AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-24)

Introduced by: California

Subject: Restorative Justice for the Treatment of Substance Use Disorders

Referred to: Reference Committee B

Whereas, Restorative Justice (RJ) is a correctional model featuring relationship building, rehabilitation, and community empowerment. Examples of Restorative Justice models include Restorative Community Conferencing (RCC) and Drug Treatment Courts, which have reduced recidivism, cut costs (one RCC estimates a cost savings of $18,500 per case per year), and promoted familial connectedness, particularly among people of color; and

Whereas, police brutality, racist sentencing practices, and implicit biases that created health inequities have contributed to the US having the highest incarceration rate in the world, with one in three black men currently incarcerated; and

Whereas, the “war on drugs” prioritized punishment over treatment for non-violent drug offenses, leading to an eight-fold increase in incarceration to 400,000 people by 1997. The Anti-Drug Abuse Act diverted $1.7 billion away from education, drug treatment, and research towards law enforcement and now the U.S. spends $12 billion annually on the war on drugs; and

Whereas, during the crack cocaine epidemic of the mid 1980s where there were an estimated 1.6 million users, the black community was devastated because of an inequitable response by law enforcement and mass incarceration due to racist sentencing practices, such as unequal mandatory minimum sentences for crack cocaine - as 80% of crack users were black (due to its affordability) as compared to more expensive powdered cocaine used preferentially by white users; and

Whereas, injected powdered cocaine delivers a fast, intense high similar to crack, and has been found to have the highest risk of overdose and death; and

Whereas, the U.S. Sentencing Commission reported in 1995 that 52% of all crack users were white and 38% were black. However, only 4.1% of those sentenced for crack offenses were White and 88% were Black. Prisoners have a higher rate of suicide, self harm, violence, HIV, and other infectious diseases and public health experts recommend that substance abuse impacts are best addressed through community resources such as family counseling, and mental health programs; and

Whereas, black patients are less likely to receive pain medication and decreasing opiate prescriptions increases the use of fentanyl and heroin. Conversely, increasing services such as medication-assisted addiction treatment, needle exchange, naloxone availability, and psychosocial treatment improve outcomes; and

Whereas, the U.S. Office of National Drug Control Policy estimated that in 1996, 3.6 million people required medical treatment for their addiction, but only one million were receiving

treatment because 19% of the $13.5 billion budget was dedicated to drug treatment as compared to 58% for criminal justice and thus, the crack cocaine epidemic caused a multitude of negative health outcomes including a four-fold increase in emergency room visits, as well as a significant increase in Sexually Transmitted Diseases; and

Whereas, some minor steps in line with “Restorative Justice” have been taken, such as The Fair Sentencing Act of 2010 and The First Step Act of 2018 which applied the Fair Sentencing Act retroactively, and reduced the sentencing disparity from 100:1 to 18:1; and

Whereas, by contrast, the opioid epidemic, which has predominantly affected white individuals, has been combatted using a “Disease Model” featuring a reduction in stigmatizing language, the expenditure of $59 million by the U.S. Department of Justice for community health interventions, and sentencing individuals to rehabilitation as opposed to incarceration; and

Whereas, in 2019 alone, the Centers for Disease Control and Prevention (CDC) granted $475 million for opioid overdose prevention and has (1) funded research to identify effective strategies for combating the epidemic, (2) worked with health departments and community-based organizations to implement evidence-based prevention strategies, (3) created an evidence-based “CDC Guideline for Prescribing Opioids for Chronic Pain” and implemented quality-improvement measures, (4) created the “Rx Awareness” campaign to educate users on the risks of opioid use, and (5) partnered with first responders, including police, with an emphasis on saving lives through naloxone administration rather than incarceration; and
Whereas, approaches, such as the CDC models for the opioid epidemic, are examples of the application of the Restorative Justice model and can be applied retroactively to those negatively impacted by the crack cocaine epidemic; therefore be it

RESOLVED, that our American Medical Association (1) continues to support the right of incarcerated individuals to receive appropriate care for substance use disorders, (2) supports providing incentives for incarcerated individuals to overcome substance use disorders, such as participation in treatment as a condition for early release, and (3) supports providing access to social services and family therapy during and after incarceration (New HOD Policy); and be it further

RESOLVED, that our AMA (1) recognizes that criminalization of substance use disproportionately impacts minoritized and disadvantaged communities due to structural racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports implicit bias and antiracism training for medical professionals working in correctional facilities. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/23/2024

RELEVANT AMA POLICY

H-95.931 AMA Support for Justice Reinvestment Initiatives
Our American Medical Association supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs. [Reaffirmed: CSAPH Rep. 4, I-23, Res. 205, A-16.]

H-430.986 Health Care While Incarcerated

1. Our American Medical Association 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 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, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages 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 advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA 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.
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. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. 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 individuals who are incarcerated and staff in correctional facilities.
10. 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 use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding;
    b. the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community;
    c. the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and
    d. collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

11. Our AMA 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.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:
    a. MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting;
    b. knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; and
    c. knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles

[Appended: Res. 429, A-23; Appended: Res. 244, A-23; Modified: Res. 127, A-22; Reaffirmed: Res. 229, A-21; Modified: Res. 503, A-21; Modified: Res. 216, I-19; Appended: Res 420, A-19; Appended: Res. 417, A-19; CMS Rep. 02, I-16.]

H-430.997 Standards of Care for Inmates of Correctional Facilities
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
[Modified: CSAPH Rep. 1, A-22; Reaffirmation: I-12; Modified in lieu of Res. 502, A-12; Reaffirmation I-09; Reaffirmed: CEJA Rep. 8, A-09; Amended: Res. 416, I-99; Reaffirmed by CLRPD Rep. 3 – I-94; Res 60, A-84.]

H-95.922 Substance Use and Substance Use Disorders
Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
[Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: BOT Rep. 14, I-20; CSAPH Rep. 01, A-18]

H-95.975 Substance Use Disorders as a Public Health Hazard
Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance use disorders are a public health priority;
(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;

(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.
[Reaffirmed: CSAPH Rep. 01, A-19; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Sunset Rep., I-99; Appended: Sub. Res. 401; Res. 7, I-89.]

D-95.962 Enhanced Funding for and Access to Outpatient Addiction Rehabilitation
Our AMA will advocate for: (1) the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state's adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition; and (2) sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations. [BOT Rep. 14, I-20]

H-430.987 Medications for Opioid Use Disorder in Correctional Facilities
1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that 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 individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, 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.
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.
[Modified: Res. 503, A-21; Appended: Res. 223, I-17; Reaffirmed: CSAPH Rep. 1, A-15; Res. 443, A-05.]

D-405.970 Racism - A Threat to Public Health
Our American Medical Association advocates for the creation of an International Classification of Diseases (ICD) code for patients presenting with conditions related to experiencing racism (including systemic racism and unconscious bias), a code that will provide physicians with a tool to document the clinical impact of racism, and capture the data needed to help provide more effective patient care.
[Modified: Res. 503, A-21; Appended: Res. 223, I-17; Reaffirmed: CSAPH Rep. 1, A-15; Res. 443, A-05]

H-65.952 Racism as a Public Health Threat
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
[Modified: Speakers Rep., A-22; Reaffirmed: Res. 013, A-22; Res. 5, I-20]

H-65.943 Redressing the Harms of Misusing Race in Medicine
1. Our American Medical Association recognizes the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field.
2. Our AMA will revise the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine.
3. Our AMA advocates for and promotes racism-conscious, reparative, community engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine.
[Modified: Speakers Rep., A-22, Reaffirmed: Res. 013, A-22, Res. 5, I-20.]