

g. Emphasizing pediatric mental health education for all physicians who see children,

h. Adequate numbers and quality of mental health professionals throughout the state,

i. Coordinating with the educational system for mentally healthy schools, and

j. Public and private payment systems that fully integrate mental health care services into primary patient care and provide appropriate payment for mental health services. (CM-CAH Rep. 1-A-01; substituted CM-CAH Rep. 1-A-11).

Related AMA policy: (Partial)

H-145.990 Prevention of Firearm Accidents in Children: Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work

with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975: 1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs. 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. 3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

H-145.997 Firearms as a Public Health Problem in the United States – Injuries and Death: Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:

(1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(5) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(6) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(7) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

H-145.972 Firearms and High-Risk Individuals: Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor

domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

H-145.976 Firearm Safety Counseling in Physician-Led Health Care Teams: 1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education. 2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

H-145.984 Data on Firearm Deaths and Injuries: The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Sources:

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