AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (J21 Special Meeting)

Report of Reference Committee E

Shane Hopkins, MD, Chair

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1 Your Reference Committee recommends the following consent calendar for acceptance:
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3 **RECOMMENDED FOR ADOPTION AS AMENDED**
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5 1. Council on Science and Public Health Report 2 – Use of Drugs to Chemically
6 Restrain Agitated Individuals Outside of Hospital Settings
7
8 2. Resolution 503 – Access to Evidence-Based Addiction Treatment in Correctional
9 Facilities*
10
11 *For Resolution 503, the double underline and double strikethrough that are
12 traditional format for indicating amendments from the Reference Committee are
13 difficult to discern. Therefore, the Reference Committee has also highlighted these
14 additions in yellow.

Amendments
If you wish to propose an amendment to an item of business, click here: Submit New Amendment
15

RECOMMENDED FOR ADOPTION AS AMENDED

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – USE OF DRUGS TO CHEMICALLY RESTRAIN AGITATED INDIVIDUALS OUTSIDE OF HOSPITAL SETTINGS

RECOMMENDATION A:

Recommendation 1 in Council on Science and Public Health Report 2 be amended by addition and deletion to read as follows:

1. That the following new AMA policy be adopted:
~~Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings~~
Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting
Our American Medical Association:

1. **Believes that current evidence does not support "excited delirium" or "excited delirium syndrome" as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated;**
2. **Recognizes that the treatment of medical emergency conditions outside of a hospital is usually done by a subset of healthcare practitioners who are trained and have expertise as emergency medical service (EMS) practitioners. It is vital that EMS practitioners and systems are overseen by physicians who have specific experience and expertise in providing EMS medical direction.**
3. **Is concerned about law enforcement officer use of force accompanying "excited delirium" that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces "excited delirium" solely as a justification for the use of force by law enforcement officers.**
4. **Opposes the use of sedative/hypnotic and dissociative agents, including ketamine, as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done ~~to chemically restrain an individual~~ solely for a law enforcement purpose and not for a legitimate medical reason;**

5. **Recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals ~~drugs for chemical restraint~~ used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of age, underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;**
6. **Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:**
   a. **Investigate any cases labeled as "excited delirium" for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;**
   b. **Evaluate the prevalence of ketamine use in the field in unmonitored individuals;**
   c. **Assess that comprehensive training and guidelines, including continuous quality improvement processes, have been properly established by supervising EMS medical directors and behavioral health specialists, to:**
      i. **Require appropriate monitoring of any patient who receives sedative/hypnotic and dissociative pharmacological interventions for treatment in the out-of-hospital setting;**
      ii. **Ensure proper use of ketamine and other sedative/hypnotic and dissociative pharmacological interventions under defined protocols/guidelines after appropriate education on indications, usage and complications;**
      iii. **Include an appropriate stepwise approach to the treatment of patients in the out-of-hospital setting, including de-escalation training, that provides safety to the patient and providers;**
   d. **Ensure that appropriate financial support by local and/or state agencies for training and reporting is available; and**

e. ~~are appropriate, and include de-escalation training; and~~

f. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training ~~to ensure patient safety~~;

7. Urges law enforcement and frontline emergency medical service personnel, who are a part of the "dual response" in emergency situations, to participate in appropriate training ~~that~~, overseen by EMS medical directors. The training should minimally include~~s~~ de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals in the out-of-hospital setting ~~drugs used to restrain individuals~~; and

8. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of- ~~a non~~-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way. (New HOD Policy)

RECOMMENDATION B:

The recommendations in Council on Science and Public Health Report 2 be adopted as amended and the remainder of the report be filed.

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

1. That the following new AMA policy be adopted:

   Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings

   Our American Medical Association:

   1. Believes that current evidence does not support "excited delirium" or "excited delirium syndrome" as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated;
   2. Is concerned about law enforcement officer use of force accompanying "excited delirium" that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces "excited delirium" solely as a justification for the use of force by law enforcement officers.
   3. Opposes the use of sedative/hypnotic agents, including ketamine, to chemically restrain an individual solely for a law enforcement purpose;
   4. Recognizes that drugs for chemical restraint used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;

   5. Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:
      a. Investigate any cases labeled as “excited delirium” for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;
      b. Evaluate the prevalence of ketamine use in the field in unmonitored individuals;
      c. Assess that training and guidelines have been properly established by supervising medical and behavioral health specialists, are appropriate, and include de-escalation training; and
      d. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training to ensure patient safety; and
   6. Urges law enforcement and emergency medical service personnel to participate in appropriate training that minimally includes de-escalation techniques and the appropriate use of drugs used to restrain individuals; and
   7. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in a non-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way. (New HOD Policy)

2. That Policy H-65.954, “Policing Reform,” which recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color, notes AMA’s willingness to work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers, states that AMA will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures, and will advocate for legislation and regulations which promote trauma-informed, community-based safety practices, be reaffirmed. (Reaffirm Current AMA Policy)

3. That Policy H-345.972, “Mental Health Crisis Interventions,” which supports jail diversion and community based treatment options for mental illness, implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs, federal funding to encourage increased community and law enforcement participation in crisis intervention training programs, and legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities, be reaffirmed. (Reaffirm Current AMA Policy)

Your Reference Committee heard passionate testimony about CSAPH Report 2. Many who testified applauded the evidence-based review of the controversial topic and are proud that the AMA has taken a stance on this issue which is a representation of systemic racism in medicine. Several commentors noted that delirium is very much an acute psychiatric condition as clearly defined in the DSM-5 and its specifiers do not include “excited;” this unfortunate term has been misapplied to individuals who are agitated in the community for a multitude of

1 reasons. Many commenters agreed that it is concerning that it disproportionately impacts
2 individuals of color, for whom inappropriate and excessive pharmacotherapy continues to be
3 the norm instead of behavioral de-escalation.
4
5 Several commentors were emergency physicians and EMS medical directors and expressed
6 concerns about the report recommendations. Notably that the proposed recommendations did
7 not adequately capture a physician-led approach for emergency response for individuals
8 experiencing delirium. In addition, concerns were raised that physicians and law enforcement
9 were being requested to undergo similar training regimens that may not be appropriate for
10 their roles. In rebuttal, other commentors noted that emergency response typically utilizes a
11 “dual response” method of law enforcement and first responders, indicating that a combined
12 or complimentary training approach may be appropriate. Further concerns were raised about
13 the oversight authority for investigating potential cases in which inappropriate
14 pharmacological intervention was suspected. CSAPH believes that independent investigators
15 were appropriate, whereas members of the emergency medicine community believe that EMS
16 Medical Directors should lead any authority, with a supporting consortium providing guidance.
17 Finally, many emergency medicine practitioners commented that they disagree with their
18 colleagues and believe that “excited delirium” is an appropriate diagnosis and one commentor
19 noted that they worry there could be legal ramifications if the diagnosis is deemed invalid.
20 Your Reference Committee agrees with the majority of testimony that current evidence does
21 not support “excited delirium” as a diagnosis.
22
23 Several amendments to the CSAPH recommendations were offered. CSAPH noted in
24 testimony that they appreciate the input and amendments proffered by our emergency
25 medicine colleagues and concur with many of the amendments, including the title change
26 which aligns with the Joint Commission preferred verbiage, the use of the term
27 pharmacological intervention, the addition of age as a risk factor, and a newly added
28 recommendation which highlights and recognizes the important work of EMS Medical Director
29 physician colleagues and reiterates long standing policy of physician oversight, supervision,
30 and leadership of the health care team, in all forms of settings including the out of the hospital
31 setting. CSAPH, however, prefers the language of their original report recommendations for
32 other items, as they think it hems closer to the findings in the body of the report and maintains
33 its initial focus on the topic that the BOT asked them to review.
34
35 Your Reference Committee agrees with the perspective that independent oversight is
36 important to evaluate this issue, but also understand the need for physician oversight of
37 frontline EMS personnel. Therefore, your Reference Committee recommends that Council on
38 Science and Public Health Report 2 be adopted as amended.

(2) RESOLUTION 503 – ACCESS TO EVIDENCE-BASED ADDICTION TREATMENT IN CORRECTIONAL FACILITIES

RECOMMENDATION A:

The first Resolve of Resolution 503 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend policy H-430.987, "Opiate Replacement Therapy Programs in Correctional Facilities," by addition and deletion to read as follows:
~~Opiate Replacement Therapy Programs~~ Medications for Opioid Use Disorder in Correctional Facilities H-430.987
1. Our AMA endorses: (a) the medical treatment model of employing ~~opiate replacement therapy (ORT)~~ medications for opioid use disorder (OUD) as ~~an effective therapy in treating opiate-addicted~~ the standard of care for persons with OUD who are incarcerated; and (b) ~~ORT for opiate-addicted~~ medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to, ~~the National Commission on Correctional Health Care and~~ the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that ~~encourage~~ require correctional facilities to increase access to evidence-based treatment of OUD ~~opioid use disorder~~, including initiation and continuation of ~~opioid replacement therapy~~ medications for OUD, in conjunction with ~~counseling~~ psychosocial treatment when available and desired by the person with OUD, in correctional facilities within the United States and that this apply to all ~~incarcerated~~ individuals who are incarcerated, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting.
3. Our AMA ~~supports~~ advocates for legislation, standards, policies, and funding that ~~encourage~~ require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD ~~opioid use disorder~~, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or

any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment ~~including medications for addiction treatment~~ ~~medication assisted therapy~~.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

(Modify Current HOD Policy)

RECOMMENDATION B:

The second Resolve of Resolution 503 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy H-430.986, "Health Care While Incarcerated," by addition and deletion to read as follows:

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA ~~supports~~ advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA ~~encourages~~ advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal ~~justice~~ legal system and throughout the incarceration

process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA ~~urges~~ advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.~~, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.~~

7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.

8.~~7~~. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of ~~incarcerated~~ women and adolescent females who are incarcerated, including gynecological care and obstetrics care for ~~pregnant and postpartum~~ ~~women~~ individuals who are pregnant or postpartum.

9.~~8~~. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both ~~inmates~~ individuals who are incarcerated and staff in correctional facilities.

10.~~9~~. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance ~~ab~~use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

11. Our American Medical Association advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention (Directive to Take Action).

12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities (Directive to Take Action).
(Modify Current HOD Policy)

RECOMMENDATION C:

Resolution 503 be adopted as amended.

RESOLVED, That our American Medical Association amend policy H-430.987, "Opiate Replacement Therapy Programs in Correctional Facilities," by addition and deletion to read as follows:

~~Opiate Replacement Therapy Programs~~ Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing ~~opiate replacement therapy (ORT)~~ medications for opioid use disorder (OUD) as ~~an effective therapy in treating opiate-addicted~~ the standard of care for persons with OUD who are incarcerated; and (b) ~~ORT for opiate-addicted~~ medications for persons with OUD who are incarcerated, an endorsement in collaboration with ~~the National Commission on Correctional Health Care and~~ the American Society of Addiction Medicine.
2. Our AMA advocates for legislation, standards, policies and funding that ~~encourage~~ require correctional facilities to increase access to evidence-based treatment of OUD ~~opioid use disorder~~, including initiation and continuation of ~~opioid replacement therapy~~ medications for OUD, in conjunction with ~~counseling~~ psychosocial treatment when available and desired by the person with OUD, in correctional facilities within the United States and that this apply to all ~~incarcerated~~ individuals who are incarcerated, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting.
3. Our AMA ~~supports~~ advocates for legislation, standards, policies, and funding that ~~encourage~~ require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD ~~opioid use disorder~~, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, including medications for addiction treatment ~~medication assisted therapy~~.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-430.986, "Health Care While Incarcerated," by addition and deletion to read as follows:

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA ~~encourages~~ advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal ~~justice~~ legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA ~~urges~~ advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.~~, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.~~
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8.~~7~~. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of ~~incarcerated~~ women and adolescent females who are incarcerated, including gynecological care and obstetrics care for ~~pregnant and postpartum women~~ individuals who are pregnant or postpartum.
9.~~8~~. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both ~~inmates~~ individuals who are incarcerated and staff in correctional facilities.
10.~~9~~. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (Modify Current HOD Policy)

Your Reference Committee heard testimony unanimously supportive of this Resolution. Several amendments were proposed to clarify some of the language in the policy and these amendments were roundly supported. An amendment was proposed to expand the policy to cover individuals held in pre-trial detention and to advocate for the prohibition of co-pays in correctional facilities. No testimony was opposed to the amendments offered. Your Reference Committee notes that while the title of this resolution would suggest these additional amendments would be limited to substance use disorder treatment, the proposed resolution is amending current AMA policy that affects all medical treatment within a correctional facility. Your Reference Committee agrees with testimony that this Resolution provides important updates for AMA policy and therefore, recommends that Resolution 503 be adopted as amended.

1 Doctor Speaker, this concludes the report of Reference Committee E. I would like to thank,
2 Michael A. DellaVecchia, MD, PhD, Farid Ghamsari, William S. Pease, MD, David A. Stumpf,
3 MD, Charles W. Van Way, III, MD, Anna Yap, MD, and all those who testified before the
4 Committee as well as our AMA staff.

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