

# THE BEYOND DO NO HARM PRINCIPLES

*Health care providers, staff, public health workers, and researchers recommit to caring for people by refusing to participate in criminalization*

IC INTERRUPTING  
CRIMINALIZATION

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This document was developed by a group of health care providers, public health workers, impacted community members, and organizers working across racial, gender, reproductive, migrant and disability justice, drug policy, sex worker, and anti-HIV criminalization movements to inspire a recommitment to the ethical values of health care provision and principles of public health.

We understand criminalization<sup>1</sup> to be inherently harmful. Acts by health care providers and public health workers that facilitate, contribute to, condone or otherwise enable criminalization are therefore inconsistent with our commitment to our highest ethical obligations - do no harm.

Below we contextualize the need for this call to action, describe how people in health care and public health spaces participate in criminalization, and offer thirteen principles for supporting people's agency, self-determination, dignity, and general wellbeing.<sup>2</sup>

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1 Criminalization is the social and political process by which society determines which actions or behaviors—and by who—will be punished by the state. At the most basic level, it involves passage and enforcement of criminal laws. While framed as neutral, decisions about what kinds of conduct to punish, how, and how much are very much a choice, guided by existing structures of economic and social inequality based on race, gender, sexuality, disability, and poverty, among others." - From *The Crisis of Criminalization*, by Andrea J. Ritchie and Beth Richie. Criminalization functions "in service of maintaining and reinforcing existing relations of power." - From *No More Police*, by Mariame Kaba and Andrea J. Ritchie.

2 These principles are grounded in existing ethics, laws, and the guidance of professional associations. They are not intended to be exhaustive, and are described in more detail below.

# BEYOND DO NO HARM

The three main ways health care providers criminalize patients are by:

1. Increasing the risk of criminalization through information gathering, recording, reporting, and other practices (p. 9);
2. Calling the police, immigration, or family regulation systems on people seeking care (p. 10);
3. Collaborating with the state in criminalization through investigations and prosecutions (p. 11).

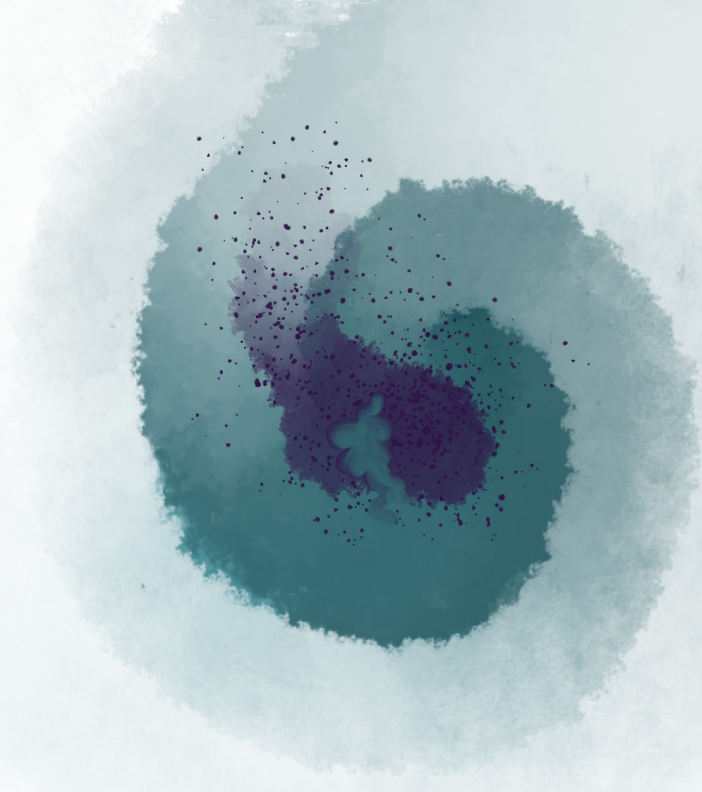
# PRINCIPLES

Health care providers, health care facility staff, and public health workers can interrupt, reduce and eliminate the harms of criminalization by adopting and implementing the following principles:

- 1.** End police and ICE presence in hospitals and in or near health care facilities
- 2.** End information gathering and documentation that is not directly relevant or related to the person's course of care
- 3.** End screening and testing without explicit and informed consent
- 4.** End the practice of calling police on suspicion of fraudulent identification documents
- 5.** Stop calling police on people with unmet mental health or medical needs
- 6.** Stop calling police on people in possession of, distributing, or using drugs
- 7.** End mandated reporting
- 8.** Stop supporting prosecution in cases against people who manage their own care or offer community-based care, fail to seek care, refuse care, or fail to disclose their private medical information
- 9.** Stop participating in or supporting prosecution in cases of transmission of infectious diseases, including HIV
- 10.** Stop participating in or supporting prosecution in cases related to drug use or overdose
- 11.** Stop providing and/or sanctioning substandard/violative care for people who are in custody or incarcerated in jails, prisons, detention centers, residential centers, group homes, and state facilities
- 12.** Stop collaborating with the criminal punishment system to violate people in custody, including through performing cavity searches at the request of police or prison officials; evaluating competency to stand trial; experimenting on and sterilizing people who are incarcerated; facilitating torture; or administering the death penalty
- 13.** Stop punishing other health providers, public health workers, and researchers by calling police on them, reporting them for disciplinary action, or terminating their employment for their refusal to participate in systems of harm

We recognize that health care providers and public health workers who refuse to participate in practices that criminalize people seeking care may face professional risks, particularly in the current political environment, in which we are seeing increased criminalization of health care providers.

We also recognize that implementation of these principles often calls on frontline providers, staff, and public health workers with the least power within medical and public health systems to take the greatest risks, potentially at significant personal and professional costs—therefore we are encouraging people to organize collectively to support refusal and mitigate the consequences of retaliation. These workers also often come from communities that are already criminalized, including Black, Indigenous, migrant, and disabled communities. We therefore call on professional associations, societies and labor unions in health care, and health care providers and public health workers with greater access to power and privilege to play a leadership role in advocating for and implementing these principles, and to offer individual and structural support to providers with less institutional power in implementing them. We are prioritizing the development of resources to support people who adhere to these principles and recommit to care, and we encourage them to advocate for and support change within their institutions, professional associations, and in legislative and policy spaces.



**“ ...we are encouraging people to organize collectively to support refusal and mitigate the consequences of retaliation.**



On October 24, 2019, a group of health care providers, public health workers, impacted community members, and organizers from racial, gender, reproductive, migrant and disability justice, drug policy, sex worker, and anti-HIV criminalization movements came together to address the harms caused when health care providers and staff, public health workers, and health care institutions facilitate, participate in, and support the criminalization of people seeking care. Based on these discussions, we developed the following principles for adoption and implementation by individual health care practitioners and staff, health care institutions, and professional associations.

Since the fall of 2019, the urgency of addressing criminalization through access to medical care has only increased. The 2020 Uprisings marked a growing acknowledgment of the violence of policing and criminalization and increased support for movements to **defund the police, divest from systems of policing and punishment, and invest in supportive community care networks.** Divestment from policing includes removing ALL forms of policing from ALL forms of health infrastructure—from public health programs and sites to hospitals and health care providers.

**“Divestment from policing means removing ALL forms of policing from ALL forms of health infrastructure**

# WHO ARE WE?

Simultaneously, the intersections of criminalization, health care, and public health have become increasingly clear in the context of the coronavirus pandemic, which has had devastating and disproportionate impacts on incarcerated people, including people incarcerated in immigration detention, nursing homes and other health care facilities, and group homes operated by family regulation systems. Instead of taking the opportunity to decarcerate and fund bold and visionary public health initiatives, resources earmarked for pandemic relief are instead being **diverted from life saving programs to policing**, increasing the risk of infection, police violence and harm.

The primary mandate of health care providers and public health workers is to DO NO HARM. Participation in and facilitation of criminalization does harm. People in need of or seeking health care, especially where it is denied or compromised, should not be

**criminalized, they should be cared for in supportive and non-coercive ways. Their self-determination should be centered and radical support prioritized.**

It is also critical to move beyond doing no harm to actively ensuring access to comprehensive care, comfort, and healing.

Contacting and collaborating with police<sup>1</sup> or otherwise participating in, facilitating, or condoning criminalization exposes people to emotional, psychological, physical, sexual, spiritual, and generational violence, and causes, contributes to, or exacerbates adverse health conditions. In addition, it undermines trust between care workers and patients that is essential for health care to meet patient needs. Criminalization or the threat of criminalization increases risk of exposure to COVID-19 and other medical conditions in facilities of detention; harm from the abhorrent conditions of confinement; denial of the most basic necessary health care, including treatment for chronic and acute care, HIV, Hepatitis C, care during pregnancy and the postpartum period, gender affirming and reproductive health care; family separation; loss of employment, housing, and community connections; loss of civil rights; detention; and deportation. Reporting parents to child welfare authorities undermines parental and fetal health and pushes patients into coerced and non-voluntary services.

Participating in criminalization is not aligned with accepted medical, midwifery, and other healing philosophies, ethics or standards of

care, and almost always involves violating the principles of confidentiality and informed consent. Criminalization in the context of seeking health care also deters patients from seeking out necessary care and assistance out of fear of surveillance or persecution by police, child welfare, or immigration authorities.

**We are urging health care providers and public health workers to root their practice in an unyielding and relentless commitment to do no harm, and to go beyond doing no harm to the active pursuit of health and care. Both of these commitments are fundamentally incompatible with criminalization. We invite health care providers, health care facility staff, public health workers, and researchers, alongside their institutions and professional associations to be bold, to refuse to participate, facilitate, condone or replicate policing and criminalization in medical settings and to recommit to caring for people.**

**“ We are urging health care providers and public health workers to root their practice in an unyielding and relentless commitment to... go beyond doing no harm to the active pursuit of health and care.**

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<sup>1</sup> Police—We use the term ‘police’ to refer to municipal, county and state police, sheriffs, Customs and Border Patrol, ICE, the Family Regulation System (child welfare system and the foster care system), and other local, state, and federal institutions authorized by the state to use force for the purpose of enforcing laws. We know that laws are often in place to reinforce the existing economic, racial, gendered, and ableist order. For a more in-depth analysis on policing, check out ‘No More Police’: [bit.ly/NoMorePolice](https://bit.ly/NoMorePolice)

# A BRIEF HISTORY OF HEALTH CARE AND CRIMINALIZATION

We must have a clear understanding of history if we seek to transform the conditions in which we provide care. Those of us rooted in the struggle to provide the best care possible to our communities have to reckon with historical and ongoing practices of surveillance, coercion, incarceration, and harm in medicine, not as shocking exceptions, but as integral to the operation of what is best understood as the Medical Industrial Complex (MIC).

In their '[Healing Histories Project](#)' Cara Page, Susan Raffo, and Anjali Taneja describe how "the medical industrial complex emerged as an extension of policing and state violence to control biology and healing practices and to define the line between "normal" and "not." The MIC expanded with the emergence of internal and external European colonization, class warfare, and the management of people perceived as deviant (disabled, queers, people who use drugs, and others who refuse the existing social order). At times medicine has been upheld as a more benevolent alternative to the violent force of state, yet this

obscures the ways that the underlying logics are the same — policing and pathologization, institutionalization and incarceration, corrections and cure.

We have seen this manifest historically in the ways that medicine has participated in the transatlantic slave trade, the ways that health care providers continue to participate in the eugenics movement sterilizing or forcing corrective surgeries, or the ways that medicine continues to uphold mandatory treatment programs and institutionalization for certain people. These struggles are ongoing and we uplift those who are working to transform the Medical Industrial Complex from within and without. We offer the Beyond Do No Harm principles as a continuation of this historic resistance at the intersection of the Medical Industrial Complex and the Prison Industrial Complex.

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***...the underlying logics are the same—policing and pathologization, institutionalization and incarceration, corrections and cure.***



# HOW HEALTH CARE PROVIDERS, PUBLIC HEALTH WORKERS AND RESEARCHERS PARTICIPATE IN CRIMINALIZATION

Health care providers, health care facility staff, public health workers, health researchers, health institutions and professional associations all currently facilitate and participate in, and, in some cases, condone or promote criminalization in the following ways. We offer this non-exhaustive list to help people identify opportunities for change at the institutional and profession-wide levels, as well as at the individual level where possible. We invite you to consider additional ways criminalization takes place in the context of accessing medical care.

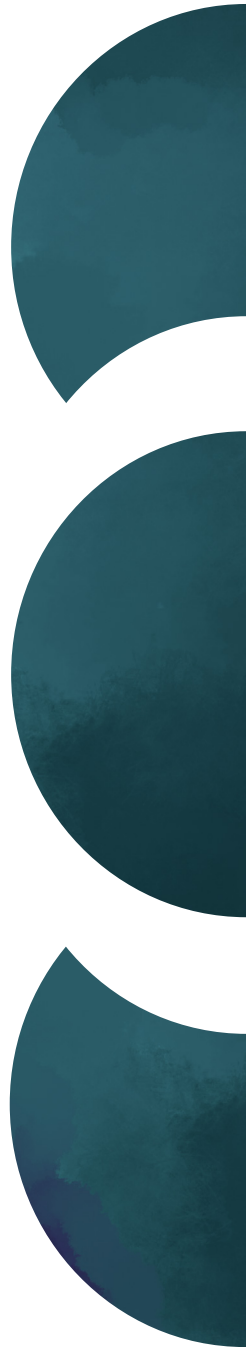
## Increasing the risk of criminalization


- Denying services or making them inaccessible (i.e. denying abortion, gender-affirming care, or pain management) in ways that push people into accessing or self-managing care in ways that may pose greater risks or expose them to criminalization.
- Hiring or contracting with police to provide security at health care offices and facilities or allowing them to engage in policing when on the grounds or inside the facility.
- Inviting or allowing police and immigration authorities to enter medical facilities.
- Participating in or enabling interrogations of people seeking or in need of care by police and child welfare workers, especially when conducted without legal representation or the presence of parents or guardians
- Testing people for alcohol or drugs in situations where it is not directly relevant or related to the person's course of care, and is done without their explicit and informed consent in ways that can produce evidence used by police, the family regulation system, immigration authorities, or the criminal punishment system.
- Utilizing screening tools and other forms of medical documentation to gather sensitive information that could trigger criminalization or contact with the criminal punishment system (i.e. reports of child, domestic, or elder abuse/neglect, drug use, involvement in the sex trades) in patient records.
- Suggesting or drawing conclusions about criminal motive or culpability in patient records, formal reports or investigations.

- Refusing or failing to document police or prison or immigration enforcement authorities as the source of injury, or contributors to other health issues that arise from police or prison violence or resultant trauma and stress.
- Publicly exposing people who seek health resources outside official channels, including self-managed and community-managed abortion and gender-affirming care.
- Giving police agencies access to data collected via public health surveillance tools (such as contact tracing).
- Failing to provide services to unhoused people and prematurely discharging unhoused people into the streets without their consent, putting them at greater risk of criminalization through interactions with police.
- Discharging patients to jail, prison, detention or deportation proceedings
- expansive people unable to obtain documents consistent with their gender identities)
- Calling security or police to medical facilities or other locations when people are perceived as “non-compliant,” to “manage patient behavior.”
- Calling police to arrest people for trespassing on hospital grounds when they believe they have not been fully treated and refuse to leave
- Calling police to pursue people attempting to leave the facilities against medical advice or against a psychiatric hold, and/or holding people against their will.
- Reporting child, domestic, and elder abuse/neglect without the informed consent of the individual who is being abused/neglected to contact authorities.
- Calling police on people engaging in non-compliance with public health or quarantine orders.
- Calling police to criminalize patients and visitors who participate in the use, possession or distribution of drugs.
- Participation in countering violent extremism or similar programs involving surveillance of patients for signs of “radicalization,” or any program that requires the provider to report confidential patient information to police.

## Calling the police

- Contacting police, including immigration authorities, when patients use identification that is suspected of being fraudulent to access health care services (including migrants unable to obtain legal documents and trans, nonbinary, gender nonconforming and gender



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- Applying for grants, conducting programs involving surveillance of patients for signs of “radicalization,” or any program that requires the provider to report confidential patient information to police.
  - Applying for grants, conducting data analyses, or publishing research at the behest of or in a way that benefits police or corrections agencies.
  - Calling for disciplinary action or the arrest of other health care providers who refuse to participate in criminalization.

## **Collaborating with the State**

- Holding people in medical facilities, without their knowledge, under the guise of providing health care, in order to investigate, test, screen, or evaluate them for criminal or child welfare culpability.
  - Collaborating with police to criminalize or civilly commit people with unmet mental health, substance use, and/or housing needs.
  - Using information obtained in the course of providing health care to draw conclusions about criminal motive or culpability (unless at the explicit request and with the full informed consent of the individual seeking care).
- Collecting or testing fluid or tissue samples without patients’ consent (i.e. toxicology screenings, STI/HIV testing, etc) and providing the results to the state via police or a child welfare agency.
  - Creating and providing evidence for and testifying against patients (or parents in case of CPS investigations). Some examples include drug prosecutions (such as overdose prosecutions) and prosecutions of pregnant people, people with HIV, parents, transgender people, disabled people and people with unmet mental health needs, and people who engage or assist with self-managed care, including abortion and gender affirming care.
  - Participation in any diversion program or alternative to incarceration requiring the provider to report confidential patient information to police, (including “non compliance”).
  - Participation in coerced or mandated drug, mental health, refeeding, or other treatment imposed as a punishment or imposed as part of a “safety” or “treatment” plan that is not voluntary or may occur through court-mandated diversion programs.

- Collaborating with police to conduct coerced, involuntary searches, including cavity searches.
- Participating in or failing to address neglect or provision of substandard care to people in jails, prisons, detention centers, foster placement, juvenile detention, nursing and other congregate facilities, and state hospitals, including shackling of pregnant people during prenatal visits, labor, delivery, and the immediate postpartum period; withholding water, food, sunlight, sleep, or pain control; purposely restricting communications or contact with loved ones; medically approving or recommending patients for sensory deprivation, solitary confinement, and torture within carceral facilities.
- Sterilizing or administering contraception, including long-acting reversible contraceptive methods, to any person without their full, free, informed consent, including in prison, immigration detention or state hospitals.
- Separating infants and their caretakers and/or preventing breast or chest feeding based on assumptions that the parent poses a risk of harm, interrupting a critical period of bonding and attachment.
- Using medical or public health facilities to remove infants or children from their family members.
- Collaborating with police, corrections, military, or intelligence agencies to facilitate torture (including “enhanced interrogation”).
- Collaborating with police in research, evaluations, or treatment intended to force or coerce people into anything that would violate their human rights.
- Participating in evaluations or treatment intended to render people competent to stand trial or be put to death.
- Collaborating in administration of the death penalty.





# BEYOND DO NO HARM PRINCIPLES

We call on health care providers, staff at health care facilities, public health workers, and researchers alongside their institutions and professional associations to rise to their mandate of 'Do No Harm' and to go beyond mitigating harm to support individual agency, self-determination, gender, sexual, reproductive, and sacred autonomy, dignity of risk<sup>1</sup> and general wellbeing by adopting the following principles:

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<sup>1</sup> Dignity of risk is a concept rooted in disability justice principles. It involves respect for self-determination, honoring an individual's choices and decisions around risks, rather than paternalistic approaches.

# 1 END POLICE AND ICE PRESENCE IN HOSPITALS AND IN OR NEAR HEALTH CARE FACILITIES.

- Everyone deserves to access health care services without fearing for their safety or the safety of their family members. Police and ICE presence at hospitals and health care facilities can cause communities who are regular targets of criminalization and immigration enforcement operations to fear or avoid accessing health care. Complicity with police and ICE includes allowing officers to roam the hallways, providing space for police to conduct interviews, and holding people in medical facilities under the guise of care to evaluate for criminal culpability. Additionally, the very presence of police can result in an reliance on these officers to solve emerging issues and contribute to increasing the targeting of

already criminalized communities —this includes calling on officers to manage patient behavior, criminalize drug use, restrain people in mental health crises, force discharge of unhoused people without their consent, or people who refuse to leave through arrests for trespassing, and pursuing people who have left against a medical or psychiatric hold. We are also critical of security officers that play these same roles and collaborate with police. Policing in health care facilities disproportionately affects Black people and people in mental health crises.

- As health care providers, we know that sometimes police have family members and friends in the hospital. If police want to visit them when they are off duty, they cannot wear or bring their gear, and if they are on duty, it is not appropriate to visit.

***Police and ICE presence at hospitals and health care facilities can cause communities... to fear or avoid accessing health care.***

# END INFORMATION GATHERING AND DOCUMENTATION THAT IS NOT DIRECTLY RELEVANT OR RELATED TO THE PERSON'S COURSE OF CARE.



2

- Do not ask for or document information that is not directly relevant to care, such as type of work/employment (i.e. this stigmatizes people who engage in criminalized work in informal economies including people in the sex or drug trades etc.) in a patient's file. Health and public health workers should not report any sensitive information that could trigger criminalization or criminal punishment (i.e. reports of criminalized activities, conclusions about "criminal" motive, etc.) in identifiable records without informed consent of the potential consequences. Use plain and accessible language and explain what you are asking for and why.
- Public identifiable disclosure of information shared confidentially during health visits, public health efforts, or research puts people at risk of criminalization.
- Police agencies should never have access to health or public health data including patient records, contact tracing data, and research data.

**“Police agencies should never have access to health or public health data**

# 3

## END SCREENING AND TESTING WITHOUT EXPLICIT AND INFORMED CONSENT.

“*There is no therapeutic benefit to toxicology performed without consent.*”

- Advise health care seekers of the medical and legal consequences of a positive test, and allow the patient the time to seek advice about the test from an advocate, as well as a health care provider, obtain documentation of the consent obtained and medical reason for the test, and do not refuse care or call authorities based on a refusal to consent to testing.
- Routine screenings and reporting of positive toxicologies for alcohol and drugs can trigger criminalization and adverse consequences for people under the control of the criminal punishment system, and lead the family regulation system to separate families and criminalize patients. Neither mandated treatment programs nor criminalization are helpful interventions.
- There is no therapeutic benefit to toxicology performed without consent. The exception to this is when people are found unconscious in an emergency situation where they are unable to consent and a toxicology screen is necessary for resuscitation and treatment. Toxicology results should never be reported to police or used to prosecute patients.



# 4

## END THE PRACTICE OF CALLING POLICE ON SUSPICION OF FRAUDULENT DOCUMENTS.

As it stands today, identification documents are an everyday need for existence, whether it is to access health care, public services, or private spaces. Due to this critical need, undocumented immigrants, trans and gender nonconforming people unable to obtain legal identification documents may find it necessary to use falsified documentation for survival purposes. Identification is typically unnecessary for billing or provision of care, and requesting it creates an additional barrier to care and opportunity for criminalization. Health care providers should also avoid requesting identification whenever possible.

## STOP CALLING POLICE ON PEOPLE WITH UNMET MENTAL HEALTH OR MEDICAL NEEDS.

Police officers are not equipped to deal with mental health crises or care for people with unmet mental health needs. As a general rule, police response to people in mental or emotional distress is further violence—and in some instances—serious bodily harm or even death. Involuntary psychiatric care has been declared to be torture by the [United Nations](#). Coerced treatment is a violation of people's rights to self-determination and autonomy within health care. It can deter people from seeking medical and psychiatric care in the future and damage therapeutic relationships. Meeting people's material needs, de-escalation and building community safety empowers communities and loved ones in times of need.

# 5

# 6 STOP CALLING POLICE ON PEOPLE IN POSSESSION OF, DISTRIBUTING, OR USING DRUGS.

- Drug use should be met with services and support, not criminalization. Criminalization of possession and use of controlled substances discourages people from reporting drug use in ways that could positively affect medical care.
- People should be informed about the complications, risk, and side-effects of using drugs in certain conditions or alongside certain medications. They should be non-coercively offered controlled alternatives to criminalized substances. Should patients decide they want to use drugs, health care providers should continue to care for them and minimize any harmful effects or help prevent overdose.

- When visitors attempt to distribute medications to people receiving treatment they should not be criminalized for attempting to help them stave off withdrawal or other unmet needs that they are addressing with drug use. Patients should have the right to refuse or accept these visitors and continue to get treatment.
- Mandatory drug treatment programs do not work. They are often predicated on a person pleading guilty and work to widen the carceral net, forcing people into coercive situations where they are sent to jail if they “fail” treatment, or denied programming or treatment when incarcerated.

**“Criminalization of possession and use of controlled substances discourages people from reporting drug use in ways that could positively affect medical care**

# END MANDATED REPORTING.

- While health care workers are often mandated reporters legally required to report some information on incidents of youth, domestic, and elder abuse/neglect as well as suicide, mandated reporting mechanisms often mobilize legal and administrative systems that put people at risk of criminalization and further harm. Health care providers are complicit when they:
  - hold people in medical facilities under the guise of care to evaluate culpability;
  - call authorities during a medical visit; or
  - use medical or public health facilities to remove infants, children, or elders from their family members without their consent.

“*...mandated reporting mechanisms often mobilize legal and administrative systems that put people at risk of criminalization and further harm.*”

- Mandated reporting has not been proven to prevent or reduce child abuse or neglect, but has been proven to expose minors to harm. The child welfare system is one in which young people and caretakers experience enormous amounts of violence. Reports that health care providers make to be “on the safe side” are often **not safe for children**, their caretakers or communities.
- Mandated reporting in situations of domestic violence without the consent of the person experiencing harm **can put them at greater risk** of retaliation, homelessness, joblessness, and other vulnerabilities. We encourage people to always offer resources, and to report abuse to the authorities only if that is what the patient experiencing harm is requesting with informed consent on the potential consequences of involving the police, after offering alternative approaches to interrupting and healing from harm and resources.
  - Mandated reporting has not been proven to prevent or reduce elder abuse or neglect, while forcing elders into residential facilities can subject them to further harm.



- We encourage people to always offer resources, and to report only if that is what the patient experiencing harm is requesting with informed consent on potential consequences of police involvement and discussion of alternative approaches to interrupting and healing from harm.
- Mandatory reporting of suicidal hotlines like **988 Lifeline which openly engages in nonconsensual rescue** (as an alternative consider TransLifeline, CallBlackLine, SamaritansNYC). The **United Nations** has called involuntary psychiatric care a form of torture. Studies show that while involuntary holds may prevent a person from dying in one moment of crisis, **suicide risk following involuntary psychiatric hospitalization increases**

**significantly.** Reporting someone for being suicidal can result in loss of educational and/or employment opportunities, and lead to a loss of custody for those with children. This can deter people from accessing counseling, medications, and other support offered by mental health workers. People in crisis should be supported and accompanied by loved ones and health care providers willing to support them non-coercively.



**STOP SUPPORTING  
PROSECUTION IN CASES  
AGAINST PEOPLE  
WHO MANAGE THEIR  
OWN CARE OR OFFER  
COMMUNITY-BASED  
CARE, FAIL TO SEEK  
CARE, REFUSE CARE, OR  
FAIL TO DISCLOSE THEIR  
PRIVATE MEDICAL  
INFORMATION.**

**“When poverty contributes to lack of access to care, criminalizing alternate pathways to care amounts to punishing poverty**

**8** When people get health care outside of “formal” medical systems, it is often because they didn’t have access to health care inside those systems or because they don’t feel safe in the health care settings accessible to them. Regardless of the reason a person seeks care outside of conventional health care systems, criminalizing people who provide or receive that care outside the system doesn’t address the underlying needs or reduce behaviors deemed to be undesirable or the risk of harm. It worsens health outcomes. When poverty contributes to lack of access to care, criminalizing alternate pathways to care amounts to punishing poverty while pushing people further from access to quality care and potentially inflicting additional trauma. This is true even if the care provided – such as criminalized reproductive care like abortions or gender-affirming care like silicone injections - comes with health risks. People with money have more options for managing risk and are therefore “allowed” to take more risks. Criminalization is not the solution to disparity. Solutions must instead focus on ensuring the universal accessibility and acceptability of safe services.

# 9

## **STOP PARTICIPATING IN OR SUPPORTING PROSECUTION IN CASES OF TRANSMISSION OF INFECTIOUS DISEASES, INCLUDING HIV.**

- Supporting prosecution includes testifying and creating or providing evidence. This includes creating evidence through public health forms and participation in public health surveillance, and requiring patients to sign forms creating an obligation to disclose their status to others.
- End laws that criminalize the transmission of HIV/AIDS and other infectious diseases. They discourage people from knowing their status, do not account for risk mitigation practices, and further criminalize communities already vulnerable to surveillance and criminalization.

Opiate overdoses are at crisis levels, requiring effective interventions - which does not include prosecutions. Punishment, like wrongful death suits or drug induced homicide charges, has shown no promise for reducing overdose deaths, and has caused much unnecessary harm. Conspiracy charges expand the carceral net and discourage people seeking help when someone is overdosing.

## **STOP PARTICIPATING IN OR SUPPORTING PROSECUTION IN CASES RELATED TO DRUG USE OR OVERDOSE.**

# 10

**STOP PROVIDING AND/  
OR SANCTIONING  
SUBSTANDARD/  
VIOLATIVE CARE  
FOR PEOPLE WHO  
ARE IN CUSTODY  
OR INCARCERATED  
IN JAILS, PRISONS,  
DETENTION CENTERS,  
RESIDENTIAL CENTERS,  
GROUP HOMES, AND  
STATE FACILITIES.**

*When people in custody...are brought to other health care facilities... they may still be subject to substandard/violative care due to prison policy or as a result of stigma and a desire to punish criminalized people*

**11**

Health care in jails, prisons and detention facilities is not only substandard, but coercive, invasive, and violent. This includes violence perpetrated by health care personnel and sanctioned via public health departments. Practices include (but are not limited to): neglect, inadequate, or coercive treatment; sterilizing or administering contraception, including long-acting reversible contraceptive methods, to any person without their full, free, informed consent; shackling pregnant people during labor and delivery, use of restraints; non-consensual forced feeding; and subjecting people to inhumane conditions like forced isolation, solitary confinement and sensory deprivation. When people in custody, incarcerated, or in immigration detention are brought to other health care facilities outside of carceral spaces, they

**”**

may still be subject to substandard/violative care due to prison policy or as a result of stigma and a desire to punish criminalized people who are seen by many as deserving of violence, and not deserving of care.



**STOP COLLABORATING WITH THE CRIMINAL PUNISHMENT SYSTEM TO VIOLATE PEOPLE IN CUSTODY, INCLUDING THROUGH PERFORMING CAVITY SEARCHES AT THE REQUEST OF POLICE OR PRISON OFFICIALS; EVALUATING COMPETENCY TO STAND TRIAL; EXPERIMENTING ON AND STERILIZING PEOPLE WHO ARE INCARCERATED; FACILITATING TORTURE; OR ADMINISTERING THE DEATH PENALTY.**

Health care providers have collaborated with police, corrections, military, and intelligence agencies to facilitate torture (including “enhanced interrogation”). They have participated in experimentation on and forced sterilization of people who are incarcerated. They are involved in evaluations to render people competent to stand trial or be put to death. And they participate in the administration of the death penalty. We call on health care providers involved in these situations to blow the whistle and refuse to participate.

**“ we call on health care providers... to blow the whistle**





**STOP PUNISHING  
OTHER HEALTH CARE  
PROVIDERS, PUBLIC  
HEALTH WORKERS,  
AND RESEARCHERS  
BY CALLING  
POLICE ON THEM,  
REPORTING THEM FOR  
DISCIPLINARY ACTION,  
OR TERMINATING  
THEIR EMPLOYMENT  
FOR THEIR REFUSAL  
TO PARTICIPATE IN  
SYSTEMS OF HARM.**

As we build this movement we need solidarity amongst health care providers, public health workers, and researchers doing this work to take stances and radically change the culture of the institutions they work in. People resisting criminalization are sometimes threatened with disciplinary measures or termination of employment, and there have been recent situations where police have arrested health care providers for refusing to participate in criminalization. These disciplinary actions can have a chilling effect on our movement and it is our responsibility to protect one another, and for institutions and professional associations to defend those upholding their ethical commitments.

**“ it is our  
responsibility  
to protect one  
another**

**13**

We are committed to interrupting criminalization wherever it happens — including in the context of seeking health care. We apply abolitionist principles in this work, including prioritizing leadership from people directly impacted by criminalization, emphasizing that nobody is disposable, acknowledging that the system is not broken but working exactly as is intended, and acting from the conviction that everyone deserves to live lives free from coercion, and that we can imagine what we desire (whether that is ‘justice’ or ‘care’) independent from the maiming and death-dealing systems that rely on policing, incarceration, and punishment.

Medicine as an institution continues to align with oppression, but we believe that the people within it can be transformed and join in the struggle for liberation. We believe in centering people’s autonomy and self-determination. We can better support the people we care for by being non-judgmental, including when providing information on how to access the care they are

**“ we believe that the people within [medicine] can be transformed and join in the struggle for liberation.**

requesting, and helping them consider how to reduce the risk of criminalization.

Our work involves divesting from systems of surveillance, policing, and punishment and investing in universal access to food, housing, and health care. Our work involves redistributing our wealth so that we can build healthier communities. And it requires democratizing the places where we live, where we work, and where we heal so we can be in the right relationship with one another when we are in conflict and create accountable communities for when there is harm. We encourage health care providers, health care facility staff, and public health workers and researchers to join local community organizations and move in solidarity with the people they care for.

We need to interrupt criminalization together in a way that is principled, strategic, and connected to broader movements for liberation. We are inspired by the work of the Black Panthers and the Young Lords to provide free, accessible, and non-coercive medicine for the people, including by collaborating with the health care providers in the Health Revolutionary Unity

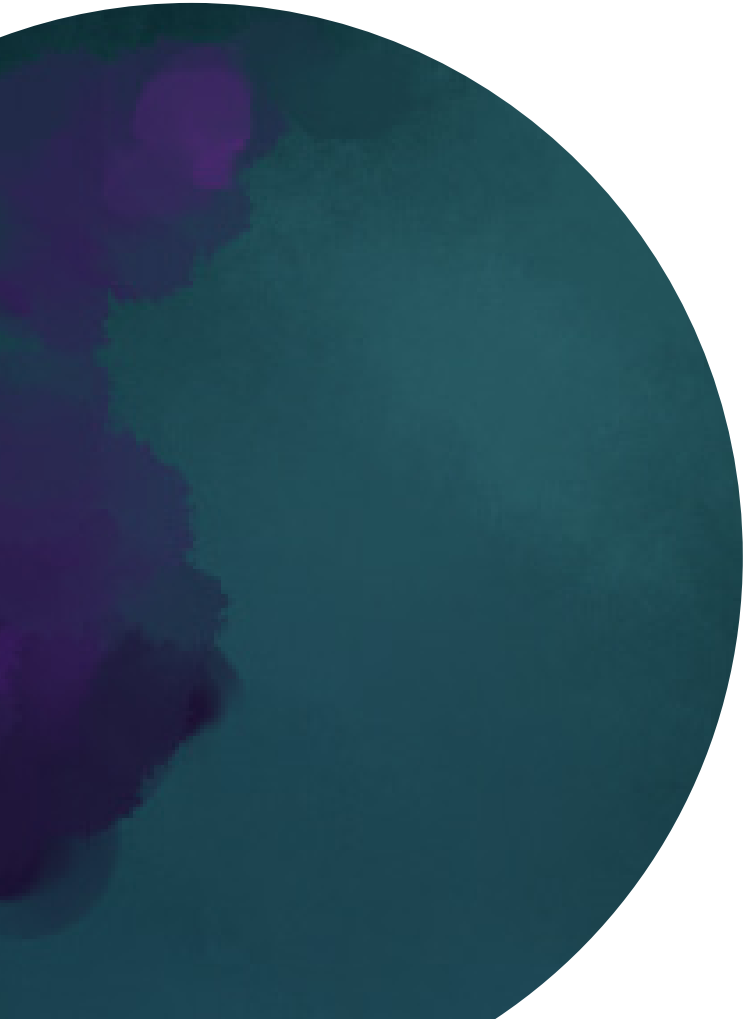
**CONCLUSION**

Revolutionary Unity Movement to commandeer mobile clinics and occupy hospitals. We are informed by the work of the Psych Liberation activists who worked with patients and physicians to break down the walls of asylums. We learn from **Liberatory Harm Reduction movements**. We are part of movements for Reproductive and Trans Justice demanding abortion and gender-affirming care in the face of repression. We are committed to movements to end family policing, in which parents are forming care collectives to support the health and wellbeing of neighborhood children. We follow the example of nurses and other health care providers who refuse to

test patients in spite of police demands. And we support people in jails, prisons, and detention facilities who speak up and speak out about neglect and violence.

We know that criminalization is a matter of power, not justice. Slavery, Jim Crow, colonialism and apartheid were all legal. We recognize the moral imperative to disobey unjust laws.

We build power by organizing, protesting, striking, boycotting, and engaging in acts of civil disobedience to make the world we need, and make it impossible for our rights to be taken away. It is our duty to fight for our people and when we interrupt criminalization in health care we move into this lineage together.



***We know that ”  
criminalization  
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justice... It is our  
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our people***



**Abortion Care Network**  
WE ARE STRONGER TOGETHER



**END POLICE VIOLENCE  
COLLECTIVE**



**National Advocates  
for Pregnant Women**

**N A P W**



**Physicians for  
Reproductive Health**

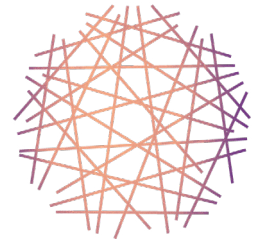


**if  
when  
how**

**Lawyering for  
Reproductive  
Justice**



**Women of Color Reproductive  
Justice Collective**



**NATIONAL NETWORK OF  
ABORTION FUNDS**



**Academy of Perinatal  
Harm Reduction**



**MOVEMENT FOR  
FAMILY POWER**

**IC INTERRUPTING  
CRIMINALIZATION**



**NETWORK MEMBERS**





# IC INTERRUPTING CRIMINALIZATION