My name is Heidi Henkel and I live in Putney, VT. I have lived in Vermont since 1997 and in Putney since 2011. I am a psychiatric survivor. My bachelor of science degree (Keene State College, 2013) is an individualized major in "Human Movement and Health." The name doesn't quite capture all that went into it- my studies included sociology and history of mental health care, mental health care reform and innovation, physical medical problems that have mental health symptoms, and physical remedies that help address mental health problems (such as nutrition, exercise, massage, medical interventions, etc).
I have experience being a one-on-one community mental health worker, working with traumatized children and adults, sometimes involving using a basket hold to restrain a person who became violent, but quickly learning how to prevent such events by keeping situations within what people could handle. I currently do home health care personal care for people with serious illnesses and disabilities. My personal care experience has included dealing with delirium and dementia.
I talked with Edgar Holmes, III, MD, extensively and did a successful application for him to be in the Vermont Ski Hall of Fame. In the process of talking with him, I learned some things about his approaches to delirium in the ER. (Edgar Holmes was an orthopedic surgeon in Rutland, VT, who worked in the ER a lot and hired and trained most of the orthopedists currently working in Rutland. He did a lot of innovations in the ER and in sports medicine.)
I participated in the recent Forensic Mental Health working group run by the Vermont Department of Mental Health, to advise the legislature about forensic mental health.

I support the goal for health care workers in emergency rooms to have good workplace safety and not get injured or work under the threat of possible injury, at their jobs. I doubt that arresting people who threaten or commit violence in the ER, and sending them back out onto the street with their physical and mental health conditions untreated, is a good way to accomplish that. I am concerned that it would leave the causes of the person's poor social functioning, which could include mental illness and/or delirium caused by the medical condition they're seeking help for by going to the ER, untreated, and push the behavior out into the community. Perhaps that behavior will be taken out on the patient's partner or child, instead of at ER staff, causing a tragedy. And since their condition isn't being treated, their condition may worsen and their behavior may escalate. Perhaps the person will be terrified by having been arrested, and be afraid in the future, to seek medical care or mental health care. I also don't think arresting people in the ER will do much to make the ER a safer place to work, because it wouldn't address the reasons why people become violent in the ER. I want there to be better workplace safety in the ER, but I see some problems with this way of going about it. I have some other suggestions about how to go about it.

3 reasons for violence in the ER:
Delirium from serious medical problems. A wide range of medical problems can cause delirium. Infections, organ failures, extreme blood loss, etc. Delirium can include anger, confusion, and even violence. Treat the medical condition. Try to de-escalate the patient. If needed, restrain and sedate the patient in order to do that. Do not leave a restrained patient alone ever, and do not keep patients restrained for long

periods of time. Be quick to treat the medical condition that is causing the delirium. When possible, treat medical conditions that could lead to delirium, before they progress to that point.
How to prevent violence in cases of delirium: Check patients for delirium and for medical conditions that could lead to delirium, thoroughly and frequently. Treat medical conditions that could lead to delirium, very quickly. One example I know about from Edgar Holmes is delirium from extreme blood loss in car accident victims. Edgar Holmes would go ahead and transfuse or give EPO right away, as soon as possible after bleeding was stopped. He was trained to give Thorazine when people appeared to become psychotic from blood loss. He learned that he could more effectively treat that or even prevent that, by transfusing or giving EPO as soon as possible. Strategies based on similar philosophies could be applied to other mechanisms by which delirium develops.
Some physiological causes of delirium can be detected more quickly by regularly taking blood pressures, oxygen saturation, temperature, and other simple things. The ER doctors will be able to figure out a lot more about this than I can. I might suggest doing these simple tests on patients in the waiting room. If someone just feels moderately sick but has an extremely low blood pressure, detected while they're sitting in the waiting room, that can move them higher in the triage. (This can be how a person with urinary tract infection and sepsis presents. You wouldn't know about the sepsis, except for the blood pressure. They can walk in the door and seem almost normal, and without the blood pressure reading, it can be tempting to let them sit in the waiting room for 5 hours. But they may deteriorate due to the sepsis. That can be predicted and interrupted by just taking their blood pressure. That is just one example I know about from my personal care experience. ER doctors will be able to think of lots of things once they start thinking along these lines.)
Preventing, detecting, and rapidly treating delirium and the physiological causes of delirium is the primary strategy.

Mental health crisis, where the patient came to the ER to get help with the mental health crisis. If the patient doesn't get help soon, the patient's condition can deteriorate, so it's important to help the patient soon. Having a cozy, friendly, low-stress architecture and décor, well-staffed living-room type situation for people in mental health crisis, would help. Peer support specialists could be a big part of this. Focus on psychosocial strategies and start addressing the mental health crisis immediately, no warehousing. Open Dialogue is the most effective modality for psychosis in the world, and can be carried out by peer support specialists who are trained in Open Dialogue. One reason Open Dialogue is so effective is because it is started within a few hours of when the patient or their family makes a request for help. Peer support strategies are also very effective- more effective than hospitalization and medication- for people considering suicide. Peer support specialists should be in ERs to help people in mental health crisis. It would be great for there to be other mental health professionals there, too. The long-term outcome of a mental health crisis is much better if psychosocial interventions begin very quickly. It should be prioritized like any other medical condition in which the long term outcome is better if intervention begins very quickly. A lumbar spine fracture with pressure on the spinal cord is an example of an injury where the long

term outcome is likely to be much better if intervention happens quickly (permanent paralysis vs not having permanent paralysis). That's triaged right after severe bleeding, cardiac arrest, and respiratory arrest. Mental health crises should be prioritized similarly because the long term outcome is similarly impacted by how quickly they're responded to. Forced medication is traumatizing, and the effects of medications are not reliable, so I'm not suggesting rushing into force-medicating people. The most effective interventions are psychosocial, so lets' make sure that gets started within an hour after the patient walks in the door. That would prevent most assaults due to mental health crisis. Also, using psychosocial strategies, de-escalating any patients who are already escalated when they first walk in the door. Restraint should only be a very last resort, and like with delirium patients, a restrained patient should never be left alone at all, and should not be restrained for long. Use de-escalation strategies.
Restraining a patient for more than a couple of hours causes risk of abnormal clotting and death, and is lazy and neglectful. Restraint should only be used very short term as a last resort, in order to actively and productively treat the patient, and then should be ended quickly. There should always be someone with the patient, willing to listen to the patient and talk to the patient in a calm and compassionate manner, and circulation to extremities should be checked frequently.
The biggest investments should be into psychosocial training for all ER staff in de-escalation, interacting with people who have emotional trauma and/or are in an extreme state, and into making sure that mental health crisis patients begin getting meaningful psychosocial care within an hour of walking in the door.

Patients who have some trauma background (known or unknown to the ER, and the patient could be receiving mental health care, or not) and then get triggered in the ER by a misunderstanding, miscommunication, or something a staff person does. People can get triggered if they don't understand what's happening, if a staff person doesn't explain what they're going to do before doing it, if there isn't consent, if the patient doesn't feel heard, if the patient's concern isn't being addressed and the patient doesn't know why, etc. Staff need training about how to do trauma-informed care, and giving staff checklists might help. The checklists could include things like Explain procedure and get patient's consent; Explain why food and drink are not being given (such as if there's a possibility of a need for surgery- eating or drinking could make that dangerous or impossible- explaining that to the patient can alleviate confusion and a feeling that their needs might be being ignored), Listen to the patient, etc. Peer support workers could help as communication helpers to make sure the patient understands what is happening, and to listen to the patient about their feelings and concerns. This could defuse some tension and help make sure the patient is getting their questions answered and getting their concerns heard.
Some patients don't know how to assert their needs without coming across as too aggressive. The communication support person can help them communicate in a way that they get taken seriously but that doesn't come across as aggressive.
It is possible for a patient with a history of opioid addiction to also have a current medical problem that is painful. ER staff should investigate possible medical problems in patients who have addiction history. They don't have to give opioids, but they should

try to diagnose and treat the medical problem if there is one, and they should investigate thoroughly like with any other patient.
Pathways Vermont can probably offer some trainings about trauma-informed care and other interpersonal skills, to all kinds of ER staff.

Some other things that may be helpful:
More staff in the ER, so patients can be treated more quickly and there are more staff available to interact interpersonally with patients, to make them feel heard, make sure they understand what's happening, detect delirium early, start meaningful psychosocial interventions quickly for people who are there for psych reasons, etc.
More other places for people to go with emergencies, to alleviate the overload on ERs. More urgent care centers, primary care, and peer-run crisis respites.
Fewer mental health emergencies, by having more and better outpatient mental health care
Video monitoring in the emergency department, so that people can be held accountable later, for violent or threatening behavior. If there's an assault or threat that's a clear behavior choice and not driven by the patient's medical condition, the hospital can prosecute using the video footage. Video footage can also protect patients in the event that they're being accused of something they didn't do or that's more complex (for example, a staff person assaulted them first, or their behavior was misunderstood, or their behavior was caused by the condition they came to the ER to get treated). Uninvolved patients can be fuzzied in videos before they're shown to anyone, to protect HIPPA rights of uninvolved patients.
A variety of pain mitigation strategies, including other methods besides opioids. I had a severe, rapidly bleeding puncture wound in the Brattleboro ER, and they had someone to just hold my hand during the entire surgery because I didn't want to be anesthetized. Hand-holding is an excellent pain mitigation strategy. Be creative. There's something in between giving opioids, and ignoring the patient's pain.
Mediation and conflict resolution: There could be a program where people who are concerned about treatment in the ER can file something explaining their chronic mental health and physical health conditions, and also where people who feel that their interactions with their local ER in the past, haven't been satisfactory, can get some conflict resolution where they can be heard and the ER staff can learn about them from them and resolve any misunderstandings so that any future ER visits can go better. The ER could even initiate a mediation with a former patient, to make sure they understand the needs of the ER and their impact on the ER. A program like this can help resolve problems so that there aren't repeated conflicts with the same patient.

Things to bear in mind:
People with mental health issues or trauma issues aren't necessarily being treated by the local designated mental health agency. They may never have received any mental health treatment, or they may just be seeing a private psychotherapist and have no interaction with the designated agency.

Many patients have combinations of mental health and physical health issues. One patient can have significant mental health needs and physical health needs at the same time.

Legal stuff:
Let go of worrying about "disorderly" patients who aren't hurting anyone and aren't threatening to hurt anyone. People who go to ERs are in a lot of distress. Openly expressing their distress shouldn't be criminalized. ER staff need to learn to deal with patients' distress with compassion and without being distracted by it. Have communication support helpers listen to some of the patients' raw feelings.

Don't criminalize behavior that's part of the condition they went to the ER to get help with. You don't want to deter people from seeking help in the ER in the future.

Use prosecution, not arrest, as the deterrent. Use video footage (with other patients blurred) to prosecute people who intentionally choose to threaten or assault ER staff.

Thank you for taking the time to read my testimony.
Please do not hesitate to get in touch with me with any questions.

Sincerely,
Heidi Henkel
Putney, VT
heidikhenkel@gmail.com
802-490-8190

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