REPORTS OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

The following reports, 1-2, were presented by Mary Anne McCaffree, MD, Chair:

1. AMA POLICY ON SMOKE-FREE ENVIRONMENTS AND WORKPLACES

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

BACKGROUND

This report proposes updates to a portion of Policy H-490.913, Smoke-Free Environments and Workplaces (AMA Policy Database). Sections 6 and 7 of this policy address smoking in hospitals. Section 6 refers to incorporating a smoke-free environment as a Joint Commission requirement. The Council notes that this has already been accomplished.

Section 7 lays out an elaborate set of principles and rules governing smoking in hospitals in which it has not been banned. The existence of these policy statements prevents our American Medical Association from fully supporting state and local advocacy efforts devoted to creating smoke-free work environments and workplaces and in reducing the health consequences of involuntary exposure to tobacco smoke. The 2006 (29th) report of the Surgeon General provides the most recent comprehensive review of the evidence on the health effects of involuntary exposure to tobacco smoke. Secondhand (or environmental) smoke comprises the (sidestream) smoke released from ignited tobacco products, and the (mainstream) smoke exhaled by smokers. Elimination of Section 7 in Policy H-490.913 would allow our AMA to share a contemporary science-based policy statement on environmental tobacco smoke exposure in order to buttress state-based and other advocacy efforts.

RECOMMENDATION

To facilitate advocacy efforts related to creating smoke-free environments and workplaces, the Council on Science and Public Health recommends that Policy H-490.913 be amended by addition, deletion, and renumbering to read as follows:

H-490.913 Smoke-Free Environments and Workplaces
On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke exposure in the workplace and other public facilities, our AMA:

(1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free campuses for business, labor, education, and government;

(2) (a) honors companies and governmental workplaces that go smoke-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking in public places and businesses, which would include language that would prohibit preemption of stronger local laws.

(3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free schools and eliminating smoking in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking control measures; (b) urges all restaurants, particularly fast food restaurants, and

convenience stores to immediately create a smoke-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, and cigar smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking efforts in the prohibition of smoking in open and closed stadia;

(4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts;

(5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools;

~~(6) supports the development and dissemination of model language to administrators of American hospitals and the membership of the AMA Hospital Medical Staff Section to emphasize and facilitate the importance of a smoke-free hospital environment, and as a matter of high priority, the incorporation of this requirement by the Joint Commission on Accreditation of Healthcare Organizations and the American Hospital Association;~~

~~(7) In hospitals where smoking has not been banned, our AMA encourages hospitals and physicians to support the following guidelines with respect to smoking in hospitals: (a) Physicians should take a leadership role in promoting the development of nonsmoking policies and programs in hospitals; (b) Smoking should be prohibited in areas where oxygen or flammable materials are stored or in use; (c) Smoking should be prohibited in all corridors, elevators, and acute care areas; (d) Bedridden patients should not be permitted to smoke; (e) Smoking on patient floors by visitors, hospital staff, and ambulatory patients should be restricted to designated, well-ventilated areas equipped to meet fire standards; (f) If smoking is permitted in cafeterias, other dining areas, employee lounges, waiting areas, and library facilities, there should be separate sections for smokers and nonsmokers. Where segregation is not feasible, smoking should be prohibited; (g) Smoking should be prohibited in all hospital staff meetings, Board meetings, and conferences (e.g., Grand Rounds); (h) Hospitals should ask all patients prior to or upon admission about their preference for a smoke-free room and should guarantee that preference; (i) Hospitals should seriously consider designating one or more entire floors as completely nonsmoking; (j) No tobacco products should be sold in hospitals or on hospital grounds; (k) Signs should be posted at entrances to the hospital and in all nonsmoking areas to inform patients, staff and visitors where smoking is prohibited. When indicated, the signs should be multilingual or should make use of symbols; (l) Designated smoking areas should not be interpreted as approval of smoking by the institution and its physicians; (m) Hospitals should develop, implement, enforce, and maintain a formal written smoking policy, to be distributed to all staff, visitors, and patients; (n) Either directly or in conjunction with other community agencies, hospitals should make smoking education and cessation programs, literature and other materials available to patients, employees, and the community; (o) Hospitals that restrict or eliminate smoking within the institution should initiate discussions with their fire and casualty insurance carriers to consider reductions in insurance premiums; and (p) Hospital administrators should be aware of all of the hazards of smoking and should take the necessary steps to reduce these hazards. Administrators should utilize appropriate nonsmoking resource materials (e.g., those of the American Hospital Association) in developing policies on nonsmoking;~~

(~~8~~6) will work with the Department of Defense to explore ways to encourage a smoke-free environment in the military through the use of mechanisms such as health education, smoking cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and

(~~9~~7) encourages and supports local and state medical societies and tobacco control coalitions to work with (1) Native American casino and tribal leadership to voluntarily prohibit smoking in their casinos; and (2) legislators and the gaming industry to support the prohibition of smoking in all casinos and gaming venues. (CSA Rep. 3, A-04; Appended: Sub. Res. 426, A-04)

2. UPDATE ON YOUTH AND SCHOOL VIOLENCE

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

BACKGROUND

Resolution 608 (I-06), introduced by the American Association of Public Health Physicians and adopted as amended, asked that our American Medical Association (AMA) continue to study the timely issue of violence in our schools, including youth violence prevention and early identification and intervention, and issue a report back to the House of Delegates. Resolution 610 (A-07), introduced by the American College of Obstetricians and Gynecologists and adopted by the House of Delegates, asked our AMA to renew its commitment to combat family and intimate partner violence and to recognize the importance of violence prevention and education by including the issue in the strategic planning process.

Our AMA and this Council have been significantly involved in examining violence-related issues and in developing educational resources. The AMA Policy Database contains no fewer than 48 separate policies related to violence. Current AMA activities related to violence include a Roadmap for Clinical Practice on Intimate Partner Violence; a Roadmap in preparation on domestic and family violence; and the continued operation of the National Advisory Council on Violence and Abuse, which is staffed by our AMA and comprised of more than 35 state and medical specialty societies and allied health professional groups.

This Council has issued seven reports on violence since 1994 including reports on School Violence in 1999, on Bullying Behaviors Among Children and Adolescents in 2002, and most recently on the Diagnosis and Management of Family Violence in 2005. In 1999, our AMA established the Commission for the Prevention of Youth Violence with funding from the Robert Wood Johnson Foundation to apply the skills, scientific rigor, and insight of medical, nursing, and public health professionals to the issue of youth and school violence. Several medical specialty societies and allied health professional associations were represented on this Commission, which in 2000 released its report, Youth and School Violence, and its recommendations for addressing this problem. Subsequently, several other noteworthy national reports have been issued, including the Surgeon General's report on youth violence; a report from the National Academy of Sciences, "Deadly Lessons: Understanding Lethal School Violence;" and a Presidential report issued by the Department of Health and Human Services on issues raised by the Virginia Tech tragedy. Additionally, the General Accounting Office (GAO) has released its preliminary findings and recommendations on the status of school districts' planning and preparedness for emergency management.

The findings and conclusions of these reports remain relevant, therefore, the Council does not believe a complete reexamination of youth and school violence is either needed or advisable. Rather, the key points of the reports noted above are summarized to establish the current framework for understanding and possibly preventing youth violence and its consequences. Additionally, new findings about the effectiveness of prevention and intervention programs for youth and school violence are briefly reviewed, and some emerging legal issues surrounding school violence are discussed in order to inform a realistic course of action for our AMA. The Council recognizes that the perpetration of violence has significant impacts on victims, including those who observe, or are only present during the incident. School-aged children exposed to violence may exhibit an array of acute as well as chronic symptoms for which mental health interventions may be necessary. Discussion of this issue goes beyond the scope of this report, but the availability of appropriate interventions and resources for victims should not be neglected in addressing issues related to violence.

METHODS

To supplement the literature search from the previous Council reports and the reports noted above, English-language studies on human subjects were selected from a MEDLINE search of the literature from 1999 to August 2007 using the term "violence," in combination with "schools" or "school-based programs," "children," "adolescents," or "prevention." When high-quality systematic reviews and meta-analyses were identified, they formed the basis for evaluative statements about the efficacy of prevention or intervention programs. Additional articles were identified by manual review of the references cited in these publications.

CURRENT UNDERSTANDING OF YOUTH AND SCHOOL VIOLENCE

Based on reports issued by the AMA Commission, the Surgeon General, and the National Academy of Sciences, several general points can be made, and some more recent concerns identified.

Commission for the Prevention of Youth Violence

The report issued by the Commission advocated a public health approach to the prevention of youth violence. That is, youth violence is not inevitable, but a social problem that can be prevented by applying some of the same principles that have reduced the impact of drunk driving, increased the use of seat belts, and reduced tobacco use. By applying community-based methods to identify sources of the problem, and epidemiological data/analyses to identify patterns of risk and protective factors (as well as ongoing surveillance and monitoring to establish trends), community-based interventions can be designed to reduce risk factors and enhance protective factors. The studies reviewed below evaluated and monitored the effectiveness of many of these interventions. Accordingly, it should be possible to share information about effective and ineffective programs to educate the public and allow for the more widespread adoption of model programs.

Critical influences on youth violence can be divided into individual influences (particularly preexisting emotional, cognitive, and developmental, and/or psychosocial problems), environmental influences (family, friends, school and neighborhood), and societal influences (media and public policy). Key risk factors include alcohol and other drug use, maltreatment as a child, active gang affiliation, easy access to firearms, and exposure to violence among intimates and peers and in the media. Various warning signs may be apparent.

Protective factors, including intact family structures, positive peer groups, and supportive communities, can buffer the effects of violence. These protective factors (or assets) may be external, focusing on support, empowerment, and the setting of boundaries and constructive use of time, or they may be internal and involved with establishing a commitment to learning or positive values, and developing social competencies and a positive identity.

Preventive interventions can be primary, directed to an entire population; secondary, involving and serving specific populations at risk for violence; or tertiary, wherein treatment is aimed at youth who have already demonstrated problem behaviors. The Commission report also identified several model intervention programs, and the key attributes of successful programs.

Finally, several priorities for preventing youth violence were offered by the Commission including: 1) support the development of healthy families; 2) promote healthy communities; 3) enhance services for early identification and intervention for children, youth, and families at risk for or involved in violence; 4) increase access to health and mental health services; 5) reduce access to and risk from firearms for children and youth; 6) reduce exposure to media violence; and 7) ensure national support and advocacy for solutions to violence through research, public policy, legislation, and funding. Each priority includes several action steps, and recommendations/action steps are offered separately for health professionals, schools, business and civic leaders, law enforcement and criminal justice, media, families, faith-based organizations, legislators, and youth themselves.[1]

Youth Violence: A Report of the Surgeon General

The impetus for the Surgeon General's report was the Columbine tragedy. The report examined the scope of youth and school violence, its possible causes, and how to prevent it among school-aged children (through high school). The report views violence from a developmental perspective and examines how youth's personal characteristics interact over time with the social contexts in which they live. The report concludes that two main trajectories or pathways to youth violence can be identified, with violent behavior developing either before or after puberty. Early-onset youth violence shows strong links between childhood factors and an eventual persistent involvement in violent behaviors; therefore, early childhood programs may be more critical for preventing the onset of a chronic, violent lifestyle.

As with the Commission's report, the Surgeon General advocates a public health approach to the problem of youth violence by defining the problem; using epidemiological analyses that identify associated risk and protective factors; designing, developing, and evaluating the effectiveness and generalizability of interventions; and disseminating successful models as part of a coordinated effort to educate and engage the public. Similarly, personal characteristics and environmental conditions that either place children or adolescents at risk of violent behavior or that seem to

protect them from the effects of risk were examined in this report. As noted above, the strongest risk factors involve the family and peer influences.

Although less is known about the genesis of later-onset violence, research demonstrates that prevention programs and strategies can be effective against both early- and late-onset forms of violence in general populations of youths, high-risk youths, and even youths who are already violent or seriously delinquent (see below). Nevertheless, many programs are ineffective, and some may cause harm. Effective intervention and prevention programs combine approaches to address individual risks, as well as environmental conditions. School programs that seek to change social context, and not individual attitudes, skills, and risk behaviors, may be more effective. Interventions designed to specifically address gangs and delinquent peer influences are notably lacking.[2]

PREVENTION AND INTERVENTIONS FOR SCHOOL AND YOUTH VIOLENCE

An array of intervention programs with well-documented effectiveness are now in place to reduce and prevent school and youth violence. Multiple studies have identified and examined specific risk factors and the personal and environmental features of young people's lives that increase the probability of violence, as well as the protective factors that appear to buffer the effects of violence. Recent systematic reviews highlight the existence of effective school-based prevention programs and interventions in preventing violent behavior in youth.

School Violence

In 2007, a systematic review was conducted by the Task Force on Community Preventive Services to assess the effectiveness of universal school-based programs in preventing violent behavior.[3] This review focused on school-based programs that assessed violent outcomes or proxies for violent outcomes. Universal programs[4] were defined as those delivered to all children in a given school or grade, not only to those who had already manifested violent or aggressive behavior or risk factors for these behaviors. Pre-kindergarten, elementary, middle, junior high, and senior high schools were included. Fifty-three studies met the inclusion criteria. For all grades combined, the median effect of universal school-based programs was a 15% reduction in violent behavior among students who participated in the program. The relative reduction rates in violent behavior were as follows: 32.4% pre-kindergarten; 18% elementary; 7.3% middle school; and 29.2% high school. All school antiviolence program strategies (eg, informational, cognitive/affective, and social skills building) were associated with a reduction in violent behavior. All program foci (eg, disruptive or antisocial behavior, bullying, or dating violence) similarly were associated with reduced violent behavior. With the exception of programs administered by school administrators or counselors, a reduction in violent behavior was reported in programs administered by all personnel, including students and peers.

In 2006, a systematic review examined the effectiveness of school-based secondary prevention programs for children identified as aggressive or at risk of being aggressive. Fifty-six studies met the inclusion criteria, which included requirements that participants be comprised of children in mandatory education identified as exhibiting, or at risk of, aggressive behavior and that school-based interventions be designed to reduce aggression, violence, bullying, conflict, or anger. In 34 of the 56 trials identified, aggressive behavior was significantly reduced in intervention groups compared to no-intervention groups. In seven studies a 12-month follow-up was conducted and reported that reduction in aggressive behavior was maintained. Subgroup analyses suggested that interventions designed to improve relationship or social skills may be more effective than interventions designed to teach skills of non-response to provocative situations. However, the benefits were similar when delivered to children in primary versus secondary school, and to groups of mixed sex versus boys alone. In conclusion, school-based secondary prevention programs to reduce aggressive behavior appear to produce improvements in behavior greater than would have been expected by chance.[5]

Youth Violence

In 2004, the National Institutes of Health held a State-of-the-Science Conference to examine and assess adolescent violence and related health-risking social behavior and to identify directions for future research. One of the key objectives was identification of the commonalities that exist among effective interventions.[6] These commonalities are as follows: they are derived from sound theoretical rationales; they address strong risk factors; they involve long-term treatments, often lasting a year and sometimes much longer; they work intensively with those targeted for treatment and often use a clinical approach; they follow a cognitive/behavioral strategy; they are multimodal and multicontextual; they focus on improving social competency and other skill development strategies for targeted youth and/or their families; they are developmentally appropriate; they are not delivered in coercive institutional settings; and they have a realistic expectation of implementing the program as designed. Unsuccessful programs

include those that aggregate high-risk youth in ways that facilitate contagion, fail to clearly articulate implementation protocols, have staff that are not well-supervised or held accountable for outcomes, and are limited to scare tactics or “toughness” strategies.

In 2007, a systematic review was conducted to identify effective interventions for preventing violent youth behavior and the commonalities of effective and ineffective interventions. Primary, secondary, and tertiary interventions were examined. Of the 41 studies evaluated, 49% were found to be effective, meaning one or more violence outcome indicator(s) was reported as significantly different at the p<0.05 level. Overall, interventions were more effective as the level of intervention increased from primary to tertiary. Programs effective at the primary level included “Responding in Peaceful and Positive Ways” (a skills-building and conflict resolution program) and the “Aban Aya Youth Project” (school development curriculum and school/community intervention). The “Moving to Opportunity” project (moving families from high to lower poverty neighborhoods), the “Early Community-Based Intervention Program” (prevention of substance abuse and other delinquent behaviors), and the “Child Haven’s Therapeutic Child-Care Program” (for abused, neglected, and at-risk infants and toddlers and their parents) were determined to be effective secondary intervention programs. The “Turning Point: Rethinking Violence” program (to educate male first-time violent crime offenders and their parents about the consequences of violence) and the “multisystematic therapy program” (for juvenile offenders meeting *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-IIIR criteria for substance abuse and dependence) were found to be effective tertiary intervention programs.[7] This study could not determine differences among programs and within subpopulations due to inadequate data.

LETHAL SCHOOL VIOLENCE

Between 1992 and 2001, 35 incidents occurred in which students came to their school or a school-sponsored event with firearms, resulting in 35 dead and 144 injured.[8] Between 2002 and 2007 (prior to the Virginia Tech tragedy), another 8 incidents occurred involving students at U.S. schools, leaving at least 12 dead. Other high profile cases occurred in Canada, Germany, and Argentina during this period, as did other incidents at U.S. schools involving adult perpetrators. These incidents created long-lasting harm and trauma to individuals and the communities involved.

In examining “case histories” of events that occurred between 1992 and 2001, the Committee to Study Youth Violence within the National Academy of Sciences developed some hypotheses on the antecedents of school violence in urban, suburban, and rural schools, and on the prospects for prevention of such behavior. First, the genesis of lethal school violence differs between the inner city and suburban/rural districts. Inner city school violence has not been marked by the “rampages” exhibited in suburban or rural settings. Rather, it is an extension of gun violence in the neighborhood, fueled by poverty, racial segregation, and illicit drug trafficking. It usually is based on specific grievances among individuals, although innocent bystanders may be harmed. In suburban and rural communities, grievances are more general, abstract, and aggravated, leading to rampage violence. Many risk factors have been identified in the gunmen, but protective factors also have been present in many cases.[9]

School and community environments certainly play a role, as does easy access to firearms. In urban/inner city schools, social disruptions are paramount, whereas in suburban schools, the existence of numerous informal and exclusive student groups in which membership determines social status, coupled with an unappreciated gulf between the community’s youth culture and adults, was more important. Nevertheless, the Committee concluded that it is virtually impossible to identify likely offenders in advance and no foolproof (or even accurate) way exists to develop a profile and predict which students at high risk will commit these kinds of acts. Areas for further research include the need to better understand the factors that might influence school shootings, including precursors (ie, nonlethal violence and bullying); signs and symptoms of developing mental health problems in grades 6-10; and the effects of rapid change in increasingly affluent rural and suburban communities on youth development, socialization, and violence. The Committee also called for more studies to assess security measures and police response to school emergencies.

EMERGENCY MANAGEMENT PLANS

The recent Virginia Tech tragedy has reinvigorated discussion on lethal school violence and its antecedents, and led to a reexamination of the challenges encountered in planning for emergencies, coordinating responses, and communicating with parents and students, as well as the various legal issues that complicate prevention of lethal school violence, particularly in the college environment. The GAO recently completed a preliminary review of the emergency management plans of school districts. In this context, planning for response to lethal school violence is part of an all-hazards approach to emergency management. While no federal laws require school districts to have

emergency management plans, at least 32 states currently have laws or policies requiring school districts to have such plans.[10] An estimated 95% of all school districts have emergency management plans in place and most districts practice their emergency management plans annually within the school community. However, more than 25% have never trained with first responders and more than two-thirds do not regularly train with community partners. Other challenges include lack of equipment, training for staff, personnel with expertise in emergency planning, partnerships, time, and funding. Ensuring that parents receive consistent information during an emergency is also of concern to school officials.

Privacy Laws and Policies

In the wake of the Virginia Tech tragedy, the need to balance the fundamental interests of individual freedoms, privacy and confidentiality, safety and security of students, and assisting those with mental health needs to receive appropriate care became apparent. The key findings in a report commissioned by President Bush following this tragedy were as follows: 1) Critical information sharing faces substantial obstacles; 2) accurate and complete information on individuals prohibited from possessing firearms is essential to keep guns out of the wrong hands; 3) improved awareness and communication are key to prevention; 4) it is critical to ensure that people with mental illness receive the services they need; and 5) "where we know what to do, we have to be better at doing it."

One of the substantial obstacles in critical information sharing is differing interpretations regarding legal restrictions on the ability to share information about persons who may be a threat to themselves or others.[11] On the federal level, the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) affect information sharing. However, state laws and regulations, which may be more restrictive than federal laws, also impact information sharing at the state level.

FERPA was designed to protect the privacy of student educational records. The law applies to all schools that receive funds under applicable U.S. Department of Education (DOE) programs. A recent DOE Memo clarifies that under FERPA, schools may release any and all information to parents, without the consent of the eligible student, if the eligible student is a dependent for tax purposes under Internal Revenue Service rules. FERPA also permits schools to disclose information from educational records to parents if a health or safety emergency involves their son or daughter. Additionally, schools may disclose information from "law enforcement unit records" to anyone, including parents and federal, state, or local law enforcement agencies, without the consent of the student.

While FERPA applies to educational records, HIPAA applies to medical records, specifically all information, written or oral, gained in the course of treatment. However, records maintained by campus health clinics are considered educational records "because they directly relate to a student and are maintained by the institution or by a party acting for the institution"; therefore, they are covered under FERPA rather than HIPAA.[12] Disclosures are permitted under HIPAA in certain situations, including when a person presents an imminent threat to the health and safety of individuals and the public.[13] The report of the Virginia Tech Review Panel highlighted the confusion about the application of FERPA to treatment records from university clinics and suggested that the law be amended to provide clarification.[14]

Access to Firearms

The report of the Virginia Tech Review Panel also highlighted the fact that Cho Seung-Hui, the Virginia Tech shooter, was able to purchase handguns despite not being legally authorized to do so. Under the federal Firearm Owners' Protection Act, which amended the Gun Control Act of 1968, a person who has been adjudicated as "a mental defective or who has been committed to a mental institution" is disqualified from purchasing a gun in the United States.[15] "Adjudicated as a mental defective" is defined to include those instances where a court, board, commission, or other lawful authority has determined that as a result of mental illness a person is a "danger to himself or to others."[16] In 2005, Cho was found to be a danger to himself by a special justice of the Montgomery County General District Court. However, this information was not forwarded to federal authorities and therefore was not in the federal National Instant Check System (NICS). State laws differ from federal laws in defining who is disqualified from purchasing firearms. However, purchasers need to be eligible under both state and federal law. The Review Panel recommended that all states report information required to conduct federal background checks on gun purchases. However, consensus is lacking on the types of mental health data that should be reported for inclusion in gun background check databases.

SUMMARY AND CONCLUSION

As the many reports and studies summarized above suggest, schools are making progress in violence prevention. Many schools have already adopted emergency management and violence prevention plans; however, these plans need to be fully implemented and practiced. The Virginia Tech tragedy has also brought several legal and policy issues to the forefront. Privacy laws need to be further clarified to ensure that critical information is shared. In addition, state and federal laws related to the reporting of mental health data for gun background checks must be enforced.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statement be adopted and that the remainder of this report be filed:

> That our American Medical Association re-examine its role in implementing current AMA policies related to violence prevention, and include such issues in a strategic issue paper.

REFERENCES

1. Commission for the Prevention of Youth Violence. Violence Prevention: Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence. Chicago: American Medical Association; 2000.
2. U. S. Department of Health and Human Services Youth Violence: A Report of the Surgeon General – Executive Summary. Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; and National Institutes of Health, National Institute of Mental Health; 2001.
3. Hahn R, et al. Effectiveness of universal school-based programs to prevent violent and aggressive behavior. Am J Prev Med. 2007;33(2S).
4. Hahn R, et al. 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. MMWR. 2007;56(RR07);1-12.
5. Mytton J, DiGuiseppi C, Gough D, Taylor R, Logan S. School-based secondary prevention programmes for preventing violence. Cochrane Database Syst Rev. 2006(Jul 19);3:CD004606.
6. National Institutes of Health, State-of-the-Science Conference Statement: Preventing Violence and Related Health-Risking Social Behaviors in Adolescents; October 13-15, 2004.
7. Limbos MA, Chan LS, Warf C, et al. Effectiveness of interventions to prevent youth violence: a systematic review. Am J Prev Med. 2007;33;65-74.
8. Moore MH, Petrie CV, Braga AA, McLaughlin BL. Deadly Lessons: Understanding Lethal School Violence. Washington, DC: National Research Council; 2002.
9. Ibid.
10. General Accounting Office. Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance; June 2007.
11. Report to the President on Issues Raised by the Virginia Tech Tragedy, June 13, 2007. Available at http://www.hhs.gov/vtreport.pdf.
12. Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Melanie P. Baise, Associate University Counsel, The University of New Mexico, date November 29, 2004.
13. 45 C.F.R.§ 164.512(j)
14. Mass Shootings at Virginia Tech: Report of the Review Panel Presented to Governor Kaine, Commonwealth of Virginia; August, 2007.
15. 18 U.S.C. § 922(g)(4)
16. 27 C.F.R. § 478.11