Former Attorney General Mills convened a Task Force in 2017 to look at the issue of deadly force incidents by the police. Three months ago, that Task Force released its report.

That Task Force looked at 10 cases where the police used deadly force. In eight, it appeared that the deceased exhibited signs of mental illness.

One of the primary recommendations from that task force is greater utilization of the PTP. It reads:

> 2. *State mental health facilities, ACT teams (multidisciplinary teams that provide intensive support and supervision of individuals with serious and persistent mental illness), and other medical or mental health practitioners, law enforcement officers, and legal guardians of those affected by serious and persistent mental illness at risk of harm to self or others, should* ***consider the more frequent use of Progressive Treatment Programs (hereafter referred to as "PTP").*** *A PTP is a treatment plan that includes intensive treatment and supervision of an individual living with a severe and persistent mental illness that poses a risk of harm to self or others, but that does not rise to the level of requiring an involuntary commitment. A PTP is court-ordered and typically includes treatment requirements and restrictions. Once in place, a PTP plan may be enforced if the individual is not in compliance with its conditions, and the individual may immediately be placed in a psychiatric facility.*

What the Task Force report does not analyze is why PTP is not utilized more often. We believe it is because of the significant legal resources necessary to be the moving party on a PTP.

My name is Miranda Chadbourne. I'm a critical care nurse, and am the Program Manager for Care Team Support and Workplace Violence Prevention at Maine Medical Center. I've been working in health care for 13 years, the last two years focused on the prevention and response to health care violence.

During the last year I've worked over 2400 Care Team Members who have felt the impact of violence and disrespect by the very patients they are trying to help.

While my colleagues will share their experiences in the emergency care departments; I'd like to also speak on the lasting effects of violence in our ambulatory practices, pharmacies, and inpatient units.

In interviewing care team members who work with patients over the phone, they report that they are sworn at, threatened and demeaned at least twice a day. It is exhausting to pick up the phone and have your life, and the lives of your children threatened by someone who is angry about appointment availability.

Currently Maine Medical Center is caring for a patient admitted following complications after a vascular surgery. As of today his hospital stay is greater than 425 days. During this time he has been verbally abusive with the use of racial slurs, and homophobic language. He frequently sexualizes our care team members asking them to preform sexual acts with him, he throws items across his room, and has punched kicked and has hit care team members with is cane. As the law currently is written, the care team members caring for this non-emergent patient have fewer legal protections than their counterparts who work in Emergency Medicine. As of note this patient's most serious mental health diagnosis is depression. He very clearly states he acts this way to get what he wants. While assisting care team members in this situation, they have turned down contacting police. They believe it won't do anything to help.

When working with care team members who have been physically assaulted, they always worry about getting law enforcement involved. This past winter, I was assisting a care team member in reporting being choked by a patient to police. The police officer is quoted saying, "You've not fixed them yet, what did you expect them to do." Referring to the patient. The truth is, this patient wasn't broken. He was angry and assaulted the nurse. This RN chose not to pursue criminal charges, because of the disrespect of the officer.

Perhaps one of the powerful experiences recently resulted in one the most amazing nurses leaving his job at Maine Health. Police had brought an intoxicated male into the hospital for evaluation. He was handcuffed upon arrival, the handcuffs were then removed in the patient. The patient then lunged and attacked the nurse. The police who had just had the patient in cuffs, didn't respond. This nurse wanted to proceed with criminal charges, he was met with such disregard from police he didn't continue with his statement. Sadly this amazing nurse, who provided excellent care to my own mother as she was dying, has resigned. It's a massive loss for our hospital and community.

I am a survivor of healthcare violence, living with the effects of PTSD after a prolonged violent encounter with a patient. This event caused me to step away from bedside nursing, a career that I loved. While stories like mine are important, that's not what we are discussing today. The patient who assaulted me was not in control of his actions or behaviors. However; many of the patients or family members who assault our care teams daily are in control of their actions and words. Yet they are not being held to the same legal standard as their counterparts who assault innocent people on the streets.

Slow Down- We need help, not only to hold people accountable for the violence they are bringing into our health care settings, but also to make sure no other care team members need to leave health care. I implore you to clarify and strengthen the law to protect our amazing health care workers from the needless acts of violence they experience every day. In 2022 The Joint Commission has expanded the needs and protections to keep our care team members safe. We need stronger legal and criminal protection to keep our care team members safe.

Thank you for your time, and I would be happy to answer questions.

Hello everyone, my name is Kelley Smith and I have been a registered nurse for 19 years. Ive spent my whole career in an emergency department, and have worked at Eastern Maine Medical Center for the past 9 years in the ER.

In April of this year I was punched in the face by a patient. From that injury I sustained a concussion. I had to stay in the dark for three days because it was almost impossible to keep my eyes open in daylight. I had a constant headache, I would vomit if I changed position, I was constantly dizzy, I couldn't eat. I was out of work for 3 weeks before I was cleared to go back. Currently I have not been notified of my assailants court date.

A coworker got punched in the side of the head and knocked unconscious when she was administering a medication, "just because".

A coworker got punched in the face by a patients brother, because he was frustrated about his brothers medical condition. He was summonsed for a class D assault but no charges were brought against him.

A coworker got punched in the face by a patient seven months ago, which caused a partial retinal detachment. He still has partial vision loss. That patient was summonsed for class D assault but was charged with a misdemeanor.

A coworker got attacked from behind. The patient had his arm around his neck, they fell backwards and my coworker said he couldn't breathe and knew he was going to pass out. No charges were brought against the patient.

We are seeing an increase in patients with behavioral issues who have limited coping skills and either physically or verbally take out their frustrations on medical staff.
Almost daily a healthcare worker gets verbally assaulted. We get spit on. We get called names, some have had their lives threatened. All as we do our jobs and provide care to help others. I have heard patients state that they know charges will be downgraded or dropped if they assault us. Patients have stated that we are supposed to take the abuse because it's part of our job and that we are there to serve them.

On top of the physical trauma of getting assaulted, the emotional trauma exists. Fear and anxiety of it possibly happening again lasts forever. The fact we have to accept that the assailants charges got dropped sends a message that those actions are ok. It is not listed anywhere in a job description that the possibility of getting assaulted at work is to be considered part of the job. It is a basic human right to be able to go to work and feel safe.

The law states that emergency medical care has to be being provided for someone to be charged with a felony assault. We are always providing some level of emergency care. In order to find out what is wrong with a patient when they come into the emergency department assessments, tests and procedures are required to get to a diagnosis.

Why does a person who has no medical background get to decide what is considered emergency care when bringing charges against the patient? We as victims need to have our voices heard. It should be a requirement that the healthcare victim have the opportunity to speak at their court date.

Healthcare workers have a passion to help others. It is part of who we are. We work long odd hours because we want to help other people. We walk away at the end of a shift feeling good that we helped someone feel better. We are elated when we save life. We cry when one is lost. A part of every one of us is truly invested in helping other people.

Sixty five percent of people are visual learners. They need to see something in order to retain it. I invite each of you to come spend time in our ER. The impact isn't the same just hearing the stories, most will truly understand if they're present for the incident. Seeing someone get punched in the face or choked to the point of unconsciousness doesn't leave your mind.

Healthcare workers are always available. Days, nights, weekends, holidays- we are always here to help. I have heard from many that our presence alone gives a sense of comfort when a patient comes in for help. Many have said they know they'll be cared for because they trust in us. I know I speak for everyone when I request from all of you that the law provide a comfort to us that the right thing will be done, and charges will be appropriate for the crime.

I greatly appreciate your time today.

Sincerely, Kelley Smith, RN

My name is Melissa Sargent. I am an RN at Maine Medical Center and have been in the Emergency Department since 2004. Over the years, I have seen an exponential increase of violence against myself and my fellow colleagues. I was bit by a patient in the waiting room after I had discharged her because she wouldn't leave the bathroom in the waiting room. Ultimately, she didn't want to leave the hospital and wanted to sleep in our waiting room. I filed a police report but I'm not sure if she was arrested. I later received a notice from the DA's office that this case was pled down to Disorderly Conduct. I had thought assaulting a health care worker was a felony. I used to be a Portland Police Officer and I'm not sure how this "felony" could be dropped down to a disorderly conduct.

I DO NOT call the police if I am assaulted by a dementia patient, or a developmentally delayed patient. We are careful to call only when there is clinical reason to believe the person is aware of their actions.

The vast majority of our patients have some psychiatric component to their diagnosis – that being said this does not give these patients the right to abuse our staff. Many have clear intent to harm staff – one patient punched several providers. His intent was to be taken to jail in the hopes he could be bailed out and go find alcohol. He clearly had a plan despite his mental health diagnosis.

Another patient, who had assaulted multiple RNs and ED techs and security officers over the course of months – was in jail and released prior to a safe housing measure implemented. So, for the subsequent two weeks waiting for this housing - the patient was in our Emergency Department EVERY DAY and SOMETIMES TWICE A DAY - putting our staff at risk for even more assaults.

These are just three examples of the dangers myself and my coworkers face on a daily basis. We face so many challenges in the healthcare field right now. We can't afford to lose any more hospital staff right now (which we have) due to assaults on healthcare providers. These FELONY assaults need to be treated as such by law enforcement and the judicial system. Take this burden off us – we need all the help we can get.

SUBMITTED BY Jim Bailinson – developed from the hospital perspective

These are follow-up questions to the presentations and Q&A at the previous public meeting that we would like posed to the various groups that provided information.

FOR DHS / DLC

How many patients received an "emergency discharge" from a residential care facility from 2018-2021? (DHHS, Page 1)

How does DHHS track/enforce the obligation for facilities that are initiating an emergency discharge to *"assist the consumer and authorized representatives in locating an appropriate placement."* (Page 1)

(Note: The hospital experience is that the burden to locate the next residential facility or placement falls almost entirely on the hospital social workers when the patient is in the hospital emergency room.)

Why do the provisions of 97.07-10 only apply to PNMI(E) facilities? (Page 2)

Why do only PNMI(E) providers have to accompany residents to the hospital emergency room? (Page 2)

What kinds of facilities transfer individuals to PNMI(E) facilities?

Are residents who file appeals of their discharge by PNMI's afforded any state support during the appeal? (Page 3)

The response to question 6 on page 6 [services received at PNMIs] only references PNMI(E) facilities; can you provide a response for the other PNMI facilities?

How many facilities requested "increased staffing" to manage difficult patients in from 2018-2021 and how many times did DHHS approve that increased staffing and how much was spent each year on this increased staffing? (Page 7)

Are all PNMIs eligible for increased staffing as needed?

How many cases have been referred to the Complex Case Unit each year from 2018-2021? (Page 7)

Does CCU track data associated with these cases, such as average length of stay? If so, please provide your tracking data.

OCFS posts data on children in residential treatment both in state and out of state, updated on a monthly basis. Is there a wait list for residential treatment for children? If so, can that be posted?

Please respond to the Alliance assertion that:

"Adults and children are often released back to a community treatment center or to their home or street with no support in place, no plan of long term care. They then wind up back in the ER in a more difficult and challenging state than they were before the initial visit to the ER or hospital." (Alliance, slide. 3.)

Crisis Teams – Hospitals report that crisis teams are directing individuals/families to the emergency department before any crisis teams conduct any community-based intervention to stabilize the individual and refer to services. How many individuals/families have been directed to the ED by the crisis team prior to conducting community-based intervention?

SUBMITTED BY Jim Bailinson – developed from the hospital perspective

For The "Alliance"

How many agencies have hired private security and how much are they spending each year? (Alliance, slide 4)

Why is the information residential facilities receive upon referral "insufficient" to accurately meet the needs of clients? Please provide specific examples of what information is missing? (Alliance, slide 4.)

For the Alliance/DHHS

We understand that PNMIs are "non-medical" but that many of the residents need behavioral health services.

Do you track/report the clinical behavioral health services (e.g. counselling, med. management) that residents of PNMIs receive? If so, could you provide some of that tracking data; such as what % of PNMI residents are receiving behavioral health clinical services? What kinds of services? And how well is the gap between what the community is providing and what hospitals provide being filled?

For Kepro/DHHS

Please provide a sample of the information provided to a residential care facility upon referral.

Please respond to the assertion that Kepro is providing insufficient information.

Do you track data associated with applications, such as the average length of time it takes for completion of a review regarding a referral? If so, please provide your tracking data.

For DAs/ DA Association

The Ellsworth PD written response stated: *"Our DA's office has been clear that they will not pursue criminal charges for assault on hospital staff if the patient suffers from mental illness."* (Green packet, page 2.)

Can we get a confirmation from the Hancock DA whether this is true and can we ask the DA association if other DA offices have a similar blanket policy?

For DAs/Judicial Branch

Can the DAs and Judicial Branch comment on the utilization of medication maintenance as a "condition of release" sentencing for those with mental illness? Should the task force consider a recommendation that DAs pursue medication adherence as a condition of release in these hospital violence cases, where appropriate?

SUBMITTED BY Jim Bailinson – developed from the hospital perspective

[Note: It is possible for courts to impose a condition of release on a defendant. A potential condition of release is that the defendant adhere to a prescribed medication protocol. Essentially, the defendant must take their pills to avoid liability for violence they commit.]

For Augusta PD/ADA Tarpinian/ADA Trainor

On a few occasions, each of you has raised the issue of a *"statement by an ED physician"* as to the mental state of the violent patient. You've also indicated that some of these statements may be better than others.

Can you please clarify what these statements are used for and is it possible for you to provide a re-dacted version of one you consider to be well done?

[Note: The few ED doctors we've asked seem unfamiliar with this statement. Training for ED personnel in preparing these statements could be a "best practices recommendation" in the final report of the Task Force and it would be helpful to have more information about this.]

From: Bethany Berry <bethberryrockland@gmail.com>
Sent: Tuesday, September 27, 2022 12:38 PM
To: Caswell, Lynne; David Miramant; Williams, Lynne; Lance Tapley; Fox, Danielle; Anne Beebe-Center; jennifer.egan@hhs.gov; Evangelos, Jeffrey; Info Request
Subject: OPPOSITION TO- LD629/Stop human rights abuse from psychotropic drugs banned by Medicare!

This message originates from outside the Maine Legislature.

Maine State Legislature Office 2 State House Station in Augusta, Maine 04333. (800) 301-3178

Dear Lynne Caswell and task force, 9/27/22

I regret I am unable to be at the task force hearing today, but as a Maine citizen and voter, wish to be heard on LD629 please. I can be reached at (207)542-7831, and I do not have a camera. Please call me so I may be heard to oppose criminalizing patients intentionally drugged into delusional assault, with NO criminal intent.

Medicare cannot cover suicide/euthanasia causing drugs (See-42 U.S. Code § 14401 - Findings and purpose) so Henry was wrongfully Ordered onto Mainecare to force suicide/violence/sterilizing euthanasia drugs! 11,647 deaths at AMHI must not be forgotten!

My son Henry Berry was a successful college student with no mental illness who re injured his head and was racially profiled wrongfully into a mental hospital for a few days and released with **ZERO** meds recommended. In Jan 2021 Henry went to Pen Bay Medical Center where doctors said he needed a neurologist NOT neurotoxic psychotropic drugs which had left my concussion-injured college son like this: http://penbay.org/berry/henry_berry_seizures.mp4 (That's not psychological! -Please play for committee to understand misdiagnosis by cop, which got Anton Black killed by police misdiagnosing schizophrenia also.) Dedimus Justice Steven Hanscom (On PBMC Board of Trustees) wrongfully blue papered Henry to PBMC ER (where he had withdrawal insomnia) undermining my guardianship, where Dr. Mark McAllister heinously forced psychosis/violence/suicide/brain damaging overdose of Olanzapine/Zyprexa after McLean discharge of **ZERO** meds recommended and Dr. Kaplan and his PCP had titrated him off the dangerous life-threatening FDA contraindicated drug which was sued for **$1.415 BILLION**. He was sent from PBMC ER to Spring Harbor after being heavily drugged out of his mind and put in solitary confinement for hours in his excrement, with an undiagnosed brain infection, and his Medicare was illegally billed for what the UN defines is torture. Spring Harbor took him off Olanzapine and experimented with a plethora of dangerous medications that did more harm. He was discharged on violence-causing Haldol which causes people to rip their eyes out, particularly when he has traumatic eye/brain injury (Just as Riverview's Mr. Staples plopped his eyes out from psychiatric drugs at MSP under Warden Liberty). Spring Harbor patient dumped Henry on Haldol saying he was fine. No warning was given to avoid propane on Haldol or compulsive eye poking or violent episodes, and fainting which caused Henry a volume of ER's including sutures and 7 staples in his head and a pen stabbed in his eye at Riverview on Christmas, etc. Haldol was sued for $485 million+$2.65 million leaving lawyers rich, and patients in jail or otherwise dead. Lorazepam was banned in California after causing 3,023 suicides, which my son is now forced 4times a day, while facing wrongful criminal charges.

Our family went to Funtown where Haldol mixed with the race car pungent propane which caused a wicked reaction, and DHHS accused me of withholding Haldol, which Judge Oceipka found I did not, but wrongfully gave my guardianship to DHHS Jody Liberty (Corrections Commissioner's wife). DHHS testified they have no policy to refuse any drug, even FDA contraindicated Clozapine forced on Henry after Maine sued Clozapine/Clozaril for $10million. Liberty kept family from seeing Henry until we had to bail him out of jail after being terrorized by Jody Liberty forcing **4** lobotomizing/violence/suicide-causing drugs over Henry's written &

religious objection to psychotropic drugs (After ZERO meds were recommended). Henry reported sexual assault at Riverview prior to DHHS banning calls to his mother! -See §555. Endangering welfare of dependent person.

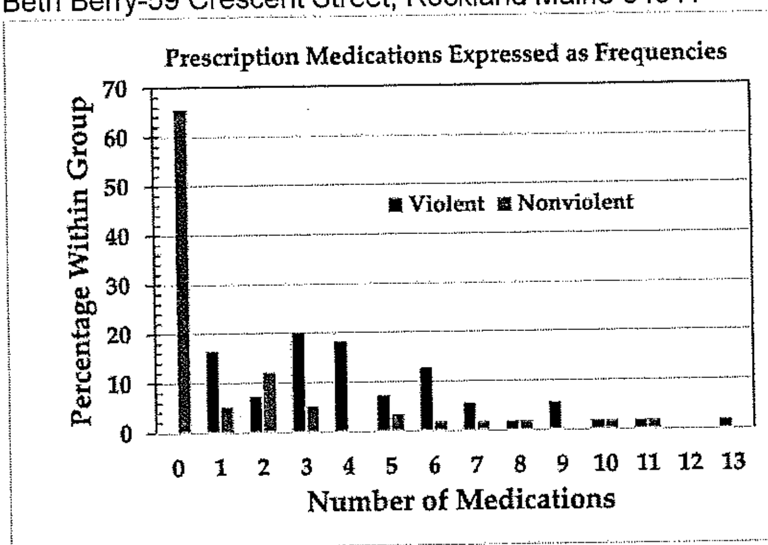
DHHS Jody Liberty had Maine General ER's Dr. Marceau force 4 mind-altering violence causing psychiatric drugs, criminally endangered Henry not letting him call family, as he was tortured in that 14th or15th ER since PBMC 2021 malpractice, which over the last 20 months caused 6 wrongful mental hospitalizations at $100,000/mo Medicare fraud, and 17 ERs, and wrongful incarceration in Kennebec County jail by the D.A. running for Henry's late grandfather's Cumberland County District Attorney seat.

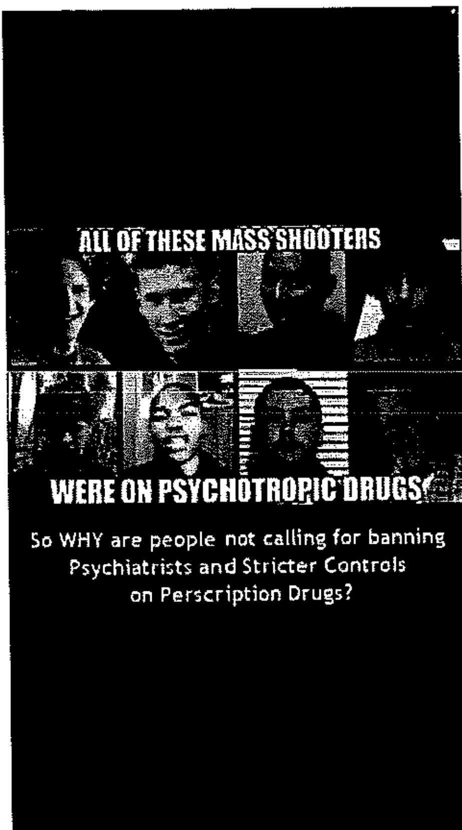
The Maine A/G is funded to prosecute medical crimes, but rather than hold the pharmaceutical manufacturers accountable for violence/suicide/lobotomizing psychotropic drugs, they want YOU to blame the true patient-victim for delusionally swatting the inexperienced nurse who took no precautions and got delusionally swatted as the patient panicked to hit the help button, after being bullied by Jody Liberty's chemical assault billed as healthcare.

I implore this task force to uphold the Maine Constitution and acknowledge the Sovereign Ruler of the Universe not to follow 34 states in this racket of forcing violence-causing psychiatric drugs in ER's that caused cruel jail incarceration for my minority son who lacked criminal intent, and **BAN violence-causing drugs under Mainecare** in place of this demonic bill designed to allow doctors and big pharma to wrongfully incarcerate patients and get staff hurt in ERs, while shareholders profit, and patients get criminal records to ruin their lives. There aren't enough competent Court appointed lawyers in Maine, and this bill will cause more deaths in Corrections, when **the moral solution is to ban Medicare covering brain damaging violence/suicide/sterilizing drugs** as California did. My son's life depends on your votes.

Faithfully,

Beth Berry-59 Crescent Street, Rockland Maine 04841





From the Citizens Commission on Human Rights: here is a link to the 64 page violence report violence-report.pdf (cchrint.org) or https://www.cchrint.org/pdfs/violence-report.pdf. In it, it talks about David Hawkins, page 5-6 - and what the Judge declared. Furthermore, I am placing a link to a woman named Jamie Juarez, from California - she won a jury trial to clear her name after being prescribed a cocktail of psychiatric drugs, https://unicourt.com/case/ca-la23-jamie-juarez-vs-aurora-charter-oak-los-angeles-llc-et-al-141872.

Maine State Legislature Office can be contacted via phone at (800) 301-3178.