House Judiciary Committee, 4/4/2023
Rep. Anne Donahue
S. 36 An articulation of issues focused on those situations where an aggressor is a patient:

Statement of the Problem and Competing Needs:
We need a solution that enables law enforcement to intervene to protect staff and others when aggressive actions of a patient are beyond the reasonable capacity of health care providers to address, without inappropriately criminalizing behavior when it has a broader context of causation related to the patient's medical condition.

Current obstacles:

- A person arrested on the applicable charges can only be cited, but not arrested or removed from the facility, even if medically stable, because of Vermont law requiring a warrant.
- If the law was changed as proposed in S.36, under federal law it would still not allow removal from an emergency room if a patient has not yet been evaluated, is not stabilized, or is awaiting inpatient admission (which could mean days.)
- Under current practice based upon CMS regulations, if the person is not being arrested, police involvement is precluded because it violates the requirement that interventions must be provided by health care providers only.
- Police sometimes currently do not want to issue citations that they perceive will not be prosecuted based on mental illness (even though the majority of situations do not involve cases where a defense of criminal insanity would not apply), or are uncertain about what response is appropriate.

Overarching considerations of context:

A. Proposed legislation must be structured with attention to being appropriate beyond its use in the emergency room crisis that is most directly in front of us, because it would currently apply to all inpatient and residential health settings, as well as outpatient clinics and medical practices of all types.
B. Proposed legislation must be reviewed through an equity lens, recognizing the extent to which implicit bias and historic discrimination regarding psychiatric illness is influencing even the discussion itself. Specifically:
   B.1 The degree of focus on mental health, despite the attributes of a general increase in disinhibited behavior and violence in society that is reflected in many patients, regardless of the medical condition for which they are seeking treatment.
   B.2 The implicit bias within the medical field against persons with psychiatric illness which results in demeanor and interactions with patients that dehumanizes and disempowers them, which can contribute to incite patient responses.
   B.3 The discrimination that results in system failure to ensure parity in access to care – both through preventive and urgent care available for other conditions, and inpatient care when needed – such that people who are experiencing deep psychological pain are left with minimal treatment or human contact in jail-like settings for 4 – 6 -- 15 days, unthinkable to leave unresolved if the issue was cardiac arrest or stroke or motor vehicle accident trauma.
C. When criminal actions or highly dysregulated behaviors occur, the context and causes of those actions as related to medical conditions must be considered in terms of whether the actions are appropriately addressed as a criminal matter.

However – **important to fully emphasize** -- the need to address broader social causes, including the need to respond to discrimination and critical gaps in mental health care, **cannot be an excuse to delay the urgency of protecting health care workers from untenable situations of assault and interference with the ability to provide safe health care.**

D.1 Improved training in implicit bias, de-escalation and trauma-informed care can help but will not resolve all situations.

D.2 Addressing the failures of the health care system in providing appropriate mental health care cannot occur rapidly enough to address the current crisis, and will also not address all situations, including the fact that many are not mental-health-specific. (Some conditions could be addressed more rapidly, for example by changing dehumanizing procedures and emergency room spaces used for mental health patients; use of peer support rather than unengaged "sitters.")

A Path Forward:

If a police protective custody status model is utilized (as currently exists for public intoxication and for persons in need of transport in a mental health crisis), the ability to provide protection within a health care setting – and to remove patients from that setting when they are medically stable – would be achieved while still meeting CMS parameters but without the effect of criminalizing behavior. The ability to utilize police support could extend to broader circumstances than under S.36.

Criminal sanctions could remain an additional option when actions are not precipitated by symptoms of the health condition or related trauma, based on the specific circumstances, but would not be required as the basis to be able to intervene to provide protection. This would protect the rights and best outcomes for patients experiencing a health emergency.

An affirmative defense should be created for patients who are cited, but can show their actions were directly tied to their emergency medical situation or condition.