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EMBEDDED HEALTHCARE POLICING

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ABSTRACT

Scholars and activists are urging a move away from policing and towards more care-based approaches to social problems and public safety. These debates contest the conventional wisdom about the role and scope of policing and call for shifting resources to systems of care, including medical, mental health, and social work. While scholars and activists in favor of reducing society's reliance on police recognize the co-constitutive relationship between policing and care work, they have not sufficiently grappled with the explicit overlapping mechanisms of carcerality. Surveillance and criminal enforcement permeate medical centers delivering care to low-income patients. Using numerous government records related to the U.S. Veterans Affairs Police Force (VAPF), this Article describes how the VAPF criminalizes low-income and sometimes Black or Latinx veterans with disabilities stemming from U.S military service. These populations are among the most medically vulnerable populations in the United States. It argues that care workers and health institutions become dependent on police to address harm and safety, and proposes alternatives grounded in anticarceral care to reduce reliance on police. In doing so, this Article shows just how difficult it will be to remove police from institutions because it requires rethinking care, not only policing. At the same time, this thick descriptive account provides a guide for how to reduce society's reliance on police in institutional contexts. This Article assesses the multiple intersections between U.S. Department of Veterans Affairs (VA) healthcare and embedded policing as a metaphorical healthcare policing web. Part I maps the process of assimilating policing into the VA, providing a primer on the agency and its patients. It explains the convergence of order maintenance, disability management, and workplace safety regulations that built the embedded policing infrastructure in place today. Part II explains how police influence clinical decisions and the care environment through Disruptive Behavior Committees, criminal enforcement, and workplace threat assessments, thereby altering the institutional culture. Part III draws lessons from the VA and proposes a list of potential solutions, adopting an abolitionist ethic for decoupling care from policing and embedded police from institutions.

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INTRODUCTION

Dan Lincoln[1] is a Black Vietnam-era U.S. Army veteran from the South. He experienced his first psychotic break while in service and was medically discharged in 1979 after months of inpatient psychiatric treatment peppered with violence and harm at the hands of staff. He has received veterans' healthcare treatment for substance use and schizophrenia, among other conditions, for many years.[2] About fifteen years ago, in distress—perhaps with thoughts of self-harm or auditory hallucinations—Mr. Lincoln went to a U.S. Department of Veterans Affairs (VA) hospital in Florida. Upon arrival and during his wait, he experienced additional distress caused by the bright lights, noise, and a crowded waiting area. Searching for a quiet place, he crawled under the desk in an unlocked dark office to calm himself. It was a hot Florida afternoon. He was sweating so he took off his shirt. When the staff member whose office he was in returned, they startled each other. The next thing he remembers is jail. He was charged with burglary of an empty structure and drug possession, among other offenses. Even though he went to the hospital for medical care, Mr. Lincoln served two years for the incident; upon release he was unhoused for nearly 15 years; and the VA placed a flag on his electronic medical records indicating a prior "disruptive" event.[3]

Since the death of George Floyd, the United States has been reckoning with racialized violence in Black communities. Common proposed antidotes to counter bloated police operations often include governmental health care, mental

1. Case documents on file with author (name and some facts changed).
2. According to the U.S. Department of Veterans Affairs (VA), about one in every three veterans seeking treatment for substance abuse disorder also has posttraumatic stress disorder (PTSD). *Treatment of Co-Occurring PTSD and Substance Use Disorder in VA*, U.S. DEP'T OF VETERANS AFFS., https://www.ptsd.va.gov/professional/treat/cooccurring/ tx_sud_va.asp#two [https://perma.cc/XNQ7-6KPA]. In addition, "[t]he vast majority of patients with PTSD will have one or more co-occurring mental health disorders." U.S. DEP'T OF VETERANS AFFS. & U.S. DEP'T OF DEF., VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER 23 (2017). As a result, the VA has put together policy recommendations and treatments for patients with co-occurring disorders. *Id.* at 23–24, 72–75, 78.
3. The VA permits hospital staff to place an electronic flag, which appears as bold red letters on the top of the records' page, when a patient has disrupted hospital operations. *See infra* Subpart II.B.

healthcare, or social work.[4] The opening example illustrates that such reforms do not necessarily account for the degree to which institutions whose primary function is to dispense care, instead serve as sites for (rather than sites free of) the regulatory, disciplinary, and violent dimensions of policing.[5] To extend the opening example, Mr. Lincoln believes the flag on his electronic record affects how hospital workers treat him, and that the Florida VA signed an order requiring Mr. Lincoln to report to VA police before any medical appointments.[6] Sometimes the police even follow him within medical facilities. He views these actions as restrictions on his access to essential medical care. The flag and order

4. *See e.g.*, *Portland in Solidarity Against Covid-19: Only Strong Communities Can Combat COVID-19*, CARE NOT COPS, https://www.carenotcops.org/ [https://perma.cc/SFP9-X4RA]. *See also* Melissa Colorado, *Oakland Group Offers Non-Police Hotline for Mental Health or Substance Abuse Emergencies*, NBC: BAY AREA (Feb. 18, 2021, 8:30 AM), https://www.nbcbayarea.com/news/local/east-bay/oakland-group-offers-non-police-hotline-for-mental-health-or-substance-abuse-emergencies/2470553 [https://perma.cc/AZA9-7PND]. *For Abolition, Not Reform*, BELIEVERS BAIL OUT (Mar. 2021), https://believersbailout.org/for-abolition-not-reform [https://perma.cc/GA4K-FLD4]; Anthony D. Romero, *Reimagining the Role of Police*, ACLU (June 5, 2020), https://www.aclu.org/news/criminal-law-reform/reimagining-the-role-of-police [https://perma.cc/L5VF-JT3Q]; Dennis Kosuth, *Chicago Unions Demand to Defund Police and Fund Health Care for All*, LABOR NOTES (July 7, 2020), https://labornotes.org/blogs/2020/07/chicago-unions-demand-defund-police-and-fund-health-care-all [https://perma.cc/ECY5-3DYA]; Martin Austermuhle, *Here's What Black Lives Matter D.C. Is Calling for, and Where the City Stands*, NPR (June 9, 2020), https://www.npr.org/local/305/2020/06/09/872859084/here-s-what-black-lives-matter-d-c-is-calling-for-and-where-the-city-stands [https://perma.cc/J8LR-7LRL].

5. Disability studies have thoughtfully addressed the intersection of carcerality and healthcare, particularly mental healthcare. *See, e.g.*, ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961) (Transaction Publishers, 2007); SUSAN M. SCHWEIK, THE UGLY LAWS: DISABILITY IN PUBLIC (2009); LIAT BEN-MOSHE, DECARCERATING DISABILITY: DEINSTITUTIONALIZATION AND PRISON ABOLITION (2020) (presenting an expansive definition of incarceration that includes treatment centers and psychiatric hospitals, and attributing the growth of prisons to neoliberalism, racism, and providing resources to policing rather than community support). In contrast, law scholarship examining police regulation has only recently begun to address this intersection. *See* Jamelia N. Morgan, *Policing Under Disability Law*, 73 STAN. L. REV. 1401 (2021); Jasmine E. Harris, *The Aesthetics of Disability*, 119 COLUM. L. REV. 895, 952 (2019) (stating that disability law has historically embodied the early twentieth-century policy goal of eugenics and provided "broader surveillance authority to police deviations from established norms"); Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons From the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53 (2011) (discussing the "transinstitutionalization" of the mentally ill from asylums to prisons during deinstitutionalization efforts of the 1960s and 1970s). The goal of my project is to examine the interconnectedness of policing and healthcare systems from an institutionalist view. This perspective on care is underappreciated in disability literature and policing scholarship.

6. The VA permits time, place, and manner restrictions on healthcare delivery, including police check-ins. *See infra* Subpart II.B.

stay with his medical records, even though Mr. Lincoln has been substance-free for three years, moved to a different state, and now owns his own home.

Reformers and scholars alike must grapple with how difficult it will be to decouple healthcare and policing to reduce its role in society. Hospitals are a case in point. They are quintessential care institutions, but even they have become policed spaces. Since 2021, over half of the states authorize hospitals to create their own police forces, backed by state legislation granting them arrest authority in response to crime reports within hospitals, parking lots, and property surrounding medical facilities.[7] In addition, care workers—such as nurses, doctors, and social workers—act as pseudopolice,[8] entrenching carceral logics[9] into the culture of care institutions through stringent federal and state safety training and reporting requirements that bring hospital employees into crime-control and surveillance frameworks.[10]

A growing law literature foregrounds how policing embeds itself in the structures and practices of healthcare delivery systems. These scholars have focused on the limits of privacy in the Fourth Amendment, excessive force

7. John Diedrich, Raquel Rutledge & Daphne Chen, *New Police Force in America: More Hospitals Are Creating Private Departments, Raising Concerns About Secrecy and Abuse*, MILWAUKEE J. SENTINEL (Jan. 13, 2021, 9:25 AM), https://www.jsonline.com/in-depth/news/investigations/2020/12/15/hospital-police-have-power-officers-but-little-oversight/6362900002/ [https://perma.cc/VZ9L-5MFG] (citing 29 states and the District of Columbia as allowing public hospitals to employ their own sworn police departments). A number of states have also proposed or passed legislation authorizing private hospitals to create their own mini police forces. *See, e.g.*, Emily Allen, *Private Hospitals Could Hire Police Officers Under Proposed House Bill*, W. VA. PUB. BROAD. (Jan. 29, 2020, 9:53 AM), https://www.wvpublic.org/post/private-hospitals-could-hire-police-officers-under-proposed-house-bill#stream/0 [https://perma.cc/96FF-AEB6]; *Description of Hospital Police Association of California*, CAL. STATEWIDE L. ENF'T ASS'N, https://cslea.com/about-us/affiliates/hpac-hospital-police-association-of-california [https://perma.cc/VH69-K5C6].

8. *See* Ji Seon Song, *Cops in Scrubs*, 48 FLA. L. REV. 861 (2022) [hereinafter Song, *Cops in Scrubs*] (making a similar argument for medical staff in Emergency Departments). My argument and approach are complementary but different. I focus on institutional design and the police as augmenting the carcerality within healthcare whereas Song focuses on the ways police and medical providers merge under a Fourth Amendment analysis and this merger's effect on healthcare professionals.

9. Carceral logic can be understood as a punishment mindset that permeates noncarceral locations or functions. MICHEL FOUCAULT, DISCIPLINE AND PUNISH: THE BIRTH OF THE PRISON 297 (Alan Sheridan trans., Second Vintage Books ed. 1979) (1995). Foucault theorizes a "carceral archipelago" which transports disciplinary control from the prison to various institutions to form a "carceral net" in which people (usually indigent, disenfranchised, or otherwise marginalized) are subjected to carceral technologies, investigation, and discipline. *Id.*

10. *See* U.S. DEP'T OF LAB. & OCCUPATIONAL SAFETY & HEALTH ADMIN., WORKPLACE VIOLENCE IN HEALTHCARE: UNDERSTANDING THE CHALLENGE (2015), https://www.osha.gov/sites/default/files/OSHA3826.pdf [https://perma.cc/DEU2-WUYE]; *See infra* Subpart II.B.

doctrine, the Health Insurance Portability and Accountability Act (HIPAA), and medical ethics.[11] Much of the work to date has focused on emergency departments, paramedic responses, and the role of care workers in knowingly and unknowingly extending police investigatory and search authority. This scholarship also connects racial bias and histories of racism in medicine, such as eugenics, to the current relationship between police and hospitals.[12] It draws attention to the violence poor and Black patients face at the intersection of law enforcement and healthcare. Yet still, more scholarly investigation is needed to understand precisely how carceral logics and care work—defined in this Article as medical, mental health, and social work—mutually influence one another.[13] Examining the nexus between these two is precisely the aim of this Article.

This Article contributes to the scholarly understanding of the co-constitutive relationship between policing and care work in a specific and unexamined context: the infrastructure of the largest embedded U.S. police force within the country's largest public healthcare system, the VA. This health system is designed to address the needs of persons with histories of complex trauma, substance use, and disabilities such as traumatic brain injuries. The VA police force (VAPF) budget supports approximately 5500 VA police officers and detectives[14] operating in 1298

11. *See* Song, *Cops in Scrubs*, *supra* note 8; Ji Seon Song, *Policing the Emergency Room*, 134 HARV. L. REV. 2646 (2021) [hereinafter Song, *Policing the ER*]; Osagie K. Obasogie & Anna Zaret, *Medical Professionals, Excessive Force, and the Fourth Amendment*, 109 CALIF. L. REV. 1 (2021); *see also* Andrea J. Ritchie & Levi Craske, *Unraveling Criminalizing Webs: Building Police Free Futures*, 15(3) SCHOLAR & FEMINIST ONLINE (2019), https://sfonline.barnard.edu/unraveling-criminalizing-webs-building-police-free-futures/introduction/#, [https://perma.cc/9CAY-MUXY]. Advocates in law and public health are bringing attention to the intersections of healthcare and policing and the ways health and care work police certain bodies. For example, the Community Resource Hub for Safety and Accountability is building collective resources. *Resources*, CMTY. RES. HUB, https://communityresourcehub.org/resources/ [https://perma.cc/ GE6G-7FZD].

12. Song, *Cops in Scrubs*, *supra* note 8.

13. This Article draws upon the scholarship of those examining the treatment, criminalization, and regulation of Black women in medical settings, and poor women receiving public assistance. These projects, like this Article, uncover ways that systems of care and social services are imbued with carceral logics. *See e.g.*, Khiara M. Bridges, *Pregnancy, Medicaid, State Regulation, and the Production of Unruly Bodies*, 3 NW. J.L. & SOC. POL'Y 62 (2008); Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474 (2012); Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163 (2017); KAARYN S. GUSTAFSON, CHEATING WELFARE: PUBLIC ASSISTANCE AND THE CRIMINALIZATION OF POVERTY 63–69 (2011). This Article extends this conversation to the VA setting, thereby illuminating yet another space in which poor people who receive government aid and healthcare face targeted regulation.

14. The 2021 budget request includes an increase for police personnel. U.S. DEP'T OF VETERANS AFFS., 3 FY 2021 BUDGET SUBMISSION: BENEFITS AND BURIAL PROGRAMS AND DEPARTMENTAL ADMINISTRATION 339 (2020). Congressional hearings over the last two years suggest Congress

VA healthcare facilities and clinics that care for nine million patients and employ nearly 400,000 workers.[15] For perspective, if the VAPF were an urban police department, it would be among the ten largest. Among federal administrative law enforcement departments, it is the eighth largest.[16]

This federal law enforcement agency polices one of the most historically marginalized and vulnerable populations in the United States—veterans of the U.S. Armed Forces accessing medical care through the VA.[17] The demographics of Veterans Healthcare Administration (VHA) clientele demonstrate how the "healthcare policing web" described here harms an already multiply-marginalized social group. Its patient population largely mirrors the communities most harmed by the police: survivors of trauma and sexual assault, people of color, people with disabilities,[18] women, and low-

may appropriate enough for the VA to nearly double its police operations. *Modernizing the VA Police Force: Ensuring Accountability: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Veterans' Affs.*, 117th Cong. 2 (2021) (statement of Leigh Ann Searight, Deputy Assistant Inspector Gen.), https://www.va.gov/oig/pubs/statements/VAOIG-statement-20210713-Searight.pdf [https://perma.cc/FF63-GMEW].

15. *Veterans Health Administration*, U.S. DEP'T OF VETERANS AFFS., https://www.va.gov/health/aboutvha.asp [https://perma.cc/7PH8-73GF] ("The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, employs more than 371,000 health care professionals and support staff providing care at 1298 health care facilities . . . to over 9 million Veterans enrolled in the VA health care program.").

16. *Compare VA Police: Protecting Those Who Protected Us*, VANTAGE POINT (Aug. 22, 2019), https://www.blogs.va.gov/VAntage/65122/va-police-protecting-us [https://perma.cc/ NSG5-ENWH], *and* ADAM ANDRZEJEWSKI & THOMAS W. SMITH, THE MILITARIZATION OF THE U.S. EXECUTIVE AGENCIES: NON-MILITARY PURCHASES OF GUNS, AMMUNITION, AND MILITARY-STYLE EQUIPMENT FY2015–FY2019, at 16 (2020), *with* Connor Brooks, *Federal Law Enforcement Officers, 2016–Statistical Tables*, U.S. DEP'T JUST.: BUREAU JUST. STAT. (2019), https://www.bjs.gov/content/pub/pdf/fleo16st.pdf [https://perma.cc/K7PM-76EU].

17. *See generally* U.S. DEP'T OF VETERANS AFFS.: OFF. OF INSPECTOR GEN., REPORT 17–01007–01, INADEQUATE GOVERNANCE OF THE VA POLICE PROGRAM AT MEDICAL FACILITIES (2018), https://www.va.gov/oig/pubs/VAOIG-17–01007–01.pdf [https://perma.cc/FE4M-JYA7]; *Examining VA's Police Force: Hearing Before the H. Subcomm. on Oversight & Investigations of the H. Comm. on Veterans' Affairs*, 116th Cong. (2019) [hereinafter, *Examining VA's Police Force*].

18. Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139 (1989); Natesha Smith, *More Than White, Heterosexual Men: Intersectionality as a Framework for Understanding the Identity of Student Veterans*, 2 J. PROGRESSIVE POL'Y & PRAC. 229, 229–35 (2014); Chalsa M. Loo, *PTSD Among Ethnic Minority Veterans*, U.S. DEP'T OF VETERANS AFFS., https://www.ptsd.va.gov/professional/treat/type/ethnic_minority_vets.asp [https://perma.cc/B89D-VLTS]; Kim Parker, Rith Igielnik, Amanda Barroso & Anthony Cilluffo, *The American Veteran Experience and the Post-9/11 Generation*, PEW RSCH. CTR. (Sept. 10, 2019), https://www.pewresearch.org/ social-

income, uninsured, and/or transgender veterans.[19] Thus, the subjects of VA policing interventions are often unhoused, Black or Latinx, in recovery, transgender, or veterans with disabilities.[20] For this reason, this Article views veterans through their intersectional identities, such as race, age, disability, and gender, even when the available policing data does not provide that demographic information; because in reality, interactions with police are mediated through multiple identities, not solely veteran status.

I use the VAPF as a cautionary tale to assist reformers and scholars with the project of decoupling police from institutions. This Article presents the VA as a concrete example of how carceral actors, logics, and practices can shape the cultures of institutions, such as hospitals, that are often assumed to exist separately from the problems of policing, and are thus removed from this moment of societal reconfiguring.[21] This Article argues that policing embeds itself in hospitals and

trends/2019/09/10/the-american-veteran-experience-and-the-post-9-11-generation [https://perma.cc/4WB8-49AY].

19. *See infra* Subpart I.A.

20. Drawing from disability rights and disability justice movements, this Article recognizes the importance of language when discussing disability. This Article primarily uses people-first language to refer to people with disabilities as a group or class. *Disability Language Style Guide*, NAT'L CTR. ON DISABILITY & JOURNALISM (Aug. 2021), https://ncdj.org/style-guide/ [https://perma.cc/VN83-YCHD]; LABIB RAHMAN, STAN. DISABILITY INITIATIVE, DISABILITY LANGUAGE GUIDE 1, 2 (2019), https://disability2022.sites.stanford.edu/sites/g/files/sbiybj26391/files/media/file/disability-language-guide-stanford_1.pdf [https://perma.cc/Q274-SEWV] ("Putting the person first, as in 'people with disability,' is called people-first language. It is commonly used to reduce the dehumanization of disability.") This Article sometimes uses the identity-first language, as in "disabled people," a linguistic prescription commonly used in the disabled community. *See* Lydia X.Z. Brown, *The Significance of Semantics: Person-First Language: Why It Matters*, AUTISTIC HOYA (Aug. 4, 2011), https://www.autistichoya.com/2011/ 08/significance-of-semantics-person-first.html. ("In the autism community, many self-advocates and their allies prefer terminology such as 'Autistic,' 'Autistic person,' or 'Autistic individual' because we understand autism as an inherent part of an individual's identity."). For careful consideration, see Disability Critical Race Theory scholars such as, Subini Ancy Annamma, David Connor & Beth Ferri, *Dis/ability Critical Race Studies (DisCrit): Theorizing at the Intersections of Race and Dis/ability*, 16 RACE ETHNICITY & EDUC. 1 (2013); Beth A. Ferri, Subini Ancy Annamma & David J. Connor, *Critical Conversations Across Race and Ability*, *in* DISCRIT: DISABILITY STUDIES AND CRITICAL RACE THEORY IN EDUCATION 213 (David J. Connor et al. eds., 2016).

21. The psych survivor movement and critical disability and psychiatry scholars have documented the ways in which health professionals may also respond punitively to disruptive behavior. As Professor Osagie Obasogie and Anna Zaret have documented, medical professionals may also use excessive force while intervening with patients in psychiatric distress. Obasogie & Zaret, *supra* note 11; *see also* JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., ALTERNATIVES TO THE POLICE: RESPONDING TO PEOPLE WITH MENTAL ILLNESS (2021), https://secureservercdn.net/198.71.233.254/d25.2ac.myftpupload.com/ wp-content/uploads/2021/04/Alt-to-the-Police-Responding-to-People-with-Mental-Illness.pdf [https://perma.cc/D7ML-ZN88] (documenting such use of force and violent techniques).

healthcare settings and creates path dependency between police and healthcare institutions to enlarge systems of behavioral monitoring, surveillance, and workplace safety. Pre-existing and sometimes invisible forms of discipline and carceral logics, expanded through embedded policing, shape the design of institutions and the structural violence they reproduce. The VA is a particularly salient example. Almost all the troubling dimensions of policing that figure as political and movement battle cries in the current moment are playing out on the bodies of veterans in the context of VA hospitals. These problems include racial profiling; police violence; institutionalized surveillance; and the exploitation, mismanagement, and inattention to people with disabilities. Scholars, policymakers, and community organizers should recognize that how police officers structure access to veterans' healthcare is relevant to debates about police reform and therefore they should include the VA as a site of contestation over the future of policing.

This Article's analysis is based on official records, court documents, and interviews. I have reviewed the Congressional record including oversight hearing transcripts. I relied on the federal register, internal audits, and reports about VA security and police operations. I spoke to VA staff, veteran patients, legal service providers and veterans' organizations in a few different locations nationally. I relied upon the VA's limited data analysis for police interactions with patients and visitors. Based on this set of information and data, I developed this Article's analytic frame for understanding how and why police are embedded in healthcare facilities that serve race- and class- marginalized patients and communities.[22]

Part I provides a primer on the VA and its patients. It then situates the history of how workplace safety concerns converged with order maintenance and disability management policing in the 1980s and 1990s. Police imbrication distorts the role of VA hospitals as centers of holistic care. Mass criminalization shapes access to essential VHA healthcare and services.[23] Part II connects criminal regulation with the two primary features of policing within the VA's healthcare: red flags and orders of behavioral restriction. These internal governance systems intersect on multiple axes as a metaphorical web.[24] I argue both police and medical

22. *See* Mario Luis Small, *'How Many Cases Do I Need': On Science and the Logic of Case Selection in Field-Based Research*, 10(1) ETHNOGRAPHY 5 (2009).

23. Professor Devon Carbado uses mass criminalization to mean "the criminalization of relatively nonserious behavior or activities and the multiple ways in which criminal justice actors, norms, and strategies shape welfare state processes and policies." Devon W. Carbado, *Blue-on-Black Violence: A Provisional Model of Some of the Causes*, 104 GEO. L.J. 1479, 1487 (2016).

24. The often-used term "pipeline" suggests a linear relationship whereby an institution imports police, and the result is carceral. A well-understood example includes the school-to-prison

staff engage in risk assessments, surveillance, and criminal enforcement to manage non-normative behavior of many veteran patients.[25] The veterans subjected to this form of policing are deemed suspicious and at risk of perpetrating violence toward care staff (or themselves).[26] Dubbed "perpetually threatening,"[27] they remain caught in the web's digital and physical threads. Part III proposes solutions from an abolitionist ethic to decouple policing from care and reorient care as liberatory. It proposes shifting to trauma-informed institutions and anticarceral care,

pipeline. While the school-to-prison pipeline is among the more well-documented pathways to incarceration, legal scholars articulate the relationship between prisons and social institutions beyond education, including social security, foster care, and immigration detention. The interconnectedness of, and overlap between, these sites and policing and state surveillance have been articulated in varying frameworks, including the web articulated in this Article. *See, e.g.*, Bridges, *supra* note 13, at 64 (arguing that the receipt of Medicaid "inaugurates poor women into the state regulatory apparatus" and "produces pregnancy as an opportunity for state supervision, management, and regulation of poor, uninsured women"); Roberts, *supra* note 13, at 1476 ("The simultaneous buildup and operation of the prison and foster care systems rely on the punishment of Black mothers, who suffer greatly from the systems' intersection."); César Cuauhtémoc García Hernández, *Naturalizing Immigration Imprisonment*, 103 CALIF. L. REV. 1449 (2015) (mapping the "many civil and criminal entryways into immigration imprisonment across every level of government"); Ocen, *supra* note 13, at 1193; Laila Hlass, *The School to Deportation Pipeline*, 34 GA. ST. U. L. REV. 697 (2018). *See also* Alicia Pantoja, *Reframing the School-to-Prison Pipeline: The Experiences of Latin@ Youth and Families*, 7 J. ASS'N MEXICAN AM. EDUCATORS 17 (2013); Caitlin Cahill, Leticia Alvarez Gutiérrez & David Alberto Quijada Cerecer, *A Dialectic of Dreams and Dispossession: The School-to-Sweatshop Pipeline*, 23 CULTURAL GEOGRAPHIES 121 (2016) (discussing a "school-to-sweatshop pipeline"); Alisa Bierria & Colby Lenz, *Battering Court Syndromes: A Structural Critique of "Failure to Protect," in* THE POLITICIZATION OF SAFETY: CRITICAL PERSPECTIVES ON DOMESTIC VIOLENCE RESPONSES (Jane K. Stover ed., 2019) (discussing the criminalization of women experiencing abuse); MALIKA SAADA SAAR, REBECCA EPSTEIN, LINDSAY ROSENTHAL & YASMIN VAFA, THE SEXUAL ABUSE TO PRISON PIPELINE: THE GIRLS' STORY; Barbara A. Fedders, *The End of School Policing*, 109 CALIF. L. REV. 1443 (2021).

25. Foucault explains that "normation" is the process that creates norms of behavior through practices that force habits and rituals. In this way, he extends the concepts of disciplinary institutions, like a prison, to a system that "compares, differentiates, hierarchizes, homogenizes, excludes. In short, it normalizes." FOUCAULT, *supra* note 9, at 183. Normation often involves reinforcing white, middle-class values and behavior while normalizing social control through the carceral network. Institutions such as hospitals and schools are normative and shape behavior. They belong within the carceral network of institutions. *Id.*

26. L. Song Richardson and Phillip Atiba Goff describe the "suspicion cascade" as a situation in which the context provokes people of color to behave more suspiciously due to stereotype threat and the concern of being perceived as criminal. L. Song Richardson & Phillip Atiba Goff, *Self-Defense and the Suspicion Heuristic*, 98 IOWA L. REV. 293, 335 (2012).

27. Tom Shakespeare, *Cultural Representation of Disabled People: Dustbins for Disavowal?*, *in* DISABILITY STUDIES: PAST, PRESENT AND FUTURE 217, 229 (Len Barton & Mike Oliver eds., 1997) ("People with impairment are the ultimate non-conformists, and as such are perpetually threatening. . . .").

removing police from care decisions, and utilizing restorative justice to address interpersonal harm.

Before continuing, I want to address the important consideration of representativeness of the VHA. The VA is the largest public healthcare system with the largest embedded police department in the United States. The VA is considered a model for managing low-income patients with complex trauma.[28] These realities make the VA worthy of its own consideration. The increasing securitization of health settings and the causes, especially in low-income urban areas, is coming to light in the media and becoming documented in medical journals.[29] To the extent we can extrapolate from one institution, we can take the lessons to other government-run hospitals and regulatory systems in public institutions that serve race- and class-based marginalized groups, as well as sites where we worry about harm from and between clientele—such as emergency rooms or schools. Studying the VAPF systems allows other health institutions, and perhaps other institutions with embedded police, to recognize the natural instinct to turn to police as the only answer for security and safety issues,[30] even when other professionals or mechanisms are available.[31]

28. *See, e.g.*, James P. Phillips, *Workplace Violence Against Health Care Workers in the United States*, 374 NEW ENG. J. MED. 1661, 1667 (2016) (discussing VA record flag system as a model to replicate nationally in other health care contexts); NAT'L INST. FOR OCCUPATIONAL SAFETY & HEALTH, NO. 2002-101, VIOLENCE: OCCUPATIONAL HAZARDS IN HOSPITALS (2002), https://www.cdc.gov/niosh/docs/2002–101/pdfs/2002–101.pdf?id=10.26616/NIOSHPUB2002101 [https://perma.cc/PMF3-TMAD] (noting VA flag system is a practice worth replicating in other hospital settings) [hereinafter "VIOLENCE: OCCUPATIONAL HAZARDS IN HOSPITALS"].

29. *See* Kate Gallen, Jake Sonnenberg, Carly Loughran, Michael J. Smith, Mildred Sheppard, Kirsten Schuster, Elinore Kaufman, Ji Seon Song & Erin C. Hall, *Health Effects of Policing in Hospitals: A Narrative Review*, J. RACIAL ETHNIC & HEALTH DISPARITIES (Mar. 10, 2022), https://doi.org/10.1007/s40615-022-01275-w (noting "[t]he increase in law enforcement and security presence in hospitals largely developed in response to high rates of workplace violence in healthcare . . ."); *A Sharp Rise in the 'Constantly Fearful' in the ER*, HOSP. EMP. HEALTH, Mar. 2019, at 1 (citing a Michigan study finding the presence of armed security officers in hospitals tripled between 2005 and 2018); Elisabeth Rosenthal, *When the Hospital Fires the Bullet*, N.Y. TIMES (Feb. 12, 2016), https:// www.nytimes.com/2016/02/14/us/hospital-guns-mental-health.html [https://perma. cc/E8ZX-E3QN] ("[M]ore and more American hospitals are arming guards with guns and Tasers, setting off a fierce debate about whether such steps—along with greater reliance on law enforcement or military veterans—improve safety or endanger patients.").

30. *See* Sunita Patel, *Transinstitutional Policing*, 136 HARV. L. REV. ___ (forthcoming 2023).

31. *See*, *infra* Subpart III.A. *See also* Isabelle Lanser, Nelson B. Freimer & Michelle G. Craske, *Reducing Policing in Mental Health Crises: A Vision for University Campuses*, J. AM. COLL. HEALTH (Sept. 8, 2021), https://doi.org/10.1080/07448481.2021.1967363 (discussing mobile campus intervention teams as a policing alternative to managing mental health crises on campus); Anastasia Loukaitou-Sideris, Jacob Wasserman, Hao Ding & Ryan

I. THE U.S. DEPARTMENT OF VETERANS AFFAIRS & ITS POLICE FORCE

This Part shows the ease with which health systems for poor and marginalized people assimilate police, thereby both expressing and expanding their preexisting carceral logics. It provides a primer of the VHA including the specific demographics and health needs of its veteran patients. This profile sets the stage for the underlying argument that care workers may view patients who are nonwhite, disabled, or are considered at risk of mental health distress as threats to personal and public safety. It then presents the internal account behind the creation of the VAPF using thousands of pages from the Congressional Record and VA documents. It roots healthcare policing in the convergence of order maintenance, disability management, and workplace violence regulations that developed over several decades despite some internal opposition. The public record illuminates the ways institutions embed police and how decisionmakers naturalize expanding the role and scope of police on all questions related to safety. Understanding precisely how police become embedded in such institutions allows reformers to better address the outsized scope of police.

A. The Veterans Healthcare Administration and Its Patients

The VA is a cabinet-level executive department whose mandate requires it to be a veteran-friendly agency meeting veterans' needs, especially those arising from military service. It is composed of three subagencies charged with administering monetary entitlements, cemeteries, and, through the VHA, veteran healthcare.[32] As the largest integrated healthcare network in the country, the VHA serves nine million qualified veterans and family members each year.[33] Its medical infrastructure includes hospitals, nursing care, outpatient mental health facilities, drug and alcohol treatment programs, and inpatient residential domiciliary facilities.

Caro, "*It Is Our Problem!*": *Strategies for Responding to Homelessness on Transit*, TRANSP. RSCH. REC. (July 20, 2022), https://doi.org/10.1177/ 03611981221111156 (reviewing transit public safety intervention programs including those without police).

32. President Ronald Reagan elevated the VA to the cabinet level in 1989. *See VA History: History–Department of Veterans Affairs (VA)*, U.S. DEP'T OF VETERANS AFFS.:VA HISTORY OFF. (May 27, 2021), https://www.va.gov/HISTORY/VA_History/Overview.asp [https://perma.cc/3BJG-2RLT]. The VA is composed of the Veterans Health Administration (VHA), Veterans Benefits Administration, and the National Cemetery Administration.

33. *Veterans Health Administration*, U.S. DEP'T OF VETERANS AFFS. (Sept. 28, 2021), https://www.va.gov/health [https://perma.cc/X79Y-VBVN].

In VHA care settings, veterans can receive specialized care for health concerns found more commonly among former service members than civilians, such as amputations, traumatic brain injury, posttraumatic stress disorder (PTSD), and military sexual trauma. About one in every three veterans seeking treatment for substance abuse disorder also has a diagnosis of PTSD.[34] The VHA also has methadone clinics and other treatment programs to address substance use and co-occurring disorders where substance use and a mental health diagnosis complicate treatment. Former service members are unhoused in large numbers, making up 8 percent of the homeless adult population nationwide.[35] Forty-five percent of all homeless veterans are Black or Latinx, despite only accounting for roughly 12 percent and 7 percent of the veteran population, respectively.[36] The VHA provides dedicated health programs to address homelessness through interdisciplinary care teams and case management,[37] as well as extensive programming to mitigate the risk of suicide, which disproportionately affects the veteran population. Although veterans represent 8 percent of the U.S. population, they account for over 14 percent of suicides; their risk of suicide is 41 percent to 61 percent higher than nonveterans, and depression rates are five times higher.[38]

34. U.S. DEP'T OF VETERANS AFFS. & U.S. DEP'T OF DEF., VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER 1, 23, 72, 78 (Version 3.0, 2017); *see Treatment of Co-Occurring PTSD and Substance Use Disorder in VA*, U.S. DEP'T OF VETERANS AFFS.: PTSD: NAT'L CTR. FOR PTSD, https://www.ptsd.va.gov/professional/treat/cooccurring/tx_sud_va.asp#two [https://perma.cc/W2NJ-ZZ47].

35. U.S. DEP'T OF HOUS. & URB. DEV., THE 2020 ANNUAL HOMELESS ASSESSMENT REPORT (AHAR) TO CONGRESS: PART 1: POINT-IN-TIME ESTIMATES OF HOMELESSNESS 52 (2021), https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf [https://perma.cc/U54U-TJQZ]. Counting is difficult, but the U.S. Department of Housing and Urban Development estimates that nearly 40,000 veterans are homeless on any given night, with an additional 1.4 million veterans considered at risk of homelessness due to poverty, lack of support networks, and overcrowded and substandard living conditions. *Id.* at *53*; *HUD Releases 2020 Annual Homeless Assessment Report Part 1: Homelessness Increasing Even Prior to COVID-19 Pandemic*, U.S. DEP'T OF HOUS. & URB. DEV.: PRESS ROOM (Mar. 18, 2021), https://www.hud.gov/press/press_releases_media_advisories/ hud_no_21_041 [https://perma.cc/PXF8-QPPD]. For the federal definition of homelessness, see 42 U.S.C. § 11302.

36. U.S. DEP'T OF HOUS. & URB. DEV., 2020 ANNUAL HOMELESS ASSESSMENT REPORT (AHAR) TO CONGRESS: PART 1: POINT-IN-TIME ESTIMATES OF HOMELESSNESS 53–54 (2021), https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf [https://perma.cc/U54U-TJQZ].

37. *See* Thomas P. O'Toole, *Primary Care for Homeless Veterans*, in HOMELESSNESS AMONG U.S. VETERANS: CRITICAL PERSPECTIVES 61, 66–70 (Jack Tsai, Thomas O'Toole & Lisa K. Kearney, eds., 2019).

38. *Suicide Among Veterans and Why It Matters*, MENTAL HEALTH FIRST AID: NAT'L COUNCIL FOR MENTAL WELLBEING (Nov. 6, 2018), https://www.mentalhealthfirstaid.org/2018/11/ suicide-among-veterans-and-why-it-matters [https://perma.cc/KRZ5-STBQ?type= image];

When a suicide occurs at a VA healthcare facility, the staff undertake a root cause analysis to better understand institutional changes that might have prevented it.[39]

Studies of VA healthcare utilization found that race, low income, lack of medical insurance, poor health status, and military service-connected disabilities predict VHA use.[40] In fiscal year 2017, 6.1 million veterans used VA healthcare, accounting for approximately half of all veterans.[41] Black, Hispanic, and Native Hawaiian and Pacific Islander veterans are more likely to use VA healthcare than white or other Asian veterans,[42] and female veterans use it at a slightly higher rate than males.[43] Although transgender veterans are not captured in the national data, several studies found that they use VA healthcare at higher rates than cisgender veterans, and one study found that transgender homeless veterans are more than twice as likely to use VHA homeless programs.[44] Disability is also a driver of VHA

CONG. RSCH. SERV., VETERAN SUICIDE PREVENTION (July 29, 2021), https://www.everycrsreport.com/files/2021-07-29_IF11886_48e7fd0010a587315ee677b9e54fab5ccac9eb4c.pdf [https://perma.cc/L4FJ-K4WB]. *See generally* 38 U.S.C. §§ 101(2), 101(18); Pub. L. 95–126, 38 C.F.R. § 3.360.

39. *See* John Hollway, Calvin Lee & Sean Smoot, *Root Cause Analysis: A Tool to Promote Officer Safety and Reduce Officer Involved Shootings Over Time*, 62 VILL. L. REV. 883, 912–14 (2017) (explaining that root cause analysis allows for implementation of reforms that will improve safety, increase morale, and restore police legitimacy); PAUL F. WILSON, LARRY D. DELL & GAYLORD F. ANDERSON, ROOT CAUSE ANALYSIS: A TOOL FOR TOTAL QUALITY MANAGEMENT 10–11 (1993) (explaining that root cause analysis is designed to provide input to management decisions regarding quality and productivity, creating effective tools to provide corrective action and preventative measures). *Cf.* Jennifer Steinhauer, *Report Slams Doctor at V.A. for Dismissing Suicide Risk of Patient Who Later Killed Himself*, N.Y. TIMES (July 28, 2020), https://www.nytimes.com/2020/07/28/us/politics/veterans-suicide.html [https://perma.cc/VSW4-9SYN].

40. *See* Donna L. Washington, W. Neil Steers, Alexis K. Huynh, Susan M. Frayne, Uchenna S. Uchendu, Deborah Riopelle, Elizabeth M. Yano, Fay S. Saechao & Katherine J. Hoggatt, *Racial and Ethnic Disparities Persist at Veterans Health Administration Patient-Centered Medical Homes*, 36 HEALTH AFFS. 1086 (2017); Andrea Carter, Sonya Borrero, Charles Wessel, Donna L. Washington, Bevanne Bean-Mayberry, Jennifer Corbelli & VA Women's Health Disparities Research Workgroup, *Racial and Ethnic Health Care Disparities Among Women in the Veterans Affairs Healthcare System: A Systematic Review*, 26 WOMEN'S HEALTH ISSUES 401 (2016).

41. NAT'L CTR. FOR VETERANS ANALYSIS & STATS., U.S. DEP'T OF VETERANS AFFS., VA UTILIZATION PROFILE FY 2017 (2020).

42. The average rate of veterans with disabilities using VHA care was 69.6 percent in Fiscal Year 2017. Black veterans' use rate is higher at 77.4 percent. The rest of the racial breakdown is as follows: white 67.6 percent, Asian 62.5 percent, Hispanic (of any race) 71.5 percent, Native Hawaiian/Pacific Islander 66.5 percent, American Indian or Alaskan-Native 70.9 percent, and other (including multiracial) 68.5 percent. *Id.* at *16.*

43. *Id.*

44. Ann Elizabeth Montgomery, Jillian C. Shipherd, Michael R. Kauth, Keith W. Harris & John R. Blosnich, *Use of Veterans Health Administration Homeless Programs Among Transgender and*

care because veterans may be eligible for limited VA healthcare to treat service-connected disabilities regardless of eligibility for comprehensive VA medical care.[45]

The number of veterans with disabilities or marginalized identities seeking VHA care is likely to increase due to corrections in eligibility requirements, and changes in the socio-economic and demographic profiles of veterans eligible for VA healthcare.[46] Historically, structural racism,[47] symptoms associated with mental health conditions,[48] in-service trauma (including sexual assault and racial harassment), and "Don't Ask, Don't Tell"[49] have led to discharge statuses that disqualify a service member from VA healthcare.[50] During the Obama Administration, Congress and the VA reformed eligibility requirements to improve access to healthcare for veterans most in need. For example, starting in July 2017, the VA authorized ninety days of emergency care to veterans with otherwise disqualifying "Other Than Honorable" discharges experiencing mental health crises and to former service members diagnosed with a mental health condition during the first five years after discharge.[51] These reforms attract

Non-Transgender Veterans Experiencing Self-Reported Housing Instability, 31 J. FOR HEALTH CARE FOR POOR & UNDERSERVED 909, 914–15 (2020).

45. CONG. RSCH. SERV., HEALTH CARE FOR VETERANS: ANSWERS TO FREQUENTLY ASKED QUESTIONS (2020), https://sgp.fas.org/crs/misc/R42747.pdf [https://perma.cc/C73H-RM2D].

46. One eligibility criterion for VA healthcare is a discharge under "other than dishonorable" conditions. Notwithstanding discharge status, veterans may be eligible for full VA health care based on another enlistment that ended with an honorable discharge. *Federal Benefits for Veterans, Dependents and Survivors: Chapter 1 Health Care Benefits*, U.S. DEP'T OF VETERANS AFFS.: OFF. OF PUB. & INTERGOVERNMENTAL AFFS. (Apr. 21, 2015), https://www.va.gov/opa/publications/benefits_book/benefits_chap01.asp [https://perma.cc/ U868-KRPG].

47. DON CHRISTENSEN & YELENA TSILKER, RACIAL DISPARITIES IN MILITARY JUSTICE 13 (2017) (from 2006 to 2015, Black soldiers were 61 percent more likely to face a general or special court-martial than white soldiers).

48. Many servicemembers receive other than honorable discharges due to behavior that stems from an undiagnosed mental health or physical condition, or the experience of trauma, or both. The symptoms of PTSD and traumatic brain injury contribute to behaviors that military commanders deem to be misconduct and can prompt other than honorable discharges. Richard Bryant, *Post-Traumatic Stress Disorder vs Traumatic Brain Injury*, 13 DIALOGUES IN CLINICAL NEUROSCIENCE 251, 251–62 (2011).

49. *See* Brandon Alford & Shawna J. Lee, *Toward Complete Inclusion: Lesbian, Gay, Bisexual, and Transgender Military Service Members After Repeal of Don't Ask, Don't Tell*, 61 SOC. WORK 257, 260 (2016).

50. *See* VETERANS LEGAL CLINIC, HARVARD L. SCH., TURNED AWAY: HOW VA UNLAWFULLY DENIES HEALTH CARE TO VETERANS WITH BAD PAPER DISCHARGES (2020).

51. *See* 38 U.S.C.A. § 1712(a) (West 2021); *VA Secretary Formalizes Expansion of Emergency Mental Health Care to Former Service Members With Other-Than-Honorable Discharges*, U.S. DEP'T OF VETERANS AFFS.: OFF. OF PUB. & INTERGOVERNMENTAL AFFS. (June 27, 2017, 11:48

veterans most vulnerable to suicide or other acute mental health crisis to VHA medical facilities.

Veterans from the Gulf Wars under Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) include more actively deployed women, parents of young children, and reserves than any previous U.S. conflict.[52] They experience higher rates of new-onset depression than those deployed without participating in combat, with women particularly affected.[53] With multiple deployments and less time between deployments, studies indicate an increase of mental health disorders such as PTSD, anxiety, and depression stemming from these wars. Unfortunately, 56 percent to 87 percent of service members experiencing psychological distress after deployment do not receive treatment.[54] The VHA and other public and private healthcare settings where veterans seek care do not have sufficient mental health providers to meet current needs.[55]

AM), https://www.va.gov/OPA/pressrel/pressrelease.cfm?id=2923 [https://perma.cc/ CBM3-27AH].

52. *See* JENNIE W. WENGER, CAOLIONN O'CONNELL & LINDA COTTRELL, RAND CORP., EXAMINATION OF RECENT DEPLOYMENT EXPERIENCE ACROSS THE SERVICES AND COMPONENTS (2018), https://www.rand.org/pubs/research_reports/RR1928.html. [https://perma.cc/ DMT3-CGJ8].

53. Timothy S. Wells, Cynthia A. LeardMann, Sarah O. Fortuna, Besa Smith, Tyler C. Smith, Magaret A. K. Ryan, Edward J. Boyko & Dan Blazer, *A Prospective Study of Depression Following Combat Deployment in Support of the Wars in Iraq and Afghanistan*, 100 AM. J. PUB. HEALTH 1, 90–99 (2010) (stating that 5.7 percent of male veterans and 15.7 percent of female veterans experienced new-onset depression after deployment with combat exposures).

54. HAL DONAHUE, KRISTEN BRACKETT, BERNARD EDELMAN & GREG CRAWFORD, U.S. DEP'T JUST. NAT'L INST. CORR., LAW ENFORCEMENT OFFICERS RESPECTING SERVICE, RESTORING HONOR FOR VETS IN CRISIS (2019), https://s3.amazonaws.com/static.nicic.gov/UserShared/033091.pdf [https://perma.cc/FPT6-GE42].

55. *See* Sandra Basu, *With New Hires, VA Has Net Increase of 8303 Employees; Still Needs Mental Health Professionals*, U.S. MED. (Mar. 14, 2018), https://www.usmedicine.com/ agencies/department-of-veterans-affairs/with-new-hires-va-has-net-increase-of-8303-employees-still-needs-mental-health-professionals [https://perma.cc/WTH9-472L]; Quill Lawrence, *With Many Veterans Waiting for Care, the VA May Change How It Uses Outside Doctors,* NPR, (Oct. 18, 2021), https://www.npr.org/2021/10/18/ 1047101449/with-many-veterans-waiting-for-care-the-va-may-change-how-it-uses-outside-doctor [https://perma.cc/F2CT-3GJP] (reporting that waiting times for mental health care can be just as long, if not longer, in private health care settings as in the VA setting); *Improving the Quality of Mental Health Care for Veterans: Lessons From RAND Research,* RAND CORP. (2019), https://www.rand.org/pubs/research_briefs/ RB10087.html [https://perma.cc/4VNV-TVBJ] (finding that veterans are unable to access high-quality mental health care in both VA and private care settings due to shortages in the mental health workforce).

B. The Creation and Expansion of the Veterans Affairs Police Force

The combination of misunderstood war disabilities and increased racial and ethnic diversity in the Vietnam era favored an outcome with police systems rather than social services to address public safety within medical grounds. The nation experienced a stark increase in Black, Mexican, and Puerto Rican men in the military during the Vietnam era, often with misunderstood and complicated trauma histories and disabilities. At the end of World War II, 12 percent of all combat troops were Black. This figure grew to 33 percent by the start of the U.S. involvement with the Vietnam War.[56] While race data for the armed services only captured Black and white at the time, biographical, and other anecdotes tell a more diverse story of Mexican, Puerto Rican, and Asian enlistees.[57] It was poor and working-class men who were targeted for the draft while middle-class white men were granted deferments. Welfare policy makers viewed the military as a mechanism to push poor men of all races into the workforce, and "rehabilitate" and "rescue" them from the cycle of poverty.[58]

In 1971, under the leadership of Congressman Olin Teague, a decorated WWII veteran and Chair of the House Committee on Veterans Affairs, the VA became the subject of a Congressional inquiry into their medical centers' vulnerability to crime and misconduct.[59] This launched a series of hearings where VA officials reported growing drug use among returning Vietnam veterans, increasing crime rates, security raids in patient quarters, and alcohol and drug use within medical facilities.[60] VHA medical centers were simultaneously targets of

56. Robert F. Burk, *Cold War, Limited War, and Limited Equality: Blacks in the U.S. Armed Forces, 1945-1970*, *in* THE FOREIGN AND DOMESTIC DIMENSIONS OF MODERN WARFARE 61, 72 (Howard Jones ed., 1988).

57. *See* LAWRENCE M. BASKIR & WILLIAM A. STRAUSS, CHANCE AND CIRCUMSTANCE: THE DRAFT, THE WAR, AND THE VIETNAM GENERATION (1978) (quoting General Marshalls on the racial disparity of the front lines: "In the average rifle company, the strength was 60 [percent] composed of Negroes, Southwestern Mexicans, Puerto Ricans, Guamanians, Nisei, and so on. But the real cross-section of American youth? Almost never.").

58. *See* AMY J. RUTENBERG, ROUGH DRAFT: COLD WAR MILITARY MANPOWER POLICY AND THE ORIGINS OF VIETNAM-ERA DRAFT RESISTANCE (2019).

59. *Oversight of VA Hospital Crisis: Hearings Before the Subcomm. on Health & Hosps. of the H. Comm. on Veterans' Affs.*, 92d Cong. 1 (1971).

60. To the credit of the VA and Congressional representatives, they did not suggest criminalizing the behavior per se, but acknowledged drug use by military veterans posed a health concern or illness warranting treatment. *See Oversight of VA Hospital Programs, 1973: Hearings Before the Subcomm. on Health & Hosps. of the H. Comm. on Veterans' Affs.*, 93d Cong. 216–218, 261, 329–330 (1973); O*versight of VA Hospital Crisis: Hearings Before the Subcomm. on Health & Hosps. of the H. Comm. on Veterans' Aff.*, 92d Cong. 77; *Security Forces at VA Medical Centers: Hearing Before the Subcomm. on Hosps. & Health Care of the H. Comm. on Veterans' Affs.*, 97th

the war on drugs and the Vietnam War protest movement.[61] The 1973 enabling legislation creating the VA's police force allowed the VA to adopt rules and criminal regulations, the violation of which was a federal misdemeanor.[62] Authority expanded to include arrests and detention.[63]

Since the late 1990s, the VAPF has steadily increased its personnel, growing from few officers in 1996 to over 3600 in 2018;[64] in 2021, Congress authorized funding for 5500 officers and detectives. As police personnel increased, so did the justification for specialized equipment.[65] In just four years, between 2015 and 2019, the VA spent $11.6 million on military weaponry, making it the federal administrative agency with the eighth-largest budget for such devices.[66] The budget included over $380,000 for night vision equipment, $1.1 million for armor-personal, $2.6 million for guns, and $4.1 million for ammunition.[67] This spending equates to $410,000 of military-style equipment per police officer.[68] Such a degree of combat stockpiling in a health system is concerning.

This Subpart sets a foundation for understanding the VHA's institutional entrenchment of police rather than relying on its care systems to address potential crime or harm between patients or between patients and healthcare workers. As the demographics of the military and veterans changed, the VA and Congress turned to a police infrastructure and expanded VAPF law enforcement authority. Two somewhat disparate rationales converged to create a foundation for today's VA police policies and practices—maintaining order and managing veterans with disabilities; and maintaining safe workplaces.

Cong. 48–49 (1981) [hereinafter, *Security Forces at VA Medical Centers*] (prepared statement of Turner Camp, M.D. Assoc. Deputy Chief Med. Dir., VA). This generally follows the strong government rhetoric of veterans' exceptionalism, even though war related trauma is policed and criminalized.

61. *Security Forces at VA Medical Centers*, *supra* note 60, at 48 (prepared statement of Turner Camp, M.D. Associate Deputy Chief Med. Dir., VA).
62. Act of June 18, 1973, Pub. L. No. 93-43, § 4, 87 Stat. 79 (1973), *repealed* by Department of Veterans Affairs Codification Act, Pub. L. No. 102-83, 105 Stat. 378 (1991).
63. *See infra* Subpart II.A.
64. ANDRZEJEWSKI & SMITH, *supra* note 16, at 18.
65. *See* ADAM ANDRZEJEWSKI & THOMAS W. SMITH, THE MILITARIZATION OF AMERICA: NON-MILITARY FEDERAL AGENCIES PURCHASES OF GUNS, AMMO, AND MILITARY-STYLE EQUIPMENT, FISCAL YEARS 2006–2014 (2016).
66. ANDRZEJEWSKI & SMITH, *supra* note 16, at 16.
67. *Id.* at 17.
68. *Id.*

1. Order Maintenance and Managing Disability

Police scholars recognize the 1980s as the advent of broken windows policing and order maintenance policing in response to rising rates of violent crime.[69] Police focused on controlling disorder, such as loitering, noise, and public drunkenness, with the belief it would reduce more severe crimes in a neighborhood. A central tenet of disorder policing research argues that police should become more involved in communities and improve the neighborhood environment to control crime efficiently.[70] Race and poverty scholars have noted, however, the racialized nature of these policies and enforcement operations that target Black neighborhoods and focus crime enforcement on the poor and unhoused—with groups stereotyped as inherently disorderly.[71] Similarly, disability justice scholars have identified order maintenance as a tool for

69. "Disorder" policing is known to encompass a variety of policing strategies to address the theory popularized by the George H. Kelling's and James Q. Wilson's *Atlantic* article, *Broken Windows: The Police and Neighborhood Safety*. George L. Kelling & James Q. Wilson, *Broken Windows: The Police and Neighborhood Safety*, ATLANTIC (Mar. 1982), https://www.theatlantic.com/magazine/archive/1982/03/broken-windows/304465 [https://perma.cc/AC4E-P2TF]. Often seen as a subsection of community policing, the broken windows theory posits that crime can be prevented by addressing relatively minor signs of disorder like panhandling and graffiti. Police departments have implemented disorder policing like "order maintenance" and "zero tolerance" policing or comparatively less severe policies like problem-oriented policing. Anthony A. Braga, *Crime and Policing, Revisited*, NEW PERSPS. IN POLICING BULL. 14 (2015); *see generally* BERNARD E. HARCOURT, ILLUSION OF ORDER: THE FALSE PROMISE OF BROKEN WINDOWS POLICING 23–27 (2001) (discussing James Wilson's and George Kelling's broken windows theory and the order maintenance approach to crime control).

70. In the 1980s, an emerging body of research connected social disorder to violent crime. Scholars posited that signs of physical deterioration within a community signaled lawlessness to its residents, instigating fear and laying a foundation for more serious crime. For police agencies experiencing a "crisis of confidence" and seeing a consistent disconnect between officer priorities (violence) and citizen priorities (social incivilities), this new theory of policing gained traction. Thus, order maintenance policing, by which officers integrated themselves into the community to understand and address the daily concerns of residents to halt further serious crime, became commonplace. Braga, *supra* note 69, at 6.

71. *See, e.g.*, Monica C. Bell, *Anti-Segregation Policing*, 95 N.Y.U. L. REV. 650, 716 (2020) (noting that "[p]olice departments do not engage in 'broken windows' policing in wealthy white neighborhoods, even if the neighborhood youths are doing more than breaking windows . . . ."); Deborah N. Archer, *The New Housing Segregation: The Jim Crow Effects of Crime-Free Housing Ordinances*, 118 MICH. L. REV. 173, 205–06 (2019) (discussing how broken windows policing disproportionately targets communities of color, in part because of the "implicit association" between people of color and criminality); Jeffrey Fagan & Garth Davies, *Street Stops and Broken Windows:* Terry, *Race, and Disorder in New York City*, 28 FORDHAM URB. L.J. 457 (2000); *cf.* HARCOURT, *supra* note 69, at 138.

managing people with disabilities and actions associated with disability.[72] Professor Camille Nelson adds the concept of "felonization," or the move to construct criminality and the way in which "negatively racialized suspects" who are seen by police as defiant or disrespectful are deemed "crazy."[73]

Similar ideas permeated VA policing. In the 1980s, Congress continued to hear reports of theft and alcohol and drug use in VA facilities. Despite the VAPF's presence, reports of theft and crime in areas surrounding VA hospitals also persisted.[74] In response, Congress expanded the VAPF's budget, capitalizing on President Ronald Reagan's enthusiasm to increase state and federal law enforcement funds. The Congressional record underscores the connection between Reagan-era policies and VAPF growth. In 1981, the Chair of the Veterans Affairs Committee pressed for Congress to use billions of federal tax dollars Reagan earmarked for crime enforcement to address the VA's crime problems.[75] By 1984, Congress had authorized $4 million for security upgrades and information-sharing technologies; it also increased the budget to hire an additional eighty VA officers.[76]

While members of Congress supported resourcing the VA's police, VHA medical leadership was less enthusiastic about embracing a criminal enforcement model. In response to the Chair's remarks at the 1981 hearing, the VA's associate

72. An extensive literature examines the relationship between disorderly conduct, management of behavior, and race. *E.g.*, Morgan, *supra* note 5. BEN-MOSHE, *supra* note 5.

73. Camille A. Nelson, *Frontlines: Policing at the Nexus of Race and Mental Health*, 43 FORDHAM URB. L.J. 615 (2016).

74. *Security Forces at VA Medical Centers*, *supra* note 60, at 1 (testimony of Hon. Ronald M. Mottl, Chairman, H. Subcomm. on Hosps. & Health Care).

75. From President Reagan's inauguration in 1981 to the end of 1983, the Justice Department's budget saw a 43 percent increase, and the Department was poised to receive an additional $200 million for the 1984 budget. Billions were put toward drug enforcement through the Drug Enforcement Administration and Federal Bureau of Investigations (FBI). Leslie Maitland Werner, *Reagan Plans Bigger Budget for U.S. Law Enforcement*, N.Y. TIMES (Jan. 2, 1984), https://www.nytimes.com/1984/01/02/us/ reagan-plans-bigger-budget-for-us-law-enforcement.html [https://perma.cc/VY88-PQKM]. *See also Security Forces at VA Medical Centers*, *supra* note 60, at 36 (quoting Hon. Ronald M. Mottl) ("I don't think we should push [safety and security of the VA] on local authority because they are squeezed for the tax dollar. We have much more of the tax dollars here in Washington… I know this President is committed to the veterans … let's take some of these billions and take care of the people that served this country.").

76. *See Security & Law Enforcement in VA Medical Centers: Hearing Before the H. Subcomm. on Hosps. & Health Care of the H. Comm. on Veteran's Affs*, 97th Cong. 4 (1982) (prepared statement of Marjorie R. Quandt, Assistant Chief Med. Dir., VA) (stating that the VA has "allocated $2.5 million for major security improvements, and $1.5 million for security equipment. [The VA] also distributed another $1 million in salary money to bring our total police strength up to 1960—a 7.6 percent increase").

deputy chief medical director testified against the enhanced criminal enforcement measures before Congress. The medical director believed the problems the VA faced were "not unlike the security problems faced by the private sector healthcare industry" for "sociocultural" or "economic" reasons.[77] In general, the healthcare industry absorbs risks for crime within and surrounding the hospitals. The medical director opposed a more robust police system. He noted that security measures adopted in 1973 such as metal detectors and wands, allowed current VAPF officers to confiscate more weapons,[78] and he appeared satisfied with these improvements.

Until the turn of the millennium, the VAPF did not carry firearms. Since the 1980s, however, VA Security's leadership and some members of Congress had been attempting to arm VA police officers[79] despite vocal opposition from the VA nurses' union, some members of Congress (including U.S. Representative James Clyburn (D.-S.C.)), veterans' organizations, and VA medical leadership (as opposed to security leadership).[80] The VA security program's leadership viewed a firearm as an essential tool for any police force and that its introduction would assist the force recruit and retain its officers.[81] The VA launched a firearms pilot program from 1998 to 1999 in part as a response to two shootings at a facility in Jackson, Mississippi.[82] The emotional testimony of the director of the VA hospital acknowledged that arming police would not actually prevent the type of incidents

77. *Security Forces at VA Medical Centers*, *supra* note 60, at 3 (testimony of Turner Camp, Assoc. Deputy Chief Med. Dir., VA); *Id.* at 48 (prepared statement testimony of Turner Camp, Assoc. Deputy Chief Med. Dir., VA).

78. *Id.*

79. *Id.* at 9 (testimony of James Fasone, Dir., Sec. Staff, VA).

80. *Safety & Security in the VA, Hearings Before the Subcomm. Oversight & Investigations of the Comm. on Veterans' Affs.*, 105th Cong. 37–38 (1997) [hereinafter, *Safety & Security in the VA*] (statement of Barbara Frango Zicafoose, Legislative Co-chair, Nurses Org. of Veterans Affs.) (discussing the ways the presence of weapons can create triggers for veterans and stress for union members; proposed alternatives to arming police drawn from social science literature); *Id.* at 14–18, 19–20 (statement of H. Rep. James E. Clyburn) (expressing concern that Congress and the VA would arm police following an emotional shooting incident without taking into account empirical evidence of the positive impact of firearms); *Id.* at 92 (Letter from Frederick Roll, Pres. of the Am. Hosp. Ass'n to H. Rep. Adam Sachs (May 19, 1997)) (stating that "the need to arm security personnel should be based on a site specific needs assessment," and then listing several factors to take into account); *Hearing Before the S. Comm. on Veteran's Affs.*, 98th Cong. 137 (1984) (prepared statement of Paul S. Egan, Deputy Dir., Nat'l Legis. Comm'n, Am. Legion, & Robert E. Lynch, Dir., Nat'l Veterans Affs. & Rehab. Comm., Am. Legion) ("[W]e believe that firearms in a health care environment can only spell trouble for all concerned.").

81. *Safety & Security in the VA, supra* note 80, at 17 (prepared statement by John H. Baffa, Deputy Assistant Sec'y for Sec. & L. Enf't).

82. *Id.* at 22 (testimony of Richard P. Miller, Dir. of G.V. "Sonny" Montgomery VA Med. Ctr., Jackson, Miss.).

that had occurred, and that most medical directors would not agree with arming VA police. His plea for arming police at his hospital was aimed to shift the psychology of the facility given the traumatic events.[83] The agency began limited firearm use in 2000.[84] After September 11, 2001, the VA pressed Congress harder to have all officers receive firearm training and authorization to use firearms.[85] On December 17, 2001, Deputy Secretary of the VA, Leo Mackay, stated, "We're accelerating the [firearms] program in the wake of September 11,"[86] and suggested that VA facilities authorize and equip police with firearms by 2003.[87] Today, VA police carry VA-issued weapons, including firearms, off of VA property in certain circumstances[88] or (with approval) for non-routine purposes, such as deployment or response to a national emergency. They also have their own canine units to detect drugs and contraband.[89]

Overall, the 1990s were a period of experimentation in policing as law enforcement agencies around the country adopted community policing models[90]

83. *Id.* at 20–22 ("I'm not foolish to think that guns are going to stop things like [the shootings at our facility]. If somebody wants to do that, they're going to do it.").

84. U.S. Dep't of Veterans Affs., *Procedures to Arm Department of Veterans Affairs Police*, *in* VA Handbook 0720 (V.A. 2000); *Dep't of Veterans Affs. Budget Request for Fiscal Year 2000, Hearing Before the H. Comm. on Veterans' Affairs*, 106th Cong. 84–85 (1999) (prepared statement of Hon. Togo D. West, Jr., Sec'y of Veterans Affs.) (explaining a request for $450,000 for the firearm program in the VA Department's Year 2000 Budget Submission).

85. *Concern Over Violence Arms VA Police*, ASSOCIATED PRESS & LOCAL WIRE (North Little Rock, Ark. Dec. 20, 2001).

86. *Id.* Deputy Secretary of the VA, Leo Mackay, also attributed the need for firearms to the previously described threats of "armed patients, hostage situations, and shootings." *Id.*

87. Beginning in 2008, the VA began phasing in more modern weapons, and most had made this change by 2014. E-mail from Randal Noller, Dept. of Veterans Affairs, to Adam Andrzejewski, Forbes Contributor & OpenTheBooks Founder (Feb. 17, 2016, 2:48 PM), http://www.openthebooks.com/assets/1/7/VA_Official_Response_to_Guns_ammo_purchases.pdf [https://perma.cc/ZR8L-WNGB].

88. 38 U.S.C.A. § 902(a)(1)(D) (West 2022). VAPF may carry their VA-issued weapon off of VA property for various reasons, including the search and recovery of a "critical missing patient" and an official vehicle's servicing. DEP'T OF VETERANS AFFS., VA DIRECTIVE 0730/3, SECURITY AND LAW ENFORCEMENT ¶ (10)(b)(2)(b) (V.A. 2014).

89. DEP'T OF VETERANS AFFS., VA HANDBOOK 0730, SECURITY AND LAW ENFORCEMENT ¶ 5(w) (V.A. 2000) (canine policy).

90. Lack of confidence in police and the alienation of the police from the public led to a general consensus among scholars in the 1990s that traditional policing practices were ineffective. This resulted in substantial changes in policing strategy across the country. Policies like community policing, pulling levers policing (which involves a "focused deterrence" strategy of policing targeting certain individuals with "swift and certain" legal action to prevent future offenses and social services if the person is deterred) and broken windows policing were implemented in most large police departments, as many scholars and even police professionals believed they would be more successful in crime prevention. *See* Anthony A. Braga & David Weisburd, *Introduction: Understanding Police Innovation*, *in* POLICE INNOVATION: CONTRASTING

focused on deterrence and policing disorder.[91] Beginning in 1991, the VA adopted order maintenance policing and broken windows policing measures to deter crime. John H. Baffa, the VA Deputy Secretary of Security and Law Enforcement, told Congress in 1997 that he "instituted a program a couple of years ago which was vigorous patrol and getting into the community," and follows the "same theory" as the order maintenance policing practices utilized in Washington, D.C. and New York City in the 1980s.[92] He posited that "if you get out there and meet with the people and you prevent crime, you don't respond to it. And our philosophy is you stop crime before it begins *by not letting people who don't belong* into the hospital."[93] Consistent with this view, he moved police officers' physical location to make them more visible to patients, increased foot patrols, and instituted bicycle patrols in some facilities.[94] The general philosophy was that more visibility and proximity to patients would deter crime.[95] These are classic order-maintenance policing tactics. Whether one agrees with broken windows policing or not, features of embedded healthcare policing described in Part II serve to normalize policing in the healthcare space, leading to carceral consequences,

PERSPECTIVES 1–12 (David Weisburd & Anthony A Braga eds., 2006). President Clinton signed the Violent Crime Control and Law Enforcement Act into law on September 13, 1994. This legislation authorized a $9 billion allocation for the Public Safety Partnership and Community Policing Act of 1994, allowing the Department of Justice to create the Community Oriented Policing Services (COPS) program. Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, §§ 10001–10003, 108 Stat. 1796. The stated goal of this program was encouraging "innovative programs" within local police departments and adding community policing officers. *Id.* § 10002.

91. *See* GEORGE L. KELLING & CATHERINE M. COLES, FIXING BROKEN WINDOWS: RESTORING ORDER AND REDUCING CRIME IN OUR COMMUNITIES 15–20 (1996).

92. *Safety & Security in the VA, supra* note 80, at 7 (testimony of John H. Baffa, Deputy Assistant Sec'y for Sec. & L. Enf't)

93. *Id.* (emphasis added). The speaker is likely referencing broken windows or order maintenance policing. *See* Steve Herbert & Elizabeth Brown, *Conceptions of Space and Crime in the Punitive Neoliberal City*, 38 ANTIPODE 755, 758–59 (2006) (noting that the popularity of broken windows policing occurred so rapidly and was so widespread that it came be seen as a "common sense" tactic among police executives). The broken windows theory asserts that when disorder is not addressed it eventually reaches a critical point where the community no longer has the "informal control mechanisms" that encourage a fear of committing crime. According to the theory, neighborhoods without this control are more vulnerable to serious crime. *See generally* William H. Sousa & George L. Kelling, *Of 'Broken Windows,' Criminology, and Criminal Justice, in* POLICE INNOVATION: CONTRASTING PERSPECTIVES 79 (David Weisburd & Anthony A. Braga eds., 2006).

94. *Safety and Security in the VA, supra* note 80, at 4 (1997) (testimony of John H. Baffa, Deputy Assistant Sec'y for Sec. and L. Enf't, Dep't of Veterans Affs.).

95. This idea of deterrence mirrors the philosophy behind broken windows. *See* KELLING & COLES, *supra* note 91, at 243; *cf.* HARCOURT, *supra* note 69.

and sometimes alienation, for individuals who deviate from accepted societal norms.

2. Regulation of Workplace Violence in Healthcare

In the 1990s, an emerging body of research examined healthcare employees' unique hazard: significant rates of workplace violence.[96] For example, studies showed that in 1999 there were 2637 nonfatal assaults in hospitals. Hospital employees experienced a rate of 8.3 assaults per 10,000 workers, compared to 2 per 10,000 workers in private sector industries.[97] This late-1990s social and political environment created the foundational belief that hospital workers require protection from their patients. Given that no federal legislation requires healthcare employers to implement workplace violence prevention programs (although some states now have requirements),[98] the Occupational Safety and Health Administration (OSHA) published guidelines to address hospital workplace violence for the first time in 1996.[99] These concerns over the potential for harm and assaults within the healthcare industry, coupled with the increasing fears about active or mass shooters, became leading justifications for a regulatory and policy regime infused with policed and securitized spaces.[100]

96. *E.g.*, VIOLENCE: OCCUPATIONAL HAZARDS IN HOSPITALS, *supra* note 28.
97. U.S. DEP'T OF LAB., OCCUPATIONAL SAFETY & HEALTH ADMIN., GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTHCARE AND SOCIAL SERVICE WORKERS 1 (1996) [hereinafter OSHA GUIDELINES, 1996].
98. *See, e.g.*, CAL. CODE REGS. tit. 8, § 3203 (West 2022).
99. OSHA GUIDELINES, 1996, *supra* note 97. OSHA suggested that organizations establish trained response teams to react to violent emergencies. *Id.* at 3. Each team should have a designated leader and one or more members of the team should be skilled in diffusing volatile situations or aggressive behaviors, managing anger, using medications as chemical restraints, and using physical restraints when required. *Id.* at 7.
100. Active shooter response trainings are now nearly universal in hospitals, even though only four such events occurred in health care facilities between 2000 and 2013. Phillips, *supra* note 28, at 1665. From 2010 to 2020, the Joint Commission received reports of 39 shootings from its member accredited organizations, of which 12 were murder suicides. *Quick Safety 4: Preparing for Active Shooter Situations*, JOINT COMM'N. (June 2021), https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-4-preparing-for-active-shooter-situations/preparing-for-active-shooter-situations-addendum-february-2017/#.Y0Uy43bMKUn [https://perma.cc/X5ZU-C3AC]. The VA's Disruptive Behavior Committee Guidebook discuses active shooters in the preface of the document, acknowledging the overwhelming attention placed on these scenarios, however, it urges the public and the agency to pay greater attention to the most common forms of workplace violence in the healthcare industry. U.S. DEP'T OF VETERANS AFFS., IMPLEMENTING MULTIDISCIPLINARY BEHAVIORAL

Within the VA, the predicates of healthcare policing connected at this point. The developments within OSHA led the VA to examine the agency's workplace safety and patient violence policies through its order maintenance ethos. Unlike other medical care settings, the VA cannot refuse medical treatment except in the rarest of circumstances.[101] In 1998, the VHA was charged with developing its Violent Behavior Prevention Program.[102] A Task Force on workplace violence found that because "patients demonstrating violent behavior tended to be older, substance abusers, and seriously mentally ill," the VA needed to take patients' risk of violent behavior into account.[103] On August 28, 2003, the VHA issued its first Directive on National Patient Record Flags which created the first version of the policy underlying today's red flags, as a means by which to identify a patient as actively or potentially engaged in disruptive behavior.[104] The red flag policy and its intersection with healthcare policing is discussed in Part II.

For the following decade, VHA implemented, evaluated, and expanded its monitoring systems. A critical change occurred in 2004 when the Office of Inspector General (OIG) evaluated the VHA's "program to identify violent patients, and to reduce the risk to employees, patients, and others visiting VA facilities of encountering threatening and violent patient behaviors."[105] The OIG recommended substantially expanding access to the VHA's preexisting behavioral flag system from clinicians (physicians, nurses, and social workers) to clerical employees and support employees.[106] This change allowed many more employees to access and initiate the red flags process. Because it would take many years to create an integrated uniform computerized flagging system, the OIG suggested

THREAT ASSESSMENT AND MANAGEMENT PRACTICE IN HEALTH CARE: DISRUPTIVE BEHAVIOR COMMITTEE (DBC) GUIDEBOOK 5 (2021) [hereinafter DBC GUIDEBOOK].

101. In the private hospital context, medical providers may "fire" patients who exhibit violent, disruptive, or rude behavior. Steven M. Harris, *Take Care When Firing a Patient*, AM. MED. NEWS (Feb. 4, 2008), https://amednews.com/article/20080204/business/302049998/5 [https://perma.cc/YAR6-KVMT]. This practice has not been permitted in the VHA since 2010. *See* 38 C.F.R. § 17.107 (2020).

102. U.S. Dep't of Veterans Affs., *Occupational Safety and Health*, *in* VA Handbook 7700.1, at 20 (V.A. 1998) (rescinded 2009) (providing "a violent behavior prevention program" "shall be developed" in the absence of federal regulation). *See generally* DEP'T OF VETERANS AFFS., VETERANS HEALTH ADMIN., DIRECTIVE 7701, COMPREHENSIVE OCCUPATIONAL SAFETY AND HEALTH PROGRAM (V. A. 2017).

103. U.S. DEP'T OF VETERANS AFFS., OFF. OF INSPECTOR GEN., REPORT NO. 02–01747–139, HEALTHCARE INSPECTION: HEALTHCARE PROGRAM EVALUATION—VETERANS HEALTH ADMINISTRATION'S MANAGEMENT OF VIOLENT PATIENTS 2 (2004) [hereinafter VA REPORT NO. 02–01747–139].

104. *Id.* at 3.

105. *Id.* at 1.

106. *Id.* at 7.

individual facilities generate and implement localized strategies until the agency operationalized a national system.[107] Thereafter, each medical facility implemented a process for flagging disruptive or potentially disruptive patients.

Six years later, in 2010, the VHA finally implemented the integrated data systems infrastructure for disruptive behavior and workplace safety. This 2010 uniform record flag policy created the Disruptive Behavior Committees that are discussed in Part II as a core feature of the police healthcare web.[108] The written guidance explicitly acknowledges that a flag will "compromise[] privacy because it reveals private patient information to anyone who opens the patient's chart."[109]

107. *Id.* at 9. For more information on the prior national system that used red flags, see U.S. DEP'T OF VETERANS AFFS., VETERANS HEALTH ADMIN., DIRECTIVE 2008–036, USE OF PATIENT RECORD FLAGS TO IDENTIFY PATIENTS AT HIGH RISK FOR SUICIDE (2008).

108. U.S. DEP'T OF VETERANS AFFS., VETERANS HEALTH ADMIN., DIRECTIVE 2010–053, PATIENT RECORD FLAGS 1 (2010) [hereinafter VHA DIRECTIVE, 2010-053]. The 2010 Patient Record Flags directive is "pending renewal as 1166." DBC GUIDEBOOK, *supra* note 100, at 14. At the time of this Article's publication, VHA Directive 1166 has not been published on the VHA website. A recent Disruptive Behavior Committee Guidebook suggests the local Category II flags may be discontinued with the new 1166 Directive. *Compare* DBC GUIDEBOOK, *supra* note 100, at 69 ("legacy Category II local patient record flags (PRFs) appear only in the record at the facility which placed the PRF) *with id.* ("Category II PRFs will be discontinued when the new PRF directive 1166 is published. The use of Behavioral Category II PRFs should not be occurring at any medical facility."). VHA Directive 1160.08(1) (Feb. 22, 2022) titled "VHA Workplace Violence Prevention Program" became available this year. U.S. DEP'T OF VETERANS AFFS., VETERANS HEALTH ADMIN., DIRECTIVE 1160.08(1), VHA Workplace Violence Prevention Program (V.A. 2022) [hereinafter VHA DIRECTIVE 1160.08(1)]. It contains no mention of local Category II flags or what will occur if the VHA discontinues these localized behavioral record flags. Based on VHA Directive 1160.08(1) and the new disruptive behavior committee guidebook, it seems likely VHA will publish an updated directive related to record flags. For purposes of this Article, a new directive is not likely to deviate from the core features of the disruptive behavior flagging or committee system, though providing more guidance and detailed instructions to VHA staff and leadership could provide a step towards avoiding overuse or use in a punitive or retaliatory manner. Until the agency publishes more information about patients referred to the Committee process (including race, ethnicity, and disability status data) and the underlying reasons for and outcomes of the referrals, it is difficult to assess whether a new directive or the more detailed guidebook addresses the problems or concerns discussed in this Article such as potential bias, stigma, privacy, or carceral logics underlying the overall approach of managing patients' actions. When data and new policies are released, I plan to publish an updated analysis of the VHA systems and whether they are likely to improve patients' or care workers' experience.

109. Additionally, access is granted "regardless of whether that person has the need to know that would normally justify revealing such information." VA REPORT NO. 02–01747–139, at 9. The problems associated with visible and stigmatizing flags beg the question of whether the VA struck the right balance between workplace safety and intrusion on patient privacy. Future projects will take up these important questions more completely.

Federal regulation promoted security and policing responses. In 2016, OSHA updated its healthcare workplace safety guidelines,[110] while the National Institute for Occupational Safety and Health (NIOSH), a Centers for Disease Control research agency in the Department of Health and Human Services, also issued recommendations specific to healthcare employers.[111] These agencies regulate hospitals and other care settings and design enforceable standards to protect against specific workplace hazards, such as toxic substances and infectious diseases.[112] For other hazards, notably workplace violence, OSHA produces only voluntary guidelines.[113] The "General Duty Clause" of the Occupational Safety and Health (OSH) Act is a catchall enabling OSHA to respond to hazards not currently regulated, such as workplace violence.[114] OSHA enforces 29 C.F.R. § 1960.8(a) which, like the General Duty Clause that applies to private workplaces, requires federal agencies "furnish to each employee a place of employment which is free from . . . hazards that are likely to cause death or serious harm."[115]

Federal agencies must comply with safety standards even though OSHA cannot impose fines.[116] OSHA monitors adherence, meting out notices of noncompliance to the VA when applicable.[117] Although OSHA and NIOSH

110. U.S. DEP'T OF LAB., OCCUPATIONAL SAFETY & HEALTH ADMIN., GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTHCARE AND SOCIAL SERVICE WORKERS (2016) [hereinafter OSHA GUIDELINES, 2016] (guidelines note that the document is "not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by the OSHA standards or the [Occupational Safety and Health (OSH)] Act").

111. *See* VIOLENCE: OCCUPATIONAL HAZARDS IN HOSPITALS, *supra* note 28; OSHA GUIDELINES, 2016, *supra* note 110.

112. OSHA standards and regulations are outlined in Title 29 of the Code of Federal Regulations. 29 C.F.R. (2021).

113. *See* Sharon A. Wey, *Healthcare and Social Service Settings in OSHA's Crosshairs*, 90 FLA. BAR J. 42 (2016).

114. 29 U.S.C.A. § 654 (West 2022).

115. 29 C.F.R. § 1960.8(a) (West 2022).

116. U.S. DEP'T OF LAB., OSHA, 3302-01R, ALL ABOUT OSHA 8 (2020); 29 U.S.C.A. § 668 (West 2022). In 2017, the VHA issued a directive on its "Comprehensive Occupational Safety and Health Program," which outlines the VHA's OSH program and establishes that each facility director is responsible for ensuring compliance with OSHA requirements, among others. U.S. DEP'T OF VETERANS AFFS., VETERANS HEALTH ADMIN., DIRECTIVE 7701, COMPREHENSIVE OCCUPATIONAL SAFETY AND HEALTH PROGRAM (2017).

117. *See, e.g.*, *US Department of Labor's OSHA Cites Veterans Health Care Center in North Chicago, Ill., for Safety and Health Violations*, U.S. DEP'T OF LAB.: OSHA (May 23, 2011), https://www.osha.gov/news/newsreleases/region5/05232011 [https://perma.cc/ FGR7-A2UJ]; *OSHA Issues Notices to Hunter Holmes McGuire VA Medical Center for Exposing Workers to an Unsafe Workplace*, U.S. DEP'T OF LAB.: OSHA (Nov. 17, 2015), https://www.osha.gov/news/newsreleases/region3/11172015 [https://perma.cc/ T7M5-4M8H]. Advocates regularly complain, however, that OSHA is severely under resourced and unable to adequately monitor workplace safety and hazards. *See* Margaret M. Seminario, *The*

guidelines are not binding, the VA generally reviews and considers them. The VA formally and informally adopted key NIOSH provisions in its workplace safety scheme including surveillance techniques such as patient monitoring through recordkeeping databases, metal detectors, video cameras, and heightened alerts for risk factors (for example, "verbally expressed anger or frustration" or "signs of drug [or] alcohol use").[118] NIOSH further advises healthcare employees to collaborate with security personnel.[119]

In sum, Part I began to show how a health system caring for poor patients with disabilities, particularly mental disabilities, saw the patients as threats in need of regulation and control. The VA and Congress created and expanded police systems to address potential and actual low-level criminal offenses and workplace safety.

II. EMBEDDED POLICE IN HEALTHCARE INSTITUTIONS

Embedding police both directly influences healthcare delivery and indirectly alters medical institutions' culture in several ways. Because of the overlapping criminal regulation and internal tracking systems discussed in this part, embedding police in health settings expands and expresses their carceral logics. Subpart A shows that VHA policies adopt a criminal enforcement response instead of care-based social response to its patients. Examining this more traditional disorderly conduct policing on VA grounds, as distinct from the other features discussed in Part II, connects embedded healthcare policing to larger questions of policing disorder, misdemeanors, and traffic enforcement. Subpart B illustrates the mechanics of how the VAPF becomes part of clinical decisions through the internal governance structure of the Disruptive Behavior Committee ("Committee"). Subpart C describes internal systems that track and monitor patients considered deviant or out of the ordinary, establishing certain nonviolent behaviors associated with symptoms of mental disabilities, houselessness, or drug use as potential precursors to violence and in need of regulation. These systems—red flags and behavioral management orders—flow from the Committees but have several other origin points beyond the Committees. Subpart D argues that

Occupation Safety and Health Act at 50—A Labor Perspective, 110(5) AM. J. PUB. HEALTH 642 (2020).

118. VIOLENCE: OCCUPATIONAL HAZARDS IN HOSPITALS, *supra* note 28, at 5–7.

119. *Id.* at 8. OSHA's guidelines are largely similar and emphasize five priority areas: management commitment and employee participation, worksite analysis, hazard prevention and control, safety and health training, and recordkeeping and program evaluation. U.S. DEP'T OF LAB., OCCUPATIONAL SAFETY & HEALTH ADMIN., GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTHCARE AND SOCIAL SERVICE WORKERS 5 (2014).

under the framework of protecting workers from potentially disruptive and violent patients, hospitals co-opt medical staff into serving pseudopolice functions. Care workers engage in threat assessments, reporting, and training as parts of comprehensive workplace safety systems that can lead to formal criminal sanction or future surveillance. Finally, Subpart E brings together these threads and reveals how such features alter the culture of care. They produce carceral responses to veteran patients perceived as difficult, even in a healthcare setting designed for their unique needs.

To be sure, the potential for violence and threatening behavior by patients, and an adequate warning system, are worth consideration. Some may find responses to behavioral health particularly important in a health system designed for military veterans. As I address later in the Article, whether the current VA violence prevention systems have significantly decreased incidents of violence or threats is unclear. The limited research suggests minimal improvement in workplace harm since their implementation. This Article maps the processes and proposes different and less carceral approaches.[120] These lessons I pick up in Part III.

Before proceeding, I note that the VHA provides high-quality, essential, and life-saving healthcare. This Article is most concerned with the interests and consequences of healthcare policing on patients, and therefore centers veterans seeking care.[121] The concerns raised in this Article are not meant to minimize the potential for patient-generated threats of violence or actual harm, or the agency's obligations to its workers. Doctors and staff that care for veterans across the country should perform their services in healthy and safe environments. I aim to engender further discussion among institutions whereby safety concerns of people receiving services and the providers of services are considered alongside a critical examination of the role and scope of police within public institutions.

A. Criminal Enforcement and Regulation

The hospital is a site of managing marginalized and poor people's behavior using the threat and actual charging of low-level offenses. VAPF can cite—and in some cases arrest—a patient or visitor for a "disturbance," defined by federal regulation 38 C.F.R. § 1.218 (a)(5) as:

120. The question I will pose in future work when more data is available is whether the infrastructure in place correctly balances patient autonomy, privacy, and dignity where the agency itself acknowledges the risk of bias, stigma, and coercion.

121. A future project will examine and center the care workers, including the role of labor unions.

> Conduct on property which creates loud or unusual noise; which unreasonably obstructs the usual use of entrances, foyers, lobbies, corridors, offices, elevators, stairways, or parking lots; which otherwise impedes or disrupts the performance of official duties by Government employees; which prevents one from obtaining medical or other services provided on the property in a timely manner; or the use of loud, abusive, or otherwise improper language; or unwarranted loitering, sleeping, or assembly is prohibited.[122]

When police charge a person with a disturbance offense, they must appear in federal court. If the offense is categorized as a federal misdemeanor, courts can issue fines up to $500, sentence patients to six months in federal prison, and place them on supervised probation for years.[123] In some situations, VA police may make arrests for state, local, or federal offenses.[124]

The VAPF can conduct investigations on[125] and off[126] of VA property, including investigations in cooperation with other federal, state, or local law enforcement agencies.[127] Congress has also authorized VA police officers to enforce federal, state, and local traffic laws, and, where permitted by state law, motor vehicle codes of the jurisdiction in which the VA property is located.[128] Scholars

122. 38 C.F.R. § 1.218(a)(5) (2011). While the federal regulation uses "disturbance," court opinions interchange "disturbance" under § 1.218 with "disorderly conduct." This interchange is an example of a type of disorderly conduct law. *See* Jamelia N. Morgan, *Rethinking Disorderly Conduct*, 168 CALIF. L. REV. 1637 (2021); RISA GOLUBOFF, VAGRANT NATION: POLICE POWER, CONSTITUTIONAL CHANGE, AND THE MAKING OF THE 1960S (2016). In conjunction with this regulatory citation, VA police may issue "orders for persons who are creating a disturbance to depart the property." 38 C.F.R. § 1.218(a)(5) (2011). In such a situation, "[f]ailure to leave the premises when so ordered constitutes a further disturbance within the meaning of this rule, and the offender is subject to arrest and removal from the premises." *Id.*

123. *See* United States v. Richardson, 771 F. App'x 833, 833–34 (9th Cir. 2019). More generally, VA regulations permit the U.S. Veterans Affairs Police Force (VAPF) to make arrests for a long list of federal regulatory offenses while on VA property. 38 C.F.R. §§ 1.218(a)(3), (5), (9), (14)(ii) (2011).

124. 38 C.F.R. §§ 1.218(c)(1), (3) (2011).

125. 38 U.S.C.A. § 902(a)(1)(E) (West 2022); DEP'T OF VETERANS AFFS., DIRECTIVE 0730/3, SECURITY AND LAW ENFORCEMENT ¶ I(1) (2014).

126. DEP'T OF VETERANS AFFS., DIRECTIVE 0730/3, SECURITY AND LAW ENFORCEMENT ¶ I(1), 2(a)–(c) (2014). With approval from the VA's Office of Operations, Security, and Preparedness (OSP) and Office of Security & Law Enforcement (OS&LE), VAPF may conduct off-property investigations when there is reason to believe that criminal activity or threats of harm will immediately affect the safety and security of VA people or assets. *Id.* ¶ I(2)(a)–(c).

127. 38 U.S.C.A. § 902(a)(1)(E) (West 2022); DEP'T OF VETERANS AFFS., DIRECTIVE 0730/3, SECURITY AND LAW ENFORCEMENT ¶ I(4) (2014).

128. 38 U.S.C.A. § 902(a)(1)(A)–(C).

and advocates have criticized police for disproportionately issuing such traffic offense charges to poor, Black, and unhoused persons.[129]

Staff and police also use the disorderly conduct offense to punish and conform the behaviors of certain veteran patients. Professor Jamelia Morgan has aptly theorized this connection:

> [T]he enforcement of disorderly conduct laws in the hospital setting reinforces discriminatory norms that track assumptions about physical and mental abilities. People with disabilities, even when seeking treatment in hospitals, are expected to conform their conduct to norms of order based on the normal body mind that is not in need of medical or mental health services. Even in this setting, policing for signs of disorder reinforces associations between disability and criminality and reinforces norms governing expectations for how bodies and minds should exist in public spaces.[130]

Court opinions interpreting the VA regulation against disturbances illustrate the problem with the agency's approach. They describe veterans in distress acting in socially inappropriate manners, such as using profanity[131] or racial slurs,[132]

129. *See e.g.*, David A. Harris, *The Stories, the Statistics, and the Law: Why "Driving While Black" Matters*, 84 MINN. L. REV. 265 (1999); Devon W. Carbado, *From Stopping Black People to Killing Black People: The Fourth Amendment Pathways to Police Violence*, 105 CALIF. L. REV. 125 (2017); Chan Tov McNamarah, *White Caller Crime: Racialized Police Communication and Existing While Black*, 24 MICH. J. RACE & L. 335 (2019); *Stop the Stops: Remove LAPD Officers From Routine Traffic Stops*, PUSH LA REIMAGINE PROTECT & SERVE, https://pushla.org/stop-the-stops [https://perma.cc/N4X9-2VE9]; Chauncee Smith, Elycia Mulholland Graves & Laura Daly, *Reimagining Traffic Safety & Bold Political Leadership in Los Angeles*, RACE COUNTS (May 4, 2021), https://www.racecounts.org/ push-la/ [https://perma.cc/9K34-53R7].

130. *See* Morgan, *supra* note 5, at 1676.

131. United States v. Fentress, 241 F. Supp. 2d 526, 528 (D. Md.), *aff'd*, 69 F. App'x 643 (4th Cir. 2003); United States v. Irby, No. 7:06-PO-00314, 2006 WL 2434230, at *1 (W.D. Va. Aug. 18, 2006); United States v. Puch, No. 3:18-PO-00062, 2020 WL 905268, at *6 (S.D. Ohio Feb. 25, 2020), *aff'd*, No. 20-3265, 2021 WL 867038 (6th Cir. Jan. 21, 2021).

132. United States v. DeGarza, 468 F. Supp. 3d 794, 799 (W.D. Tex. 2020); United States v. Stagno, No. 2:17-CR-00163-TLN, 2019 WL 7048982, at *1 (E.D. Cal. Dec. 23, 2019), *aff'd*, 839 F. App'x 112 (9th Cir. 2020).

spitting, gesturing as if spitting,[133] "talking constantly,"[134] talking loudly[135] or gesturing,[136] and pacing.[137] Some react negatively to the police or other authority figures who attempt to soothe them or put a hand on them.[138] Others receive citations after being brought to the emergency room against their will.[139] Some patients make threats[140] or only "implied violence" through their speech and actions.[141] Some defendants are merely reluctant to provide identification, personal information, or go in the hospital, perhaps because they fear others overhearing their identity or purpose for the hospital visit.[142] From a trauma-informed lens, survivors of sexual assault may fear being followed or have negative experiences with hospitals associated with their trauma. Others may experience auditory disturbances influencing encounters with care staff. A few court decisions show Black or transgender veterans viewing their interactions with VAPF officers as racialized and discriminatory.[143] The language of the courts reinforces the process of normation Professor Morgan describes, and patients that behave out of the norm are subject to criminal regulation.[144]

Another way the VA regulation mutes a care-based response is its explicit erosion of disability as a mediating factor or process; the VHA directive defining disruptive behavior curtails consideration of disability. The directive implementing the regulations instructs:

133. United States v. Biear, 75 F. App'x 855, 856 (2d Cir. 2003).
134. *Id.* ("talking constantly without siting down"); United States v. DeGarza, 468 F. Supp. 3d 794, 799-800 (W.D. Tex. 2020) (noting testimony that defendant "was asked to lower voice volume and did not"); United States v. Turnboe, No. 10-MC-50147, 2010 WL 2756325, at *2 (E.D. Mich. July 12, 2010) (noting testimony that defendant was "irate," "belligerent," "very loud" and "yelling" because a VA driver reportedly did not find the patient's name on list for transportation back to his residence).
135. State v. Amsden, 75 A.3d 612, 621 (Vt. 2013) (upholding conviction for disorderly conduct where, among other evidence, police testified that defendant's outbursts disrupted patient care).
136. United States v. Roper, No. 03-M-361 (CLP), 2003 WL 24017061, at *3 (E.D.N.Y. Nov. 24, 2003) ("gesturing with his hands").
137. United States v. Biear, 75 F. App'x 855, 856 (2d Cir. 2003) ("pacing back and forth").
138. United States v. Kimes, 246 F.3d 800, 803 (6th Cir. 2001).
139. United States v. Rone, 61 F. App'x 535, 536 (10th Cir. 2003).
140. United States v. Hawkins, 303 F. App'x 17, 18 (2d Cir. 2008); United States v. Szabo, 760 F.3d 997, 1003 (9th Cir. 2014).
141. *Biear*, 75 F. App'x at 856.
142. *See, e.g.*, United States v. Renfro, 702 F. App'x 799, 802 (11th Cir. 2017).
143. *See, e.g.*, United States v. Roper, No. 03–M–361 (CLP) 2003 WL 24017061, at *2 (E.D.N.Y. Nov. 24, 2003); *Renfro*, 702 F. App'x at 802 (discussing transgender Muslim woman stating she was being treated like a "n*** of the VA").
144. *See* sources and text discussed, *supra* note 24-26.

> [D]isruptive behavior does not depend upon the [patient's] stated intent or justification for [their] behavior, the presence of psychological or physical impairment, whether the individual has decision-making capacity, or whether the individual later expresses remorse or an apology.[145]

The criminal regulation and implementing directive assert that patients who exhibit disruptive behavior may be flagged and policed without consideration of their diagnoses. The rationale behind including such a statement is that prior to the guidance, providers were concerned that referrals for criminal enforcement, reporting harmful patient behavior to superiors, or disruptive record flags would alienate them from their patients.[146]

The lack of consideration for disabilities carries forward to federal court adjudication. Several courts reviewing the VAPF's actions excluded evidence of PTSD or heightened distress levels at the time of police encounters.[147] An alternative approach, aligned with the trauma-informed proposals in Part III, would allow more understanding of the patient's circumstances, including cognitive impairments, distress level, and trauma triggers—defined as reminders and intrusive memories of previous traumatic events. Such an approach is consistent with state level criminal law reforms. For example, in California, sentencing reforms specifically allow former U.S. military service members to request resentencing where a court did not consider PTSD, substance use, or mental health concerns stemming from a defendant's time in military service.[148]

Additionally, embedding police creates a culture where staff and police officers can abuse and misuse criminal enforcement to retaliate against veterans who complain or cover up their own inappropriate or harmful actions. There have been instances in which VA police used the federal regulation to inappropriately charge patients with criminal disturbances on VA grounds. Mr. Jean Telfort was medically discharged from the U.S. Army after 10 years of service with a

145. U.S. DEP'T OF VETERANS AFFS., VETERANS HEALTH ADMIN., DIRECTIVE 2012–026, SEXUAL ASSAULTS AND OTHER DEFINED PUBLIC SAFETY INCIDENTS IN VETERANS HEALTH ADMINISTRATION (VHA) FACILITIES (2012).

146. Similar reports appear outside the VHA context. *See* Armando Lara-Millán, *Emergency Room Overcrowding in the Era of Mass Imprisonment*, 79 AM. SOCIO. REV. 866 (2014); GALLEN ET AL., *supra* note 29.

147. *See e.g.*, *Renfro*, 702 F. App'x at 802–03; United States v. Szabo, 760 F.3d 997, 1001 n.2 (9th Cir. 2014). Renfro filed a civil suit challenging her arrest and detention. In that case, Renfro identifies herself as a Muslim, transgender woman. *See* Renfro v. Carroll, No. 14-CV-161, 2014 WL 6886059, at *1 (N.D. Fla. Dec. 8, 2014). For a full discussion of the circumstances surrounding this encounter, see Morgan, *supra* note 5, at 1668.

148. CAL. PENAL CODE 1170.91(b)(1) (2020).

determination that he was unemployable as a result of physical injuries from his time in the military.[149] Following a spinal surgery connected to those injuries, he entered a VA hospital to receive occupational and physical therapy to manage post-operative and spinal pain.[150] Mr. Telfort reported to U.S. Representative Kathleen Rice (D-N.Y.) that he was body slammed and handcuffed after arguing with hospital staff over whether the services could be rendered at the medical center.[151] During an oversight hearing in June 2019, Representative Rice reported the incident to members of Congress.[152] "He informed them [the police] . . . I can't breathe, I just had spinal surgery."[153] The officer allegedly continued the hold maneuver despite Mr. Telfort's pleas, until a physical therapist, who knew Mr. Telfort from a prior appointment, intervened.[154] Representative Rice further testified that notes were improperly placed in the patient's electronic records to justify the actions.[155]

In circumstances such as Mr. Telfort's, the veteran is mailed or given a ticket in person (called a Uniform Offense Report). Reported incidents show the ex-ante criminal enforcement that have led to fraud and abuse to hide police violence. The Department of Justice and FBI have charged several VA police officers with federal civil rights, fraud, or obstruction charges for injuring patients with excessive force and then writing false arrest reports.[156] Other patients have complained of similar situations to the media or filed federal tort claims when VA staff or police enter false information in their medical records.[157]

149. *Examining VA's Police Force*, *supra* note 17, at 11.
150. *Id.*
151. *Id.*
152. *Id.*
153. *Id.*
154. *Id.*
155. *Id.*
156. *See e.g., Former Veterans Affairs Police Officer Sentenced to 24 Months In Prison For Criminal Civil Rights Violation and Making False Entries in a Report*, DEP'T JUST.: U.S. ATT'Y OFF. FOR MIDDLE DIST. FLA. (June 24, 2020), https://www.justice.gov/usao-mdfl/pr/former-veterans-affairs-police-officer-sentenced-24-months-prison-criminal-civil-rights [https://perma.cc/3T7R-3QF9]; *Former Department of Veterans Affairs Police Officer Indicted for Civil Rights Violation and Obstruction of Justice*, DEP'T JUST., OFF. OF PUB. AFFS. (Jan. 19, 2018), https://www.justice.gov/opa/pr/former-department-veterans-affairs-police-officer-indicted-civil-rights-violation-and [https://perma.cc/ XS98-CUGC].
157. The media, civil plaintiffs, veterans' organizations, and members of Congress have raised this concern over police violence and modifying official records to justify such actions. *Examining VA's Police Force, supra* note 17, at 15 (statement of H. Rep. Kathleen Rice) (describing Telifort incident and staff later changed electronic records to represent the patient as behaving more aggressive and violent); Jasper Craven, *Abusing Those Who Served*, INTERCEPT (July 8, 2019, 4:00 AM), https://theintercept.com/2019/07/08/ veterans-affairs-police-va/ [https://perma.cc/YP3X-PBAJ] (investigating multiple incidents of VA police body

As further explored in subsequent Parts, the retail criminal enforcement through disorderly conduct-type of offenses, when used in medical spaces for poor people must be understood as part of a larger web encompassing surveillance, workplace safety, and behavioral management.[158] In addition, criminal enforcement in VA medical spaces should also be understood as part of and en route to violence against marginalized veterans.[159]

B. Police and Clinical Decisionmaking

The carceral logics in healthcare become more deeply entrenched when police become part of clinical decisionmaking and institutional culture. For VHA medical facilities, a primary internal process of infusing policing into care work occurs through the Disruptive Behavior Committees, which, by mandate, must include senior VA police leadership.[160] The purpose of the Committee is to engage in "threat assessments" to "evaluate the risk of violence in a given setting or situation, with a given patient and recommend measures to mitigate that violence risk."[161] The VHA conceived of these Committees as part of its clinical

slamming, tackling, and choking veteran patients in facilities across the United States); Complaint, Lewis v. Mossbrooks, No. 2:15-CV-08756 (C.D. Cal. Nov. 10, 2015) (police officers came to veteran's home, interrogated, threatened violence, and allegedly called plaintiff "Vietnam baby-killer").

158. Morgan, *supra* note 5; Morgan, *supra* note 122; Bridges, *supra* note 13 (arguing poor pregnant women are characterized as unpredictable and at-risk, and thus in need of broad-reaching social and medical regulation). For a discussion of regulating disorderly conduct outside of medical spaces, see Jyoti Nanda, *The Construction and Criminalization of Disability in School Incarceration*, 9 COLUM. J. RACE & L. 265 (2019) (discussing how for students of color, disability is often attributed to criminalized behavior, for instance, disorderly conduct, resulting in surveillance and potential criminal justice involvement); Damien M. Sojoyner, *Black Radicals Make for Bad Citizens: Undoing the Myth of the School to Prison Pipeline*, 4 BERKELEY REV. OF EDUC. 241, 245 (2013) (framing educational policy as disciplinary towards Black movements for freedom).

159. *See* Carbado, *supra* note 23; Carbado, *supra* note 129.

160. Mandatory members of the Committee are a chair, a senior-ranking VA police, a representative of the facility's PMDB program, a representative from patient safety of risk management, one member representing community-based programs (such as home-based primary care, U.S. Dept. of Housing and Urban Development-VA Supportive Housing Program, Homeless Programs, Mental Health Intensive Case Management, Caregiver Support, or Transitional care), a patient advocate, staff union delegate, a representative from each workplace designated as high risk, clerical, and administrative personnel. VHA DIRECTIVE 1106.08(1), *supra* note 108, at D1–D2.

161. VHA DIRECTIVE 2010-053, *supra* note 108, at attach. C, Threat Assessment. *See also* VHA DIRECTIVE 1106.08(1), *supra* note 108, at 2 (DBC is "a multidisciplinary behavioral threat assessment and management team . . . to address patient-generated disruptive behavior, threats, or violence that undermine a culture of safety within the VA medical facility, and to

infrastructure to safeguard its employees while maintaining its obligation to care for all veteran patients,[162] even patients engaged in "disruptive behavior."[163] Yet, the Committee's interlocking systems that I discuss in this Part—red flags, behavioral management orders, and criminal enforcement of disturbances—place police in decision making roles alongside physicians and medical personnel.

Patients referred to the Committees experience four potential outcomes. First, the Committees may enter a red flag—which appears in large, all-caps, red letters—into a patients' electronic medical records to alert all staff at any VA facility around the country that a patient engaged in or is at risk of engaging in disruptive behavior.[164] Second, Committees may place formal restrictions on care through behavioral management orders. The types of restrictions include listing hours for outpatient care, specifying care in designated areas or health facility, identifying specific personnel or medical staff to work with the patient, requiring police escort or check-in, and terminating treatment if certain behaviors occur.[165] Third, the VAPF may cite or arrest a patient for criminal

implement the requirements of 38 CFR § 17.107"). For a discussion of the appeals process, see *infra* Subpart II.C.

162. 38 C.F.R. § 17.107(a) (2020) ("A patient's disruptive behavior must be assessed in connection with VA's duty to provide good quality care, including care designed to reduce or otherwise clinically address the patient's behavior.").

163. "Disruptive behavior" is defined broadly in a recent agency directive as, "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, VA employees, or individuals at the facility." VHA DIRECTIVE 1160.08(1), *supra* note 108, at 2. It further defines the term as behavior that "would create fear in a reasonable person; interferes with the safe, secure and effective delivery of VA health care; compromises the ability of VA to engage in its mission of serving Veterans; or impedes the daily operation of the facility." *Id. Cf.* 38 U.S.C. § 1.218(a)(5). The use of such a vague category is similar to the use of Oppositional Defiant Disorder category for youth in schools. *See* Matthew C. Fadus, *Unconscious Bias and the Diagnosis of Disruptive Behavior Disorders and ADHD in African American and Hispanic Youth*, 44 ACADEMIC PSYCHIATRY 95 (2019).

164. VHA DIRECTIVE 2010–053, *supra* note 108, at 2(j). *See also* DBC GUIDEBOOK, *supra* note 100, at 69; U.S. DEP'T OF VETERANS AFFS., PATIENT RECORD FLAGS (PRF) USER GUIDE 50 (Vers. 5.3, 2019).

165. 38 C.F.R. § 17.107(d) (2020) (providing examples of the types of care restrictions permissible by law); VHA DIRECTIVE 2010-053, *supra* note 108. The regulation and enacting policy allow limits to the time, place, and manner of care veterans receive on subsequent visits to VHA facilities. 38 C.F.R. § 17.107(b) (2020). Each facility evaluates a veteran's access to care based on the severity of their disruptive conduct without uniform standards defining "disruptive behavior" for purposes of referral to the disruptive behavior committee. *See* DEP'T OF VETERANS AFFS., OFF. OF INSPECTOR GENERAL, REPORT NO. 11-02585-129, HEALTHCARE INSPECTION: MANAGEMENT OF DISRUPTIVE PATIENT BEHAVIOR AT VA MEDICAL FACILITIES 12–13 (2013) [hereinafter "VA REPORT 11-02585-129"]; DBC GUIDEBOOK, *supra* note 100, at 65–67.

charges or for a "disturbance" as defined within 38 C.F.R. § 1.218 (a)(5), especially if a disturbance occurs following a behavioral management order.[166] As discussed in Part A, this charge is brought through the VAPF and converts the surveillance, tracking, and monitoring of patients in health spaces into criminal enforcement. Fourth, the Committee can also choose to take no action or adopt a "watch and wait" approach to monitoring the patient's future actions.[167]

Each health facility, working with its local Committee is charged with establishing its own criteria for what behaviors are sufficiently disruptive to warrant referral to them.[168] Because police serve as a primary source of patient referrals to the Committees,[169] they are part of defining (almost codifying) what constitutes disruptive behavior and are then involved with adjudicating patient conduct in the extralegal Committee setting. The criminal prosecutions of disturbances within care spaces show an attempt to control and manage poor veterans' behavior for actions sometimes associated with their disability or military trauma. Hospital policing risks subsuming clinical decision making in favor of criminal and behavioral regulation.

The Committee process also serves an expressive function. It not only labels behaviors as disruptive, but also poor veterans and veterans with disabilities as deviant and threatening.[170] The infrastructure behind the Committee and VA police presumes the poor exhibit latent criminality and veterans with disabilities

166. DBC GUIDEBOOK, *supra* note 100, at 26, 68.

167. The Office of Inspector General's (OIG's) 2013 report found no action was taken in ten percent of the 889 individual cases it reviewed. VA REPORT 11-02585-129, *supra* note 165, at 13, tbl.3. DBC GUIDEBOOK, at 65 (discussing strategy of Committees to "watch and wait" when an assessment determines no immediate threat "but does suggest that problems could develop in the future").

168. *See* Report 11-02585-129, *supra* note 165, at i ("We found significant differences in how VHA facilities define disruptive behavior[.]"). *Compare* VHA DIRECTIVE 1160.08(1) *supra* note 108, at 2. *See generally* U.S. DEP'T. VETERANS AFFS., REPORT NO. 11–00215–194, COMBINED ASSESSMENT PROGRAM SUMMARY REPORT: MANAGEMENT OF WORKPLACE VIOLENCE IN VETERANS HEALTH ADMINISTRATION FACILITIES (2012) [hereinafter VA REPORT 11-00215-194].

169. VA REPORT 11-02585-129, *supra* note 165, at 6. Referrals to the committee also come from telephone clerks, reception area staff, and clinical providers. *Id.*

170. *See* Cass Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2029–34 (arguing law's meaning caries consequences in shaping social norms and legal officials must contend with the statements they communicate through legal action); Shirin Sinnar & Beth A. Colgan, *Revisiting Hate Crimes Enhancements in the Shadow of Mass Incarceration*, 95 N.Y.U. L. REV. ONLINE 149 (2020) (discussing potential sentencing reforms to hate crime laws that retain their expressive purpose). *See generally* JOEL FEINBERG, DOING AND DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY (1970); Avlana Eisenberg, *Expressive Enforcement*, 61 UCLA L. REV. 858, 861 (2014).

are threats to public safety.[171] The Committee is also responsible for connecting the informal regulation of disruptive behavior to formal criminal enforcement, even though the Committee's stated purpose is to support veterans' care and manage clinical decision making in situations where patients' medical care might otherwise be terminated in non-VHA hospitals or clinics. As noted in oversight reports and evident from reported federal cases, the supportive intentions are in tension with police practices and the easy escalation from flags to police interactions and criminal enforcement, as well as complaints of racial profiling from the National Association of Minority Veterans.[172] The Committee's mechanisms' criminalizing and subordinating force risks compromising competing aspirations to protect and care for veterans.

Most significantly, none of the VA violence prevention systems have been shown to substantially improve safety, be it those the Committee implement or VHA's workplace monitoring systems. In 2018, faculty in the Department of Psychiatry at the University of Southern California (USC) and affiliates of the VHA studied VHA workplace safety procedures. The researchers asked three questions: Do behavioral flags reduce workplace violence against staff and patients? Do they obstruct access to healthcare? And if so, are there alternatives to manage the risk of violence?[173] The researchers used the same case files and data as the OIG in its 2013 audit and reviewed other available data including a prior six-year study by other researchers examining assault rates in 138 VA facilities with violence prevention strategies. Results showed a small (5 percent) reduction in assault incident rates across VA facilities, even after training, encouraging staff reporting, and other system-wide attention to workplace safety. The 2018 study also found that facilities focused on safety training practices only had "marginally lower assault rates."[174] The OIG data, combined with these study results, led the USC researchers to conclude the behavioral flag system "held minimal benefit" to the VHA or workplace safety when balanced with the potential to obstruct

171. *See* GUSTAFSON, *supra* note 13, at 70 (theorizing the criminalization of poverty); BEN-MOSHE, *supra* note 5, at 23-27 (discussing the intersection of disability rights discourses and deinstitutionalization struggles as race-ability and their more specific theory of "racial criminal pathologization").

172. SUNITA PATEL, MAYA CHAUDHURI & WILL OSTRANDER, NATIONAL ASSOCIATION OF MINORITY VETERANS (NAMVETS) AND UCLA VETERANS LEGAL CLINIC ADVISORY: THE U.S. DEPARTMENT OF VETERANS AFFAIRS POLICE FORCE (2020).

173. Linda E. Weinberger, Shoba Sreenivasan, Daniel E. Smee, James McGuire & Thomas Garrick, *Balancing Safety Against Obstruction to Health Care Access: An Examination of Behavioral Flags in the VA Health Care System*, 5 J. THREAT ASSESSMENT & MGMT. 37 (2018).

174. *Id.*

access to medical care.[175] I agree. Moreover, the benefit seems even less when one accounts for the potential disproportionate effect on historically marginalized veterans and the societal and political harm that comes from failing to meet obligations to veterans or alienating them from veteran-centered care. Studies in the emergency room context also raise important concerns with patient-provider trust, legal and ethical considerations, and physical and psychological effects when police use restraints.[176]

Because of its embeddedness, policing impacts access to healthcare and influences care decisions through the Committee structure. This infrastructure compounds the routine criminalization of patients through more day-to-day VA police enforcement activity.[177]

C. Tracking Patients

Utilizing the flags and behavioral management orders, the Committee structure creates a mechanism for tracking and surveilling patients exhibiting conduct that is often associated with disabilities. While monitoring patient health is routine and improves health outcomes in medical contexts, embedded police can morph these health systems into carceral mechanisms to control, regulate, and criminalize a person's behavior. VHA policy allows staff to place Category I flags for disruptive behavior, which is then visible throughout the national network of VA medical facilities. Thus, any care worker at any VA facility who opens a flagged patient's electronic records is immediately alerted to prior disruptive behavior.[178] The fact that these disruptive behavior flags are the only flags currently visible in all facilities nationally underlines the primacy placed on making a patient's past disruptions immediately and prominently visible.[179] This technological infrastructure allows clinical staff and police to monitor patients' actions with the

175. *Id.* The recently published DBC Guidebook mentions that a PRF "may inform the admission process [for VA programs], and the potential for disruptive or violent behaviors in certain settings can preclude admission pending resolution of identified risk," even though "mere presence of a PRF may not be used preemptively to deny access to clinically indicated services." DBC GUIDEBOOK, *supra* note 100, at 70. Using flags in this manner directly affects access to healthcare. Further information on red flags is needed to understand the full picture.

176. *See* Gallen et al., *supra* note 29, at 3–6; Armando Lara-Millán, *Emergency Room Overcrowding in the Era of Mass Imprisonment*, 79 AM. SOCIO. REV. 866 (2014).

177. *See infra* Subpart II.D.

178. VHA DIRECTIVE 2010–053, *supra* note 108, at 2.k(1)–(2). Category II flags identify patients who are at risk for other reasons, such as drug-seeking behavior, history of wandering, suicide attempts, or spinal cord injuries. These local flags are not shared across facilities. *Id.*

179. *Id.* at attach. B, at A-5.

presumption that certain health conditions cause behavior threatening to staff, visitors, or the patient themselves.

VHA staff and police use their own subjectivity to determine whether a patient's actions are disruptive under the VA's definition.[180] With each facility implementing a different policy and definition of disruptive behavior, there is significant interpretive variation among facilities.[181] Despite the variation, a broad spectrum of conduct—as severe as physical violence and as moderate as complaining about wait times, threatening a lawsuit, or rude behavior—can lead to Committee intervention.[182]

For patients with disabilities, Black, and otherwise historically marginalized veterans, police and staff may presume many benign actions carry a risk of violence in the future. Implicit bias in the medical setting is generally well-documented, including its discriminatory effects on the delivery of care and unequal health outcomes.[183] A recent study of Black patients receiving VA mental healthcare examined their experiences of race.[184] Black veterans expressed negative

180. *See id.* at attach. A ("Standards for Category I and Category II Patient Record Flags").

181. *See* VA Report 11-02585-129, *supra* note 165, at 14 ("Our review found significant variation in how VHA facilities identify and manage disruptive patient behavior . . . . Most facilities have applied their own definitions of disruptive behavior . . . ").

182. *Id.*

183. *See generally* ARMANDO LARA-MILLÁN, REDISTRIBUTING THE POOR: JAILS, HOSPITALS, AND THE CRISIS OF LAW AND FISCAL AUSTERITY 101–107 (2021) (ethnographic narrative accounts based on direct observation in the emergency room located at USC Hospital in Los Angeles). Ji Seon Song extensively reviews the problem of bias in health care delivery including, among others, steering of ICU beds, racial factors in health algorithms, implicit bias, among others. Song, *Cops in Scrubs*, *supra* note 8. Song builds on a long literature exploring race, structural inequality, and bias in medicine. *See* Barbara A. Noah, *Racist Health Care*, 48 FLA. L. REV. 357 (1996); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y, L., & ETHICS 95 (2001); Osagie K. Obasogie, *The Return of the Biological Race? Regulating Race and Genetics Through Administrative Agency Race Impact Assessments*, 22 S. CAL. INTERDISC. L.J. 1, 5–6 (2012); William J. Hall, Mimi V. Chapman, Kent M. Lee, Yesenia M. Merino, Tainayah W. Thomas, B. Keith Payne, Eugenia Eng, Steven H. Day & Tamera Coyne-Beasley, *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH e60, e72 (2015); Osagie K. Obasogie, *Race and Science: Preconcilitation as Reconciliation*, *in* RACIAL RECONCILIATION AND THE HEALING OF A NATION: BEYOND LAW AND RIGHTS 49, 50 (Charles Ogletree & Austin Sara eds., 2017). The American Medical Association has also recognized the role medicine has in perpetuating racial bias in medical treatment and other racial inequities in the medical profession. *New AMA Policy Recognizes Racism as a Public Health Threat*, AM. MED. ASS'N (Nov. 16, 2020), https://www.ama-assn.org/press-center/press-releases/new-ama-policy-recognizes-racism-public-health-threat [https://perma.cc/65U6-F8AM].

184. Johanne Eliacin, Marianne S. Matthias, Brooke Cunningham & Diana J. Burgess, *Veterans' Perceptions of Racial Bias in VA Mental Healthcare and Their Impacts on Patient Engagement and Patient-Provider Communication*, 103 PATIENT EDUC. & COUNSELING 1798, 1798–99 (2020).

judgments based on stereotypes associated with African Americans, including feelings of being feared, judged, or showing disrespect in care interactions.[185] One participant noted they were perceived as an "angry, big Black men" whom providers viewed as a physical threat and thus reacted to fearfully.[186] Another participant, a 47 year-old female noted stereotypes in her experiences: "They see me, an African-American female . . . . The first personification of us is . . . that I have two children out of wedlock, I was an addict, I was incarcerated . . . they think that I come from an impoverished background, [that] I have no education. . . . the way they talk to me, it was really insulting."[187] Most importantly for this Article, the researchers expressed concern over patient reluctance to follow up with mental healthcare or preventative care following experiences with perceived stereotype-threat.[188] While this is only one study with a limited number of patient participants, its conclusions are consistent with others outside the VA context found in medical literature.[189]

Less attention has been paid to whether stereotype-threat or implicit bias plays a role in referrals to hospital security, refusing medical attention, or for the VA, referrals to its Disruptive Behavior Committees. These settings rely on the perception that people with mental disabilities are dangerous. For example, persons with mental disabilities are responsible for 4 percent of gun violence[190] yet are more frequently perceived as dangerous by police officers.[191]

185. *Id.*
186. *Id.*
187. *Id.*
188. *Id.*
189. *See* Weinberger, Sreenivasan, Smee, McGuire & Garrick, *supra* note 173. *See also infra* note 201 and accompanying text for a discussion of these trends beyond the VA context.
190. Jonathan M. Metzl & Kenneth T. MacLeish, *Mental Illness, Mass Shootings, and the Politics of American Firearms*, 105 AM. J. PUB. HEALTH 240 (2015).
191. Bruce G. Link, Jo C. Phelan, Michaeline Bresnahan, Ann Steve & Bernice Pescosolido, *Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance*, 89 AM. J. PUB. HEALTH 1328–33 (1999); Melissa Schaefer Morabito & Kelly M. Socia, *Is Dangerousness a Myth? Injuries and Police Encounters With People With Mental Illnesses*, 14 CRIMINOLOGY & PUB. POL'Y 253, 254, 258–59 (2015). More recent studies have examined police use of force and persons with serious mental illnesses (SMI). In a nine-city study using police use of force and suspect injury data from 2011 to 2017, Professor Phillip Goff and his colleagues found police used force against persons with serious mental illness (SMI) in 17% of use of force cases and 20% of persons injured in police interactions. The researchers also found the risk that persons with SMI will experience police use of force is 11.6 times higher than persons without SMI. Ayobami Laniyonu & Phillip Atiba Goff, *Measuring Disparities in Police Use of Force and Injury Among Persons with Serious Mental Illness*, 21 BMC PSYCHIATRY (2021), https://doi.org/10.1186/ s12888-021-03510-w.

Based on a review of 889 unique patients referred to Disruptive Behavior Committees in thirty different facilities around the country, the OIG expressed concern that flags and committee referrals were overused by VHA employees. The OIG found that in fiscal year 2011 only 16.8 percent of referrals to the Committee were for physical violence.[192] The majority of referrals to Committees (56.6 percent) were for verbal encounters,[193] with another 21.5 percent for "other" (including everything from rudeness, venting, slamming doors, stealing from the canteen, or throwing a chair through a window). This means over 75 percent of referrals may have stemmed from arguments though the report tells us little more about the circumstances or the proportion of "other" that may fit into a threat or violence category.[194] All types of threats accounted for over 40 percent of referrals, but the range of threats or potential threatening actions shows the low threshold for a referral. Almost 10 percent of referrals were for "vague and unspecified threats," 7.9 percent were for threats of harm (with a weapon) and,

192. VA REPORT 11-02585-129, *supra* note 165, at 9, tbl.1. A follow-up report published in 2018 focused on systems of documenting workplace violence. The OIG included an appendix related to record keeping and file management for disruptive behavior incidents and DBC referrals. The 2018 table only stems from investigators' review of electronic health records, rather than the more comprehensive method of the 2013 report which included medical records, disruptive behavior committee files, and interviews with relevant personnel. Unfortunately, the purpose of the subsequent data gathering was different, and comparisons are not useful. Moreover, the information compiled does not provide the basis for behavioral record flags or orders, making the 2012 report the best source of information. *See* DEP'T VETERANS AFFS., REPORT NO. 17-04460-84, COMBINED ASSESSMENT PROGRAM SUMMARY REPORT: MANAGEMENT OF DISRUPTIVE AND VIOLENT BEHAVIOR IN VETERANS HEALTH ADMINISTRATION FACILITIES, 14, tbl.2 (2018) [hereinafter "VA REPORT 17-04460-84"].

193. "Verbal aggression" and "verbal attack" were grouped together in the publicly available report. *Id.* Examples of verbal aggression or attack included screaming, swearing, or using ethnic or racial slurs. *Id.*

194. Given the age of the available data and my interest in analyzing the record flag data differently, the UCLA Veterans Legal Clinic engaged in a Freedom of Information Action (FOIA) request on behalf of NAMVETS with VHA and OIG to obtain detailed records and data related the 2012 and 2018 reports. The OIG responded that it had already destroyed the underlying 2012 report data and litigation is pending in the U.S. District Court of the District of Columbia to obtain the underlying records related to the 2018 report. Complaint, Nat'l Ass'n of Minority Veterans v. Dep't of Veterans Affs., No. 21-1298 at ¶¶ 11, 15 (2021). Future work can explore different categorizations and provide a deeper understanding of the reasons for the referrals, analyze the "other" category further, and aggregate violent and customer service-based incidents. With more detailed records, an analysis may take into account identity markers such as race and health status, as well as whether certain locations, staff type, or individual medical providers account for a high number of behavioral record flags. Further analysis can also take into account implicit bias and de-escalation training as well as the demographics of the staff, patients, and surrounding community.

15 percent for a "threat of harm (with no mention of a weapon)."[195] While I do not mean to understate the effects of threats or violence in a workplace—including missed days of work, stress, injury, and unsafe conditions—these data suggest that a large percentage of referrals to Committees occurred following speech in an unacceptable or inappropriate manner. Patients with disabilities, particularly traumatic brain injuries or complex mental illnesses that might lead to paranoia and agitation with verbal reactions, are more likely to be flagged.[196] The picture is quite complex and further study and evaluation is needed.

In fact, mental disabilities were the likely underlying basis for a portion of referrals to Committees in the OIG sample. The threat of suicide comprised 6.4 percent of referrals to a Disruptive Behavior Committee and "drug-seeking behavior" made up 20.7 percent of referrals.[197] Suicidal ideation characterized and framed as disruptive suggests an overuse or abuse of the monitoring system.[198] Even drug-seeking behavior indicates cooccurring disorders, recognized by the VHA and Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) as a mental disability. Unfortunately, even health institutions may view such veteran patients as presumptively violent and in need of management and control, and interactions with care staff are viewed through this lens. The inclusion of police in the committee determining whether disorderly conduct warrants criminal sanction compounds the problem.

Given the demographics discussed in Part I.A, showing a high percentage of unhoused, Black or Latinx, and patients with disabilities, the previously mentioned racial bias within healthcare, and the multiple studies showing disproportionate rates of policing among Black persons across the country,[199] it is

195. *Id.* Percentages do not equal 100 because 45 percent of the unique patient referrals involved multiple incidents or behaviors.

196. The only study I was able to locate on record flags within the VA used the same behavioral record flag data as the 2013 report. It provided additional context for behavioral flags and their interaction with access to care. *See* Weinberger, Sreenivasan, Smee, McGuire & Garrick, *supra* note 173, at 38–39 (discussing the dehumanizing effect on patients, the negative reactions in care-providers that can influence medical treatment, and the manner in which a flag can lead to escalation and police involvement).

197. VA REPORT 11-02585-129, *supra* note 165, at 9, tbl.1.

198. Unfortunately, the OIG report does not provide detailed information by Veterans Integrated Services Network (VISN) (regional level) or medical facility, preventing analysis on variations between implementation of the policies and procedures. In response to a 2020 FOIA request, the OIG responded that it had destroyed the relevant records according to federal record retention law. Complaint, Nat'l Ass'n of Minority Veterans v. Dep't of Veterans Affs., No. 21-1298 at ¶ 11 (2021).

199. *See, e.g.*, Report of David Abrams, Ph.D., Collins v. Milwaukee, No. 17-CV-234 (E.D. Wis. 2017), 2017 WL 1050594, https://www.aclu.org/legal-document/expert-report-david-abrams-phd [https://perma.cc/4N52-7MUS] (Black drivers and pedestrians six times more

also likely Black veterans are overrepresented among veterans referred to the Committee. Black bodies are already considered worthy of control, regulation, and surveillance, compounded in this context with high rates of disabilities and homelessness.

In addition to the red flags, orders restricting healthcare delivery—the second tool available to the Committees—show even more starkly how embedded police can inculcate carceral logics in response to conduct that may be connected to a health condition. Consider the following data: one of every four patients referred to the Committee in the OIG sample could not receive patient care at a VHA facility without first checking in with a VA police officer and 12 percent required "police escorts or standby for appointments."[200] Thus, police were literally and physically surveilling over one-third of the sample set. Although race and gender data are not available for the sample, understanding structural racism and racial bias in healthcare delivery suggests Black patients and visitors are likely overrepresented in these figures.[201]

I am not suggesting that patient violence or threats with a weapon should be ignored, or that modification in care may not be warranted. The VHA has creatively used other methods to provide safety to its workers while setting limits with patients. The OIG found 26.5 percent of orders involved "Other" non-restrictive healthcare actions, which included assigning a new primary care physician, case manager, or coordinator, requiring a provider or staff of a different gender, or requiring two staff members during patient care provision.[202] Other

likely to be stopped than white drivers); *Racial Disparities in Stops by the D.C. Metropolitan Police Department: Review of Five Months of Data*, ACLU: D.C. (June 16, 2020),https://www.acludc.org/sites/default/files/2020_06_15_aclu_stops_report_final.pdf [https://perma.cc/4D4R-CA77] (Black people compose seventy-two percent of those stopped in the District despite making up 46 percent of the D.C. population); Ben Poston & Cindy Chang, *LAPD Searches Blacks and Latinos More. But They're Less Likely to Have Contraband Than Whites*, L.A. TIMES (Oct. 8, 2019), https://www.latimes.com/ local/lanow/la-me-lapd-searches-20190605-story.html [https://perma.cc/QS4J-PVVA] (finding that during LAPD traffic stops, "24 [percent] of [B]lack drivers and passengers were searched, compared with 16 [percent] of Latin[x] [people] and 5 [percent] of [white people]."); Enquirer Ed. Bd., *Editorial: Racial Disparities in Police Stops Demands Attention*, CINCINNATI ENQUIRER (Dec. 20, 2019), https://www.cincinnati.com/story/ opinion/2019/12/20/editorial-racial-disparities-police-stops-demands-attention/ 2666685001 [https://perma.cc/RN36-3S8Q] (determining Black motorists were thirty percent more likely to be pulled over than white motorists).

200. VA REPORT 11-02585-129, *supra* note 165, at 13–14, tbl.3.

201. Song, *Cops in Scrubs*, *supra* note 8; *see* Bloche, *supra* note 183; Obasogie, *supra* note 183; Eliacin, Matthias, Cunningham & Burgess, *supra* note 184.

202. VA REPORT 11-02585-129, *supra* note 165, at 13, tbl.3; DBC GUIDEBOOK, *supra* note 100, at tbl.5.1, 63–65 (describing options such as warning letters, letters of concern, and behavioral agreements).

patients were counseled (4.9 percent), provided a clinical intervention (4.9 percent), entered into a healthcare agreement (3 percent), given a clinical warning (1.1 percent), or banned from the main medical facility (1.1 percent).[203] More recently, a guidebook acknowledges these "non-restrictive" tools and strategies may be implemented without the Committee's involvement or a red flag.[204] These approaches may strike a better balance and respect the autonomy of persons with disabilities to enter into agreements and make decisions for their own care. Such strategies seem better tailored to actions or reactions from a veteran patient and, significant for this Article, they attend to safety of the care provider without necessarily utilizing police or surveillance responses.[205]

The VHA, however, prefers providers merge these therapeutic and non-restrictive options with the Committee and red flag structure, creating more opportunity for surveilling patient conduct.[206] The Committee has the option of placing a red flag on a patient's record even when non-restrictive options are pursued or a current threat is not apparent.[207] When the Committee determines behavior does not rise to the level of warranting a red flag or behavioral restriction order, the Committee often adopts a "watch and wait" approach.[208] It gathers more information from VA police and providers over time. I prefer a system that does not involve the Committee for situations with no immediate threat. Overall, more study is necessary to understand how the orders and behavioral flags operate and whether the other options strike the right balance.

203. *Id.*
204. DBC GUIDEBOOK, *supra* note 100, at 62.
205. Even with these approaches, however, VHA suggests police would have beneficial effects. DBC GUIDEBOOK, *supra* note 100, at 62 (explaining counseling as "a conversation that may occur between patient and his/her provider or other appropriate personnel in the medical center. . . It may be helpful to involve a mental health professional in the counseling process. Sometimes a conversation with a VA Police Officer may have a salutary outcome[.]").
206. *Id.* Committee may "provide consultation . . . [with] the implementation of these strategies, before a case has escalated to the point where the DBC has to take more official actions." *Id.* My concern is VHA bringing every action of a patient, regardless of disability status and potential bias on the part of providers, to the attention of a Committee acting to surveil patients. Without more information on the actual practices of the Committees and the outcomes from the patients' and workers' perspective, it is difficult to determine if the protective goals of the surveillance system outweighs the managerial ones.
207. DBC GUIDEBOOK, *supra* note 100, at 64 (while discussing non-restrictive strategies, stating, the "DBC may place a Behavioral Patient Record Flag. . . on the patient's chart.").
208. *Id.* at 65 (In these cases "threat assessment might not generate strong evidence for serious or immediate threat, but does suggest that problems could develop in the future. Additional DBRS reports, follow up by providers, and information from VA police could lead to additional assessment and development of more active strategies.").

Finally, another carceral feature of the Committee structure is the difficulty of removing oneself from the hospital policing apparatus. Medical facilities routinely fail to inform patients of behavioral record flags or the more restrictive behavioral management orders.[209] VHA provides for no process to appeal a patient record flag.[210] Regulation and policy requires patient flag reassessments every two years,[211] though it is unclear whether these reviews take place in the required time frame. Although the agency directive's implementing regulations allows patients to contest any behavioral management restrictions in writing to the Chief of Staff for the issuing facility when submitted within thirty days of the order practical barriers stand in the way.[212] Despite the procedural due process concerns with only providing thirty days for such a review and no assurance of immediate notice, the 2018 OIG audit determined that medical staff routinely failed even to inform patients a healthcare restriction order was in effect, let alone inform them of methods for reviewing the decision.[213] Since that report issued in 2018, I have not discovered any public information on whether or how often patients are notified of behavioral flags or orders, though the agency and courts strictly construes the thirty-day requirement.[214] Thus, the inability to extract oneself from the electronic red flag and behavioral management system exacerbates

209. The OIG reported in 2018 that "most of the time . . . most clinicians had reviewed previously place flags as required," VA REPORT 17-04460-84, *supra* note 192, at ii. However, OIG also found noncompliance with the policy to inform patients about the red flags. It determined that "[i]n 49% of the [health records reviewed] OIG found no evidence that DBC/B clinician informed patients of [the right to amend the record flag]," *id.* at 6, and "[i]n 27% of reviewed [electronic health records], OIG found no evidence the clinicians notified patients of the [record flag's] placement," *id.*

210. DBC GUIDEBOOK, *supra* note 100, at 63.

211. DBC GUIDEBOOK, *supra* note 100, at 69 ("Behavioral [patient record flags] must be reviewed every two years at a minimum. . . "); 38 C.F.R. § 17.107 (West 2022).

212. 38 C.F.R. § 17.107(e). The Chief of Staff forwards the request for review to the Network Director who issues a final decision within thirty days. 38 C.F.R. § 17.107(b)(4) ("The patient receives a copy of the order and written notice of the procedure for appealing the order to the Network Director of the jurisdiction as soon as possible after issuance").

213. In 2018, the OIG found no evidence that patients were informed of an order of behavioral restriction in 13 percent of patient records and no evidence patients were informed of their right to request an appeal or amendment in 25 percent of new orders. VA REPORT 17-04460-84, *supra* note 192, at 7.

214. VHA DIRECTIVE 1160.08(1), *supra* note 108, at b.(1)(B)a–c ("As provided in 38 C.F.R. 17.107, there is no additional review process for an [Order of Behavioral Restriction].") *See* Veasy v. United States, No. CV 16-4151, 2017 WL 528322, at *2–*4 (E.D. Pa. Feb. 9, 2017) (dismissing for failure to exhaust where veteran patient wrote several letters to the VA objecting to the police escort requirement, they were not addressed to the Chief of Staff and not within 30 days).

the carceral nature of these VA systems by extending the length of their effect and manifesting a stickiness to the policing web.

D. Care Workers as Pseudopolice

In addition to the criminal enforcement and surveillance systems already discussed, workplace safety regulations and risk assessment policies help construct the healthcare policing web in a few ways. First, workplace safety requirements bring nearly 400,000 hospital workers[215] into the VHA's comprehensive security and surveillance framework through Occupational Safety and Health Act (OSHA) and National Institute for Occupational Safety and Health (NIOSH). In addition to OSHA's recommended surveillance techniques noted earlier, such as "high alert for risk factors" and surveillance cameras,[216] NIOSH advises healthcare employees to collaborate with security personnel.[217] OSHA also recommends healthcare facilities report all violent behavior and threats, investigate "near misses," establish a "zero tolerance" policy, and implement a liaison with local police.[218] These guidelines and recommendations thrust healthcare employees into a regulatory framework where they exercise discretion in determining which patients pose a threat and should be monitored, reported, criminalized, and otherwise surveilled.

Under a framework of protecting workers, medical staff are co-opted into serving police-like functions through formal criminalization when they engage embedded police.[219] Protecting workers from harm is obviously an important goal, but requiring criminal reporting and behavioral monitoring for patients risks

215. *See Veterans Health Administration*, *supra* note 15.
216. *See supra* Subpart II.C.
217. *Id. See also* OSHA GUIDELINES, 2016, *supra* note 110, at 5.
218. *Id.* at 19–24. *Cf.* DBC GUIDEBOOK, *supra* note 100, at 46 ("Every report of patient-related threatening, disruptive, or violent behavior requires attention.").
219. Ji Seon Song analyzes a similar phenomenon in emergency departments when health care workers extend the Fourth Amendment search capacity of police. *See* Song, *Cops in Scrubs*, *supra* note 8. Other scholars uncovering the harm to Black women, prisoners, and children in multiple contexts likewise emphasize the role of the state agent—social worker, nurse, case worker, or prison guard—in enforcing carceral policies. *See generally*, Bridges, *supra* note 13 (discussing the role of social workers and nutritionists in regulating poor pregnant women); Roberts, *supra* note 13, at 1474 (exploring child welfare agencies' role in mass incarceration and punishing Black mothers); Decoteau J. Irby, *Trouble at School: Understanding School Discipline Systems as Nets of Social Control*, 47 EQUITY & EXCELLENCE IN EDUC. 513, 517–19 (2014) (presenting teachers as the "upper net" of school discipline, disciplining, managing their classrooms and otherwise referring students to school personnel); Nanda, *supra* note 158, at 298–99 (describing how teachers observe student behavior and performance, making subjective determinations about whether it is out of the ordinary).

creating unfriendly, and even hostile, care environments that potentially undermine VHA's patient-centered goals.

Second, care workers further carcerality in less visible ways as well. They regulate certain types of unruly and nonnormative behavior through the VA's workplace safety policies. Violence prevention policies adopt a lens of promoting safety and reducing violence while also regulating care workers' behavior.[220] Workers must adopt discretion, in a manner consistent with systems viewing patients as potential threats to their safety. In addition, police, guns, overuse of record flags, and criminal enforcement can become naturalized in such an environment. Specifically, carcerality influences VA policies and procedures governing employee training and reporting, as well as threat assessments—each of which I discuss in turn below.[221]

Employee Training: VHA medical facilities conduct annual Workplace Behavioral Risk Assessments to determine the potential for patient harm against employees.[222] Employees are categorized on a scale of "minimal risk," "low risk," "moderate risk," to "high risk" according to their risk of encountering disruptive or violent patients.[223] All new workers must complete an initial training for Prevention and Management of Disruptive Behavior, with additional training based on their level of risk for treating patients engaging in verbal or physical harm. The highest level of training is for staff encountering patients who may require "therapeutic containment responses."[224]

Reporting: For reformers reimagining conceptions of public safety, it is critical to understand how medical directors and their staff assess risk and threats of violence and reporting requirements that may affect the culture of health institutions. VA employees are required to report patients' and coworkers' disruptive behavior under multiple and overlapping regulations, directives, and

220. *E.g.*, VHA DIRECTIVE 1160.08(1), *supra* note 108.

221. The VHA's website characterizes its Workplace Violence Prevention Program as a four-pronged approach. The goal of each component is described as protecting workers from patients or visitors and tracks discussion in this Part. *See VHA's Workplace Violence Prevention Program (WVPP)*, DEP'T OF VETERANS AFFS. (Dec. 21, 2016), https://www.publichealth.va.gov/about/occhealth/violence-prevention.asp [https://perma.cc/ 3YEL-7XLY].

222. "An annual report of all disruptive events occurring at a VA medical facilities (and its components)." VHA DIRECTIVE 1160.08(1), *supra* note 108, at 3.n. & App. C.

223. *Id.* at B1–B2.

224. This training program was launched the year after the 2012 unifying directive. *See* VA REPORT NO. 11-00215-194, *supra* note 168, at 3; VA REPORT 17-04460-84, *supra* note 192, at 8; VHA DIRECTIVE 1160.08(1), *supra* note 108, at 3.o.14 (defining levels of risk). *See generally* DBC GUIDEBOOK, *supra* note 100, ch. 4 ("Threats").

guidelines.[225] Some facilities prefer what can be characterized as "behavioral approaches" that limit services or require police check-ins or escorts.[226] Others view disruptive behavior as indicators of underlying psychosocial or patient satisfaction issues. These hospitals prefer "clinical interventions" such as interviewing and counseling patients, changing providers, healthcare agreements, or assigning care coordinators.[227] Federal regulations mandate workers report suspected crimes, creating cop-like duties.[228] And VA management officials must report "information about actual or possible violations of criminal laws" on VA premises to the VA Police.[229]

Threat Assessment: VA staff and medical workers have engaged in harm to veteran patients.[230] In response, in 2012 the VA issued a directive requiring medical facilities to establish interdisciplinary Employee Threat Assessment Teams (ETATs) charged with addressing the risk of violence stemming from employee-generated disruptive behavior or actions that undermine a culture of safety.[231] Over time, the VA operationalized these teams to also assess patient

225. *See, e.g.*, VHA DIRECTIVE 1160.08(1), *supra* note 108, at 12, 15 (Chairs of DBC and ETAT required to notify VA Police with report of sexual assault is received); *Id.*, at C-2 (reporting system must permit VA employees to meet mandatory reporting of acts of violence in workplace); 38 C.F.R. § 1.201.

226. VA Report 11-02585-129, *supra* note 165, at 14.

227. *Id.*

228. Khiara Bridges discusses a similar phenomenon for pregnant women, in which legislation mandates healthcare professionals screen for and report substance abuse or "suspicion" of substance abuse among pregnant women. In many cases, the determination of whether to screen a patient enables class-based and race-based biases to come into play. Bridges, *supra* note 13.

229. Employee's Duty to Report, 38 C.F.R. § 1.201; Information to Report to the VA Police, 38 C.F.R. § 1.203. *See generally* VHA DIRECTIVE 1160.08(1), *supra* note 108.

230. The OIG and VA acknowledge staff-generated violence in multiple reports. *See e.g.*, VA REPORT 11-02585-129, *supra* note 165, at 2–3 (discussing violent and disruptive employees; "We recommended that VHA define processes for managing disruptive or violent behavior by employees. . ."); VA Report 17-04460-84, *supra* note 192, at ii ("facility directors need to address employee-generated violence. . . .").

231. DEP'T OF VETERANS AFFS., VHA DIRECTIVE 2012–026, SEXUAL ASSAULTS AND OTHER DEFINED PUBLIC SAFETY INCIDENTS IN VETERANS HEALTH ADMINISTRATION (VHA) FACILITIES (2012); VHA CTR. FOR ENG'G & OCCUPATIONAL SAFETY & HEALTH, EMPLOYEE THREAT ASSESSMENT TEAM (ETAT): A GUIDEBOOK FOR MANAGING RISKS POSED BY THE DISRUPTIVE AND THREATENING EMPLOYEE (2016) (citing the purpose of ETAT as preventing employee generated violence); VHA Directive 1160_08(1) at app. D, at D-3, App. C. The ETAT process appears to be newer and less developed than the patient-focused disruptive behavior committees. *Id.* at 5 (In August 2021 directive, stating "VHA. . . has begun to develop and train multidisciplinary [ETATs] charged with reducing the risk of employee-generated disruptive behavior.").

threats against staff, creating additional methods for monitoring the risk of patient-generated violence or harm.[232]

The training, reporting, and ETATs stemmed from the agency's goal of addressing the potential for violent or disruptive behaviors by employees. The policies and procedures discussed in this Part require employees to report harm against patients and other employee misconduct or corruption to VA Police. In practice, however, the system primarily focuses on the risk of patient violence towards workers. The OIG raised the same concern in its 2018 assessment of the VA's workplace violence systems, emphasizing the VHA's lopsided focus on managing patients exhibiting disruptive behavior.[233] It determined VHA "lacked specific guidance concerning assaults that involve nonpatients (employees, visitors, students, and others) as victims or perpetrators."[234] The report identified thirty-one incidents of employee assaults on patients but no uniform system to address the harms.[235] The 2018 finding is remarkable because five years prior, in response to the OIG's request that the VA create a system to address employee threats, it developed the measures discussed in this part. A newer guidance issued this year shows some promise for focusing the employee threat assessment towards harm against patients.[236] I have concerns that such a process will still carry punitive approaches against patients and workers.

The VA has adopted an anemic lens through which it views workplace safety. The overemphasis on the risk for patient-generated harm influences the way care workers interpret nonharmful actions. The VA OIG found that hospital workers sometimes incorrectly associated "gray area actions" (such as talking loudly, repeated phone calls, or reacting rudely) as precursors to violent or disruptive behavior.[237] Because police are in close physical proximity and embedded within the institution, complaints about wait times or administrative delays can lead to police involvement and potential violence.[238] Fortunately, professional healthcare

232. The DBC Guidebook suggests a more robust set of policies and guidelines for ETATs that may avoid the problem of utilizing ETAT to further surveil patients. *See* DBC GUIDEBOOK, *supra* note 100, at 3, E-1–E-4.
233. VA REPORT 17-04460-84, *supra* note 192.
234. *Id.* at ii.
235. *Id.*
236. VHA DIRECTIVE 1160.08(1), *supra* note 108, at 5–6. As of the date of publication, more recent and updated ETAT information referenced in this VHA directive is not available publicly.
237. *Id.*; *see* VA Report 11-02585-129, *supra* note 165, at 10 (describing patients in the "gray areas").
238. One example led to death. See *Family of Veteran Recovers Against VA Hospital for Fatal Tackle*, LAW OFFS. OF JERRY L. STEERING, https://steeringlaw.com/police-misconduct-blog/john-montano [https://perma.cc/EAE8-BWFA] (alleging elderly Black veteran with pacemaker problem died of complications after VA police body slammed him in an emergency room after

associations have started responding by calling for limiting securitized and criminal responses to patients.[239]

As seen, workplace safety protocols in healthcare institutions are infused with carceral logics that draw hospital care workers into a policing and surveillance framework that I call a healthcare policing web. The medical worker's subjective view of the patient's actions, augmented by medical record flags, influences how they utilize the safety controls, including embedded police, at their disposal. Workplace regulatory systems compound bias and categorize patients with disabilities, particularly those with mental disabilities and war trauma, as perpetually threatening. The regulations compromise a patient's personal dignity and may not adequately address the concern of violence in the workplace. The consequences to patients are the extension of surveillance, threat of police action, and an attendant otherizing on the basis of their marginal and intersecting identities. The policies further manage and criminalize veteran patients and form a core expressive and constitutive feature of the healthcare policing web. In this way, the Committee and workplace safety systems wind together to extend carcerality already found in care delivery, particularly mental healthcare.

E. Altering the Culture of Veteran Care

Having laid the foundation for the features of the healthcare policing web—the red flags, the orders, and criminal regulation in and out of the Committee structure, I turn to how embedded police alter the institutional culture of veteran healthcare.

The overlapping Committee and workplace safety systems used to manage patients at risk of disruptive behavior may reinforce or create a bias against those patients. Even the VA acknowledges that once the Committee designates veterans

complaining about a long wait time and attempting to leave; citing nurse's notes that speech slower and slurred after hitting head during take down); Stipulation for Compromise Settlement and Release of Federal Tort Claims Act Claims Pursuant to 28 U.S.C. § 2677, Montano v. United States, No. 2:14-CV-03995 ¶ 2 (C.D. Cal. July 24, 2015) (agreeing to pay plaintiff $500,000 in damages).

239. *Advancing Public Health Interventions to Address the Harms of the Carceral System*, #ENDPOLICEVIOLENCE (2021), https://www.endingpoliceviolence.com [https://perma.cc/6QQU-R4ZH]; NAT'L ADVOCS. FOR PREGNANT WOMEN, UNDERSTANDING CAPTA AND STATE OBLIGATIONS (2020), https://mk0nationaladvoq87fj.kinstacdn.com/wp-content/uploads/2020/11/2020-revision-CAPTA-requirements-for-states-10–29–20–1-1.pdf [https://perma.cc/2YX5-N5HX]; *Decriminalization of Self-Induced Abortion*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Dec. 2017), https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2017/decriminalization-of-self-induced-abortion [https://perma.cc/E9CA-DC3J].

as at risk of displaying violent or disruptive behavior, the visible nature of the red flag can "stigmatize[] patients, labeling them as difficult, whether for clinical or behavioral reasons."[240] When care workers open patient medical records with large, all-caps, red letters on the screen it is likely to activate their implicit biases.[241] Care workers then interpret the behavior of patients engaging in nonthreatening actions as potential future threats.

For example, if a flagged patient complains or is rude, the staff member may subconsciously interpret the actions as more indicative of a public safety risk than warranted, prompting a call to the VAPF. Even in situations where the patient or care staff may have concerns about police involvement, healthcare workers regularly call VA police for a wide range of actions from rudeness to harassing incidents and even self-harm events.[242] Such discretionary decisions on the part of medical workers carry a cascading effect on veterans' experiences of surveillance and care.[243] In this way, VA police are the failsafe for safety and security concerns.

Staff expressed ambivalence and disagreement over grey areas of patient behavior to the Office of Inspector General during its 2013 investigation. Such behavior included patients who call repeatedly and take up staff time; unduly loud patients; patients who complain about wait times, their care, or providers; or patients who use profanity.[244] Care staff expressed uncertainty over the seriousness of these disruptions but nonetheless wielded the flag system in such situations. Medical staff also incorrectly interpreted patients' decisions not to

240. VHA DIRECTIVE 2010–053, *supra* note 108, at 58.

241. At least one VA nurse remarked that colleagues would note, sometimes with alarm, when a patient with a scheduled appointment demonstrated disruptive behavior flag prior to meeting the patient. Interview with VA nurse, Nov. 2, 2021 (notes on file with author) (name withheld upon request). *See* VHA Directive 1160_08(01), App. C (disruptive behavior reports are "a person's subjective report of what they heard, saw, thought, or experienced. Such reports are, by their nature, subject to being incomplete, contextually anchored, and possibly biased.").

242. *See supra* Subpart II.C; DBC GUIDEBOOK, *supra* note 100, at 22 ("[o]rganizations should train employees to recognize the value and importance of reporting all episodes of disruptive behavior. The 'see something, say something' awareness is invaluable . . . ").

243. Similar concerns have been raised by feminist and legal scholars concerned by the ways in which Title IX expansion (expanded to support survivors of sexual violence) has incorporated carceral regulation. *See, e.g.*, Erin Collins, *The Criminalization of Title IX*, 13 OHIO ST. J. CRIM. L. 365 (2016) (critiquing the "risk management" approach to sexual violence prevention and discussing how "key tenets of the criminal law approach have been imported into emerging Title IX policies"); *see also* Nancy Chi Cantalupo, *For the Title IX Civil Rights Movement: Congratulations and Cautions*, 125 YALE L.J.F. 281 (2016) (cautioning against the infusion of carceral practices—such as mandated reporting to law enforcement and increased burdens of proof—into the Title IX regulatory framework, as such practices fail to adequately balance the rights of survivors and the accused, and disproportionately burden already marginalized survivors).

244. VA REPORT 11-02585-129, *supra* note 165, at 9–10.

adhere to treatment plans, or other exercises of their rights, as disruptive behavior.[245] The interpretation and assignment of disruptive intentions versus assertion of rights are especially indicative of the coercive and, at times carceral, aspects of mental healthcare.[246]

Patients may feel alienated from their healthcare providers. Medical researchers have noted the serious adverse effects of the flags and workplace safety systems on veterans seeking care. Flags may lead them to become discouraged and turn away from requesting care, or terminate it to avoid humiliation, lack of privacy, or police encounters;[247] they end up feeling devalued and dehumanized in the very care setting that should understand their unique disabilities and needs.[248] Such unintended consequences create negative health outcomes for veterans who may have no other insurance or healthcare options. During the COVID-19 pandemic and with the impending rise in houselessness, disconnection from the VHA may cause other severe ripple effects such as escalating distress and increased housing insecurity.

Police presence influences the atmosphere of health institutions. The presence of firearms and other weapons is just one concrete example.[249] Research shows guns in the workplace may lead to workplace stress and even increase the risk of gun violence in hospital settings.[250] Studies in the nursing field suggest that

245. *See id.* at 10 ("Providing clear guidance to facility staff may help to ensure that staff understand their role in supporting patients' rights to choose and participate in their care, including nonadherence to treatment plans, and avoid making referrals related to patients exercising their rights or for issues that could be addressed through better customer service.").

246. DBC GUIDEBOOK, *supra* note 100, at 66 (acknowledging that a "patient may experience an [order of behavioral restriction] as coercive. . ." and noting "use of an OBR as punishment or retribution is prohibited"). More data on the process, outcomes, and experiences of veterans and care providers is needed to assess the extent of the carceral pull.

247. Weinberger, Sreenivasan, Smee, McGuire & Garrick, *supra* note 173.

248. *Id.* at 38.

249. Reducing access to care is another. In one sociological account, patients left emergency department waiting rooms when police details arrived and served medical staff functions like checking on waitlisted patients. LARA-MILLÁN, *supra* note 183, at 107–110 (determining a police unit's presence in an emergency room contributes to the 20 percent of patients leaving without being seen).

250. Gabor D. Kelen, Christina L. Catlett, Joshua G. Kubit & Yu-Hsiang Hsieh, *Hospital-Based Shootings in the United States: 2000–2011*, 60 ANNALS EMERGENCY MED. 790, 793 (2012) (finding that in 23 percent of emergency department shootings, the perpetrator acquired the firearms from law enforcement personnel); *see also* Jennifer Tsai, *Get Armed Police Out of Emergency Rooms*, SCI. AM. (July 14, 2020), https://www.scientificamerican.com/article/get-armed-police-out-of-emergency-rooms [https://perma.cc/BU8U-MTFY] (describing the fear experienced as an emergency physician when seeing armed personnel); AM. MED. ASS'N, MEMORIAL RESOLUTIONS: ADOPTED

armed security intervention in patient-perpetuated violence can generate a feeling of fear within the healthcare environment, or worse yet, enable hospital violence.[251] For military veterans, firearms, authority figures in uniforms, and the policed environment may additionally lead to trauma responses.[252] The potential for triggers is particularly the case for combat veterans or patients with a history of sexual or other personal trauma connected to military experience. Some patients perceive healthcare environments as a threat to their physical and psychological safety, leading to hyperarousal or "flight responses."[253] As a result, veteran patients may perceive certain situations as threatening or potentially threatening, even when they are in physically safe environments.[254]

In a well-publicized 2015 incident at a non-VA Houston hospital, a confused college student with bipolar disorder wandered in and out of his room without clothes and would not allow nurses to button his gown.[255] Although the nurse reported he was calm and polite, protocol required her to call hospital police. The patient was alarmed by the police and threw a tray. Police tazed him multiple times and then shot him in the chest. While the hospital policy aimed to keep the nurse safe from a manic (and thus presumed potentially violent) patient, the violent and harmful encounter showed hospitals must take a different approach.[256] In response to this incident, the American Medical Association (AMA) adopted a

UNANIMOUSLY 428 (2016), https://www.ama-assn.org/sites/ama-assn.org/files/corp/ media-browser/public/hod/a16-resolutions.pdf [https://perma.cc/P9SR-RLZF]

251. *Id.*; Jill Beattie, Debra Griffiths, Kelli Innes & Julia Morphet, *Workplace Violence Perpetrated by Clients of Health Care: A Need for Safety and Trauma-Informed Care*, 28 J. CLINICAL NURSING 116, 118 (2019).

252. *See* Recognizing PTSD Reactions, U.S. Dep't of Veterans Affs.: PTSD: Nat'l Ctr. for PTSD, https://www.ptsd.va.gov/professional/treat/care/toolkits/police/policeworkRecognizingPtsd.asp [https://perma.cc/3SSA-N5UJ] ("A person who was assaulted by someone in uniform avoids or refuses to talk or make eye contact with you because you are in uniform."); *see also id.* ("A person with PTSD constantly scans the environment for potential danger and may feel extremely threatened by anyone approaching him or her.").

253. Beattie, Griffiths, Innes & Morphet, *supra* note 251, at 121.

254. Triggers—like noise, distress, and denial of assistance—influence the perception that the environment is not safe. Carceral logics infused into the healthcare setting may exacerbate negative behavior following a trigger. *Id.* For patients who experience prolonged stress, anxiety, or other mental health issues an "invalid" perception of safety or danger may contribute to patient violence or aggression. Beattie, Griffiths, Innes & Morphet, *supra* note 251, at 118; Frederic C. Blow, Kristen Lawton Barry, Laurel A. Copeland, Richard A. McCormick, Laurent S. Lehmann & Esther Ullman, *Repeated Assaults by Patients in VA Hospital and Clinic Settings*, 50 PSYCHIATRIC SERVS. 390, 392 (1999) (finding high incidences of mental health issues and increased use of VHA's services over time in patients who perpetrated multiple assaults).

255. Rosenthal, *supra* note 29.

256. *Id.*

resolution for their members to "advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present."[257]

Although the focus of this Article is the VA's own police force, its community clinics and hospitals also utilize private security companies. Studies note the presence of security in hospitals has the potential to escalate encounters with patients, breach trust, and create patient fear of violence and coercion.[258] At least one VA nurse viewed the private security she observed in several community clinics as insensitive, untrained, and unprofessional. She viewed them as "a body in uniform" to show authority over the space, but ill-equipped to address emergencies and lacking authority to engage if medical practitioners face true safety concerns.[259] Other police scholars have reasoned private police security may not serve as an adequate alternative to police.[260] They can evade court review and escape transparency, and their prominence raises important questions for the legal regulation of policing.[261] I briefly address responding to emergencies in Part III, but further study is needed to determine what existing or new infrastructure or personnel can address worker safety while attending to the problems of embedded

257. MEMORIAL RESOLUTIONS, *supra* note 250; *see* Nathaniel P. Morris, *Guns and Tasers Have No Place in Hospitals*, SCI. AM. (Jan. 1, 2017), https://www.scientificamerican.com/ article/guns-and-tasers-have-no-place-in-hospitals [https://perma.cc/TYV6-VUKL].

258. Studies in low-income and urban hospital settings note harsh or aggressive treatment towards patients. One survey of 7000 emergency nurses nationwide showed higher rates of physical violence and verbal abuse when security personnel were present. EMERGENCY NURSES ASS'N, EMERGENCY DEPARTMENT VIOLENCE SURVEILLANCE STUDY 34–35 (2011). Some research indicates security is an important part of rapid response or crisis intervention teams, and others find security staff ineffective at creating a secure workplace. *See* Elizabeth C. Kelley, *Reducing Violence in the Emergency Department: A Rapid Response Team Approach*, 40 J. EMERGENCY NURS. 60 (2014); Beattie, Griffiths, Innes & Morphet, *supra* note 251, at 118; Nicola Ramacciati, Andrea Ceccagnoli, Beniamino Addey, Enrico Lumini & Laura Rasero, *Interventions to Reduce the Risk of Violence Toward Emergency Department Staff: Current Approaches*, 8 J. OF EMERGENCY MED. 17 (2018). One challenge with any review of existing research on workplace harm in healthcare is the dearth of study beyond the emergency room context. Phillips, *supra* note 28, at 1662–63 (reviewing literature and coming to the same conclusion; finding no peer-reviewed studies defining scope of problem in outpatient or office-based practices).

259. Interview with VHA Registered Nurse, Dec. 6, 2021 (notes on file with author) (name withheld by request).

260. Care settings rely on arrangements with local police or private security. *Cf.* Lillian Reed & Tim Prudente, *Johns Hopkins University to Move Forward With Private Police Force, Hires Massachusetts Police Commission to Lead Security Efforts*, BALT. SUN (July 27, 2021), https://www.baltimoresun.com/education/bs-md-hopkins-public-safety-20210727-20210727-djzghhbaebczpi52yaudzfhs5q-story.html [https://perma.cc/L6P9-9F9N]. *See also* David A. Sklansky, *The Private Police*, 46 UCLA L. REV. 1165 (1999).

261. *See generally* Stephen Rushin, *The Regulation of Private Police*, 115 W. VA. L. REV. 159 (2012); Sklansky, *supra* note 227.

healthcare policing outlined in this Article. In short, we must address the needs of patients and workers.

F. Altering the Patient

For marginalized patients, medicine and medical facilities are sites of subordination where they receive a social service and navigate structural inequality. As such, policing in care settings is a way to manage "unruly bodies"[262] and out of the norm social behaviors.[263] Thus, the story of VA healthcare is one of poor veterans receiving their benefits while being simultaneously connected to a policing structure, which leads to the more extensive problems often associated with the regulation of poor and marginalized persons who receive public assistance.[264] By expanding previous studies of policing disability status through an in-depth look at the VA,[265] this Article creates space for broader discussions of policing, race, and poverty.[266] Police imbrication distorts VA medical centers' aim to provide holistic care and capitalizes on their carceral logics. At least for some patients, mass criminalization[267] shapes access to essential VHA healthcare and services. VA police, but also other agency personnel, and care workers become implicated in the process of mass criminalization.

262. Bridges, *supra* note 13. Professor Bridges applies Michele Foucault's theory of the "regulatory controls" over the "biopolitics" of the population to Black women receiving Medicaid in a New York hospital. She defines the "unruly body" of the women as "one whose reproduction is dangerously unrestrained" and therefore subjected to an entire medically managed system of prenatal care that links to the state apparatus of surveillance. *Id.* at 100. I show the mechanisms that permit the bodies and minds of veterans with disabilities—considered a threat based on military service, deviation from or instantiation of gender norms, race, poverty, and disability status—to be subject to surveillance systems formally and informally connected to carcerality.

263. *See supra* Part II.A–II.B; *see also* Morgan, *supra* note 122; GOLUBOFF, *supra* note 122.

264. *Cf.* GUSTAFSON, *supra* note 13, at 63–69 (providing framework for criminalization of poverty in the context of welfare benefits).

265. *See* Jamelia N. Morgan, *Policing Under Disability Law*, 73 STAN. L. REV. 1401 (2021); Jeffrey Fagan & Alexis Campbell, *Race and Reasonableness in Police Killings*, 100 B.U. L. REV. 951 (2020); Abigail Adams, *Black, Disabled and at Risk: The Overlooked Problem of Police Violence Against Americans With Disabilities*, TIME (June 25, 2020, 8:56 AM), https://time.com/5857438/police-violence-black-disabled [https://perma.cc/ZY7U-WX6V] ("The combination of disability and skin color amounts to a double bind.").

266. *E.g.*, GUSTAFSON, *supra* note 13.

267. Professor Devon Carbado uses mass criminalization to "mean the criminalization of relatively nonserious behavior or activities and the multiple ways in which criminal justice actors, norms, and strategies shape welfare state processes and policies." Carbado, *supra* note 23, at 1487.

Another feature of this Article's healthcare policing web focuses on care workers. The workers morph into pseudopolice[268] through workplace safety protocols and a culture that leads workers to view patients with mental disabilities, especially Black, Latinx, or other patients with marginal identities, as perpetually threatening, dangerous, and in need of regulation. The internal governance structure and workplace safety features sometimes operate in tandem and may cover the same interactions among police, care workers, and patients.[269] The veterans subjected to this form of policing are deemed suspicious and at risk of perpetrating violence toward care staff or themselves.[270] Dubbed perpetually threatening,[271] they remain caught in the web's digital and physical threads.

This Article also draws from critical disability literature in its understanding of the subordinating consequences of the Committees and workplace violence prevention practices. Critical disability scholars have explored the carceral influences within care systems for some time. Social hierarchies of disability reinforce "able-bodyminds" and "disabled bodyminds"[272] that compound the subordination of people based on poverty, race, gender, citizenship, or sexuality.[273] This literature also connects disability with deviance.[274]

In a recent article, Professor Morgan draws on critical disability literature in considering the ways low-level disorderly conduct infractions are used to police community norms—centering primarily white, male, able-bodied, and middle-class values. Her focus is on legal regulations that "otherize certain non-conforming behavior, delegitimize them through the label of disorderly, and in

268. *Cf.* Song, *Cops in Scrubs*, *supra* note 8.
269. GUSTAFSON, *supra* note 13, at 63–69.
270. Richardson & Atiba Goff, *supra* note 26, at 335.
271. Shakespeare, *supra* note 27, at 229 ("People with impairment are the ultimate non-conformists, and as such are perpetually threatening . . . .").
272. *See* SAMI SCHALK, BODYMINDS REIMAGINED: (DIS)ABILITY, RACE, AND GENDER IN BLACK WOMEN'S SPECULATIVE FICTION 5 (2018) (defining the term "bodymind") (citation omitted).
273. *See, e.g.*, Doron Dorfman, *Re-Claiming Disability: Identity, Procedural Justice, and the Disability Determination Process*, 42 L. & SOC. INQUIRY 195, 197 (2017).
274. Critical disability literature highlights the ways "mental illness," or mental disability, is seen as a sign of deviance in society. One prominent scholar discusses the ways media reports of the primarily white mass shooters in schools across the country use mental disabilities as a social marker. A signal "of deviance that will separate the killers from us." Nirmala Erevelles, *Crippin' Jim Crow: Disability, Dis-Location, and the School-to-Prison Pipeline*, *in* DISABILITY INCARCERATED: IMPRISONMENT AND DISABILITY IN THE UNITED STATES AND CANADA 83 (Liat Ben-Moshe, Chris Chapman & Allison C. Carey eds., 2014). For a discussion on negative attributes associated with disabilities, see also Jasmine E. Harris, *The Aesthetics of Disability*, 119 COLUM. L. REV. 895 (2019).

doing so exclude certain historically marginalized groups from normative conceptions of community."[275] In the same way, low-level infractions in hospitals represent much more than policing order or tranquility. The VA police aim to reproduce normative behavior for veteran patients who generally fit one or multiple axes of marginal identity—poverty, disability, trauma, houselessness, gender, and race. To support this argument, I look not only to formal legal regulation, but also extralegal administrative regulation and safety policies.[276]

On the question of whether reforms to behavioral monitoring systems in healthcare are the correct tool to provide safe working conditions, I have no definitive answer and the question requires further study. The current structure—infused with carceral logics of care and subject to police judgment—produces the wrong results. The question requires further research into Disruptive Behavior Committees within the many VHA health facilities. Examination into similar structures in schools and universities may provide further information on whether the infrastructure will inevitably lead to other harmful expressions of carcerality, or whether it can be improved to meet its goals of reducing workplace violence without compromising patient autonomy and dignity or reducing trust between the VA and its patients. Reforms to the Committee structure may provide an opportunity for health professionals to use care-based judgment where patients attempt to obtain support for mental health symptoms or potential suicidal ideations. Given the history of structural inequity and carceral logics in healthcare, as I suggest in Part III, the use of care-based responses to threats of violence will require, among other interventions, anticarceral care approaches.

III. TOWARDS DECOUPLING POLICE AND CARE

The detailed account of the interactions between the features of the healthcare policing web presents a cautionary tale for police reformers, including police abolitionists.[277] The story offers two types of lessons—one anchored in the

275. *See* Morgan, *supra* note 5, at 1637.

276. *See* Seth Stoughton, *How the Fourth Amendment Frustrates the Regulation of Police Violence*, 70 EMORY L.J. 521 (2021) (arguing for a broad regulation of police through formal constitutional protections); Obasogie & Zaret, *supra* note 11, at 55–61 (suggesting a process involving stakeholders and federal health regulations to redefine "reasonableness" under the Fourth Amendment as it applies to police and paramedic use of chemical restraints). I will expand the analysis connecting subcriminal processes with systems of mass criminalization in another project. *See* Patel, *supra* note 30.

277. A variety of definitions and scholarly views are emerging to "reform police," "defund police," "abolish police," "reimagine police" and "transform police." *See* Bernard E. Harcourt, *Introduction to Police Abolition*, COLUM. UNIV.: ABOLITION DEMOCRACY 13/13

call to remove or reduce the role of police; and the other grounded in the turn to care as an alternative to police. With the lessons come potential solutions.

First, the VHA story shows how difficult it will be to unravel policing webs from institutional settings such as emergency rooms, hospitals, universities, K-12 schools, and public transit. Thus, the pipelines-to-prison discourses[278] understate the carceral nature and inclination of social institutions with embedded police. Police express preexisting carceral logics of institutions and build upon the instinct to surveil, monitor, and regulate disabled, Black, gendered, or otherwise marginalized persons. The VA police, similar to school resource officers and transit police, amplify the carceral characteristics of its institutional home. Removing the police officers leaves a hole that institutions are likely to fill with other personnel, but to achieve the same carceral ends. As I have argued, health workers are coopted into mechanisms of sometimes invisible discipline and regulation of unruly bodies.

In addition, when hospitals and other institutions embed police, it feels natural to continually expand their duties and numbers. Whenever an institution charged with providing a social benefit addresses mental disabilities among its constituency, it systematizes police responses instead of other professionals. Reformers must attend to the ways institutions use police for more than punishment or criminal enforcement. Reformers become naturalized into institutional culture and practices. Slippage becomes frequent yet unnoticed. All behavioral problems become problems for the police to resolve. Police become the school guidance counselors and hospital suicide watch staff. Moreover, police gain

(Oct. 3, 2020), http://blogs.law.columbia.edu/abolition1313/bernard-e-harcourt-introduction-to-3-13-on-police-abolition [https://perma.cc/5WDH-SGGJ] (offering four categories of abolition: traditional reform, law and order, reimagining, and strong reform); Jessica M. Eaglin, *To "Defund" the Police*, 73 STAN. L. REV. ONLINE 120 (2021). Regardless of which aspect of the reform positionality one takes, without the ins and outs of interfacing systems, it remains difficult to actually root out policing and the influence of its logics. *Cf.* Amna A. Akbar, *An Abolitionist Horizon for (Police) Reform*, 108 CALIF. L. REV. 1781, 1819 (2020); Allegra M. McLeod, *Envisioning Abolition Democracy*, 132 HARV. L. REV. 1613, 1623–27 (2019); Mariame Kaba, Opinion, *Yes, We Mean Literally Abolish the Police*, N.Y. TIMES (June 12, 2020), https://www.nytimes.com/2020/06/12/opinion/ sunday/floyd-abolish-defund-police.html [https://perma.cc/8D6M-K23U] ("The only way to diminish police violence is to reduce contact between the public and the police."); Tracey L. Meares, *Synthesizing Narratives of Policing and Making a Case for Policing as a Public Good*, 63 ST. LOUIS U. L.J. 553 (2019); CMTYS. UNITED FOR POLICE REFORM, THE PATH FORWARD: HOW TO DEFUND THE NYPD, INVEST IN COMMUNITIES & MAKE NEW YORK SAFER 13 (2020), https://www.changethenypd.org/sites/default/files/cpr_budget_justice_report_final_v3.pdf [https://perma.cc/J4EH-E48A] (calling for the elimination of police in schools to permit the reinvestment of over $300 million into the Department of Education).

278. For several examples of these dynamics, see generally sources discussed *supra* note 24.

footholds in areas such as mental health services and houselessness prevention where they lack expertise or experience with care approaches.[279] Police are imbricated into institutions to modify and control the behavior of the unwell and disabled, non-white, poor, disruptive, and unhoused.

Second, this Article provides lessons for reformers and scholars suggesting that more healthcare or mental healthcare should replace some of the roles police play today (such as responding to persons in mental health distress). The web concept provides a blueprint of carceral logics enmeshed in care delivery. The racialized consequences of behavioral monitoring and tracking is most understood in schools,[280] but are also explored in other settings. Although healthcare workers are particularly vulnerable to workplace violence, workplace safety programs in many institutions rely on similar crime reporting, threat assessment, and behavioral monitoring schemes as the VHA. As previously noted, the VHA is considered a model for other health settings in this regard. Therefore, to turn to care as an anecdote to bloated police departments requires reformulating care work as well.[281] The VHA, as well as other understaffed institutions, have systems in place that do not necessarily reduce workplace violence in a meaningful way. My aim is to generate a list of reforms that address some of the institutional shortcomings expressed by both healthcare workers and patients.

The remainder of this Part offers four groups of reforms consistent with an abolition ethic.[282] For purposes of this Article, I use the term abolitionist ethic as a

279. Even some prominent police agree that they are overtasked and underequipped to function as all-purpose first responders for behavioral issues. Brady Dennis, Mark Berman & Elahe Izadi, *Dallas Police Chief Says 'We're Asking Cops to Do Too Much in This Country*,' WASH. POST (July 11, 2016), https://www.washingtonpost.com/news/post-nation/wp/2016/07/11/grief-and-anger-continue-after-dallas-attacks-and-police-shootings-as-debate-rages-over-policing [https://perma.cc/7RYL-6SMK]; John Wilkens, *Abolish the Police? It's a Real Thing. Even Cops Say They've Taken on Too Much*, SAN DIEGO UNION-TRIB. (June 6, 2020, 6:00 AM), https://www.sandiegouniontribune.com/news/ public-safety/story/2020-06-06/abolish-police-movement [https://perma.cc/44ZM-3GQ8]. *But see* Natalie Bonfine, Christian Ritter & Mark R. Munetz, *Police Officer Perceptions of the Impact of Crisis Intervention Team (CIT) Programs*, 37 INT'L J.L. & PSYCHIATRY 341 (2014).

280. *E.g.*, Thalia González, *Race, School Policing, and Public Health*, 73 STAN. L. REV. ONLINE 180 (2021).

281. As discussed in Subpart III.B, some health professionals, police reformers, and scholars already understand the carceral features of care work.

282. Allegra M. McLeod, *Confronting the Carceral State*, 104 GEO. L.J. 1405, 1414 (2016) ("The ultimate goal of an abolitionist ethic is to eliminate practices of caging, shackling, confining, and minutely surveilling human beings in favor of other forms of ensuring collective peace."); Allegra M. McLeod, *Prison Abolition and Grounded Justice*, 62 UCLA L. REV. 1156, 1225-56 (2015) (pointing to strategies in an abolitionist framework such as justice reinvestment to

way of describing a set of principles to guide reforms aimed to reduce police personnel and functions within institutions. I propose interventions that limit policing while making room for different methods to address harm and violence in hospital contexts. More specifically, this Part offers ways to disentangle embedded police from institutions and reform care in ways that accept alternatives to police.

The menu of proposals in this Part—trauma-informed institutional practices, anticarceral care, removing police from service delivery decisions, training, and restorative justice to address interpersonal harm—arise from lessons learned in the VA context. With coauthors, I have already proposed that VA health centers should serve as places of respite and sanctuaries for veterans[283] rather than as gateways to a sprawling system of surveillance, policing, and criminalization. These recommendations propose steps and measures administrators should consider that ease the process of reducing the number of police and scope of policing at VA hospitals while also shifting towards a different framework for care. To begin the process of minimizing the influence of police and carceral logics, some proposals presented here can be implemented immediately. Others will take more time to implement and require new structures or legal reforms. Nonetheless, these proposals are intended as steps toward achieving care spaces and institutions without police as part of a larger project of reducing the police apparatus and carceral influence on healthcare. These solutions may carry forward to other institutions with embedded police and require further study to determine their application writ large.[284]

promote social flourishing and security of employment, education, unionism, and community organizations). See generally Jamelia Morgan, *Responding to Abolition Anxieties: A Roadmap for Legal Analysis*, 120 MICH. L. REV. 1199 (2022) (reviewing Mariame Kaba's *We Do This 'Til We Free Us*, which argues abolitionist ethic (and critique) offers a methodology for legal scholarship).

283. PATEL, CHAUDHURI & OSTRANDER, *supra* note 172. Professor Song has developed a vision for emergency departments as sanctuaries for care and healing drawing from migrant justice movements. Song, *Policing the ER*, *supra* note 11 (relying on sanctuary in immigration literature). The proposals in this Article could fit within her sanctuary model of care. *Cf.* ALL. FOR CMTY. TRANSIT—L.A., AM. C.L. UNION OF S. CAL., CODESIGN @ HARVARD GRADUATE SCH. OF DESIGN, PUB. COUNS.—STATEWIDE EDUC. RTS. PROJECT & TAMIKA L. BUTLER CONSULTING, METRO AS A SANCTUARY: REIMAGINING SAFETY ON PUBLIC TRANSIT (2021), http://allianceforcommunitytransit.org/wp-content/uploads/2021/03/Metro-as-a-Sanctuary-ACT-LA.pdf [https://perma.cc/8X4B-NZF7] (recommending transportation systems serve as "transit sanctuaries" without reliance on police for safety).

284. *See, e.g.*, Patel, *supra* note 30.

A. Trauma-Informed Institutions

Uplifting trauma-informed care from individual patient approaches to the institutional level will lead to less reliance on police. Trauma-informed care is an approach to care that seeks to better serve individuals who have experienced traumatic life events[285] through assessing and adjusting an institution's policies and practices to ensure that an environment is safe and welcoming for both patients and staff.[286] Many healthcare providers and hospital systems train providers to adopt trauma-informed care approaches and are committed to becoming trauma-informed institutions, including the VA.[287] While care work has progressed in some ways, this Article demonstrates that hospitals and other healthcare spaces continue to adopt systems that punish trauma responses and patients' attempts to assert agency over their care. This is antithetical to the principles of trauma-informed care. A trauma-informed care approach can also address the unique needs of communities in which care centers are located and allow tailoring services to prevent triggering responses that lead to agitation and potential violence from patients.[288] Trauma-informed care also requires developing and implementing protocols to recognize and address healthcare providers' exposure to trauma. Through investing in trauma-informed care, care settings create safe, health-promoting environments for patients and staff.

To minimize workplace violence, hospitals and other institutions must fully staff their clinical facilities. Government reports have pointed to the effectiveness of adequate staffing levels for workplace safety.[289] With shorter wait times and better customer service, patients are less likely to engage in actions that might escalate to perceived threats or harm. In addition, with appropriate levels of trained care staff, workers can respond to low-level incidents with empathy, patience, and conflict resolution skills. When employees work long shifts or double shifts, the situation is ripe for overuse of police or other security measures rather than engaging in trauma-informed practices. Reduced stress and burnout further a stable workforce, which in turn lowers rates of turnover and increases job

285. Sheela Raja, Memoona Hasnain, Michelle Hoersch, Stephanie Gove-Yin & Chelsea Rajagopalan, *Trauma Informed Care in Medicine: Current Knowledge and Future Research Directions*, 38 FAM. & CMTY. HEALTH 216, 217 (2015).

286. Joan Fleishman, Hannah Kamsky & Stephanie Sundborg, *Trauma-Informed Nursing Practice*, 24 ONLINE J. ISSUES IN NURSING 3 (2019).]

287. Courtney Valdez, Rachel Kimerling, Jenny K. Hyun, Hanna F. Mark, Meghan Saweikis & Joanne Pavao, *Veterans Health Administration Mental Health Treatment Settings of Patients Who Report Military Sexual Trauma*, 12 J. TRAUMA & DISSOCIATION 232, 233–34 (2011).

288. *See* Fleishman, Kamsky & Sundborg, *supra* note 286.

289. OSHA GUIDELINES, 2016, *supra* note 110, at 19–20; VIOLENCE: OCCUPATIONAL HAZARDS IN HOSPITALS, *supra* note 28, at 6.

satisfaction. This approach actualizes the practice an abolition ethic counsels—eradicate the very structures that make policing and surveillance possible.

A tangible barrier to implementing these proposals is cost. For the VHA and other public health and education institutions, funding and resource allocation become a political calculation. Congress has increased the budget of VHA specifically for police and security, however, and these resources could be diverted to alternative methods of safety. Similar arguments have been made for police in public institutions such as schools, where local governments maintain or increase police personnel, yet teachers remain at low levels of pay.

Reorienting an institutional-built environment around the needs of medically vulnerable and patients with disabilities provides another layer of nonpunitive trauma-informed institutional investment; these reforms also benefit medical staff. The VHA example in this Article illustrates the ways healthcare administrators seek to regulate waiting rooms and entry spaces for hospitals.[290] Simple patient-centered design changes can positively affect focus on specific mental health needs and limit police intervention.[291] For instance, waiting areas can include an option for quiet rooms or spaces with less light.[292] Sensory activities or musical selections with plugins and disposable or personal headphones can help calm nervous system reactions to the stress associated with health settings.[293] Healing or therapeutic gardens have proven beneficial for a variety of health conditions.[294] Additionally, these built environment

290. *See* Lara-Millán, *supra* note 146.

291. Calbert H. Douglas & Mary R. Douglas, *Patient-Friendly Hospital Environments: Exploring the Patients' Perspective*, 7 HEALTH EXPECTATIONS 61 (2004) (finding that patient attitudes and perceptions to the built environment of hospitals relate to whether the hospital provides a welcoming, health promoting space).

292. Phil Leather, Diane Beale, Angeli Santos, Janine Watts & Laura Lee, *Outcomes of Environmental Appraisal of Different Hospital Waiting Areas*, 35 ENV'T & BEHAV. 842, 843 (2003) (finding that a waiting room with a softened design was perceived more positively by patients on a number of metrics); HAYA R. RUBIN, AMANDA J. OWENS & GRETA GOLDEN, CTR. FOR HEALTH DESIGN, STATUS REPORT (1998): AN INVESTIGATION TO DETERMINE WHETHER THE BUILT ENVIRONMENT AFFECTS PATIENTS' MEDICAL OUTCOMES 2 (1998) (noting that intensity of artificial lighting and placement of UV lights have been found to influence at least one health outcome).

293. Izumi Nomura Cabrera & Mathew H.M. Lee, *Reducing Noise Pollution in the Hospital Setting by Establishing a Department of Sound: A Survey of Recent Research on the Effects of Noise and Music in Health Care*, 30 PREVENTIVE MED. 339 (2000) (discussing the potential for music to reduce anxiety, alleviate pain, and relax patients in health care settings); RUBIN OWENS & GOLDEN, *supra* note 292, at 9–10 (discussing how music can affect health outcomes).

294. Sandra A. Sherman, James W. Varni, Roger S. Ulrich & Vanessa L. Malcarne, *Post-Occupancy Evaluation of Healing Gardens in a Pediatric Cancer Center*, 73 LANDSCAPE & URB. PLAN. 167 (2005) (finding that emotional distress and pain for child patients suffering from cancer, adult

changes provide therapeutic relief to care workers.[295] Although such changes require resource investments, many private and public care spaces already adopt these methods and could provide models for institutions interested in low-cost solutions.

B. Anti-Carceral Care

As the VHA example highlights, care systems are already carceral.[296] Transforming care systems is critical to the project of abolition. Feminist anticarceral social work argues that the rise of the prison industrial complex has coincided with the growth of carceral logics within social work.[297] Social workers collaborate with law enforcement or child welfare systems on cases related to gender-based violence, child abuse, and sex work.[298] Anticarceral social workers argue that rather than promoting clients' welfare, social work may approve of punitive treatment towards social problems. Carceral social work's use of coercive and punitive practices contributes to the management of Black, Indigenous, other people of color, and low-income people.[299] Proponents of anticarceral social work advocate for reduced reliance on policing and other punishing institutions, greater use of community-based interventions, social work promoting self-determination (strength-based practice), and harm reduction. They urge social workers to address more extensive systems of social

caregivers, and staff were lower when in a healing garden surrounding a cancer center than when in the hospital area).

295. *Id.* (finding that employees at one medical center reported being positively impacted by therapeutic design features in their work environment).

296. BEN-MOSHE, *supra* note 5.

297. *See* Leah A. Jacobs, Mimi E. Kim, Darren L. Whitfield, Rachel E. Gartner, Meg Panichelli, Shanna K. Kattari, Margaret Mary Downey, Shanté Stuart McQueen & Sarah E. Mountz, *Defund the Police: Moving Towards an Anti-Carceral Social Work*, 32 J. PROGRESSIVE HUM. SERVS. 37, 39–40 (2020); Patricia O'Brien, Mimi Kim, Elizabeth Beck & Rupaleem Bhuyan, *Introduction to Special Topic on Anticarceral Feminisms: Imagining a World Without Prisons*, 35 AFFILIA 5, 6–9 (2020); Beth E. Richie & Kayla M. Martensen, *Resisting Carcerality, Embracing Abolition: Implications for Feminist Social Work Practice*, 35 AFFILIA 12 (2020).

298. Jacobs et al., *supra* note 297, at 37; Heather Bergen & Salina Abji, *Facilitating the Carceral Pipeline: Social Work's Role in Funneling Newcomer Children From the Child Protection System to Jail and Deportation*, 35 AFFILIA 34 (2020); Theresa Anasti, *"Officers are Doing the Best They Can:" Concerns Around Law Enforcement and Social Service Collaboration in Service Provision to Sex Workers*, 35 AFFILIA 49 (2020).

299. Jacobs et al., *supra* note 297, at 37; O'Brien, Kim, Beck & Bhuyan,, *supra* note 297, at 6; Richie & Martensen, *supra* note 297, at 13.

oppression impacting themselves and their clients, but to also reimagine the constraints of social safety nets.[300]

Implementing medical center navigators or ambassadors is one concrete example of an anticarceral and trauma-informed approach to hospital care delivery. Such persons would greet patients arriving to institutional settings and help them find appointment locations and navigate the inherently stressful circumstances. In the VA example, some number of patients receive disruptive behavior flags from initial interactions with VAPF or frontline desk staff. Patients often enter routine health appointments in distress, vulnerable, and anxious. It should be behavioral health specialists and anticarceral social workers, not police or security, who perform the initial intake and manage patient needs upon arrival in care institutions. It may be possible for community organizations or peer support specialists to play these roles as well. Similar measures have been proposed in transit studies to reduce security and police presence in public transportation systems.[301] Los Angeles passed a measure in 2022 to begin a transit ambassador program without police involvement.[302] These approaches are likely to support the needs of elderly riders or persons with traumatic brain injuries or cognitive disabilities. Health institutions should consider this model as an alternative to security and provide peer based and social work support in the first interactions.

C. Remove Police from Service Delivery Decisions

Whenever an institution serves people with disabilities, particularly mental disabilities, administrators are faced with the choice of whether or not to engage police if persons are in distress or unwell. Most embed police or have special relationships with a local police department. For the VHA, the Disruptive Behavior Committee is a core component of their healthcare policing web. Many institutions may have other decision-making features that formally (or

300. *See* Jonathan Foiles, *We Can't Just Replace Cops With Social Workers*, SLATE (July 1, 2020, 11:46 AM), https://slate.com/technology/2020/07/social-workers-cant-replace-cops.html [https://perma.cc/3VVY-76NP].

301. Anastasia Loukaitou-Sideris, Jacob Wasserman, Hao Ding & Ryan Caro, *"It Is Our Problem!": Strategies for Responding to Homelessness on Transit*, TRANSP. RSCH. REC., at 4–7 (July 22, 2022), https://doi.org/10.1177/03611981221111156 (reviewing transit public safety intervention programs across the United States including those without police). When evaluating the needs of elderly patients, some with new conditions affecting memory, their behaviors, attitudes, and emotions benefit from third-party guidance from trauma-informed practitioners. *See* Bruno Aguiar & Rosário Macário, *The Need for an Elderly Centered Mobility Policy*, 25 TRANSP. RSCH. PROCEDIA 4355 (2017); *Cf.* METRO AS A SANCTUARY, *supra* note 283.

302. Rachel Uranga, *Crime Is up on Buses and Trains. Metro Has a Plan to Make You Feel Safe*, L.A. TIMES (July 3, 2022), https://www.latimes.com/california/story/2022-07-03/ crime-bus-trains-los-angeles-metro-plan [https://perma.cc/S3RJ-CJ2M].

informally) incorporate police and alter the culture of service delivery. The number of red flags and care modification orders that fall outside the intended purpose warrants reconsideration of the Committees and the red flag system altogether. Regardless, the VA should remove police from the Committees and exclude VA police officers from any other roles that influence clinical decision-making.

D. Training

Removing the instinct to call upon police to address low-level interactions is one step towards removing police from care decisions. A rich body of scholarship in multiple disciplines points to cognitive and stereotype threat that leads to criminalizing Black and other perceptively deviant bodies.[303] Ji Seon Song documents the historic role of racial bias in the medical field and discusses how such bias compounds when medical professionals are interpreting criminality.[304] This Article further illuminates the consequences of combining biases in the two professions. VA health staff and medical professionals call upon police for patient actions that could be innocent or the consequence of underlying distress or disability.[305] The VA inculcates the police perspective into clinical care decisions through regulation of behavior it deems disruptive. Training on the history of structural racism and bias in the medical profession and hiring more anticarceral medical care staff will aid in shifting the reliance on police, particularly in gray area circumstances or where the patient is rude or loud.

E. Restorative Justice to Address Interpersonal Harm

Finding mechanisms without criminalizing consequences to address interpersonal harm in care spaces is an important aspect of reducing institutional reliance on police. Restorative justice is one potential mechanism to address workplace safety and harm. At its core, restorative justice "is a process to involve, to the extent possible, those who have a stake in a specific offense and to collectively identify and address harms, needs, and obligations, in order to heal and put things as right as possible."[306] The process encourages accountability and healing in a

303. *See supra* notes 183–189 and accompanying text.
304. *See* Song, *Cops in Scrubs*, *supra* note 8. *See also* Lara-Millán, *supra* note 146, at 107–110.
305. *See supra* Part II.
306. *Restorative Justice*, TRANSFORMHARM.ORG (2020), https://transformharm.org/restorative-justice [https://perma.cc/6EHN-QGZC] (quoting Howard Zehr). *Cf.* DANIELLE SERED, UNTIL WE RECKON: VIOLENCE, MASS INCARCERATION AND A ROAD TO REPAIR 237 (2021)

community setting rather than focus on punishment and isolation. Instead of state authorities like judges, restorative justice typically utilizes facilitators with willing participants to determine how to address the harmful encounter.[307] While restorative justice practices have existed in Indigenous communities[308] in the United States for quite some time, they appeared in non-Indigenous local and state jurisdictions in the 1990s.[309]

One study analyzed the implementation of restorative justice processes between care staff and patients in mental health hospital wards in the United Kingdom. The researchers found that when a patient assaults a staff member, restorative justice could be used as an alternative to criminal justice measures, thus mitigating disruption to the patient's treatment. Staff members noted restorative justice preserved a therapeutic environment in the wards and supported the patients' rehabilitation, as some incidents of harm in the ward mirrored the patients' criminal offenses.[310] The researchers noted that facilitators working in mental health wards need a high level of training to address the patients' mental health needs and histories of offense.[311] Restorative justice models for workplace violence could potentially replace some of the violence-reporting mandates instituted in most hospital settings and potentially in other workplaces.[312]

("Acts of individual and structural harm are meaningfully different, but the key elements of accountability—acknowledging responsibility for one's actions, acknowledging the impact of one's actions on others, expressing genuine remorse, taking actions to repair the harm to the degree possible, and no longer committing similar harm—apply to both.").

307. John Braithwaite, *A Future Where Punishment Is Marginalized: Realistic or Utopian?*, 46 UCLA L. REV. 1727 (1999) (arguing in favor of restorative justice as an alternative to punitive justice); *see also* JOSEPH V. REES, REFORMING THE WORKPLACE: A STUDY OF SELF-REGULATION IN OCCUPATIONAL SAFETY 153 (Keith Hawkins & John M. Thomas eds., 1988).

308. *See* Ada Pecos Melton, *Indigenous Justice Systems and Tribal Society*, 79 JUDICATURE 126 (1995); Braithwaite, *supra* note 307, at 1743–46. *See generally* Mary Louise Frampton, *Finding Common Ground in Restorative Justice: Transforming Our Juvenile Justice Systems*, 22 U.C. DAVIS J. JUV. L. & POL'Y 101, 106 (2018); John Braithwaite, *Restorative Justice: Assessing Optimistic and Pessimistic Accounts*, 25 CRIME & JUST. 1, 27–30 (1999).

309. Mark S. Umbreit, Betty Vos, Robert B. Coates & Elizabeth Lightfoot, *Restorative Justice in the Twenty-First Century: A Social Movement Full of Opportunities and Pitfalls*, 89 MARQ. L. REV. 251, 259–60 (2005).

310. Andy Cook, Gerard Drennan & Margie M. Callanan, *A Qualitative Exploration of the Experience of Restorative Approaches in a Forensic Mental Health Setting*, 26 J. FORENSIC PSYCHIATRY & PSYCH. 510, 521 (2015).

311. *Id.* at 526.

312. An Australian study on using restorative justice to address workplace bullying among nurses offers some parallels between issues of workplace violence in the United States. The researchers recommend restorative justice to address workplace violence and emphasize that restorative justice values and processes must be introduced to nurses as they are being trained. The study notes that workplace bullying among nurses has proliferated, despite zero tolerance policies that ban bullying statements. Marie Hutchinson, *Restorative Approaches to Workplace*

Restorative justice programs are sometimes considered poor substitutes for large-scale policing. They are generally small-scale and require intensive resources for successful outcomes. The power imbalance between patients and providers might make for an ill fit in care settings; however, even if restorative justice models are used among staff members or among patients, they may have a ripple effect in changing hospital culture and reducing reliance on police.[313] As hospitals and care spaces divest from securitized practices and police forces, care spaces can expand investment in trauma-informed care, police-free crisis responses, and shift institutional culture towards other practices.[314] To eliminate carceral logics, care spaces should also reorient workplace safety policies and responses to interpersonal harm. Of course, fully realizing this reform may require OSHA to implement legal or regulatory reforms and limit mandatory police reporting requirements, though institutions can begin with small-scale restorative justice models to address interpersonal harm.

Decoupling the symbiotic relationship between care work and policing would be a step towards a society with less reliance on police. Ultimately, to benefit patients and care workers, health settings should adopt an ethic of care within an abolition framework and experiment with short-term fixes to reduce reliance on police. This Part offered several suggestions for interrupting and unraveling the healthcare policing web to remove embeddedness of police in healthcare that may have application to social welfare and public institutions.

CONCLUSION

The solution of turning to systems of care as an alternative to society's overreliance on policing requires expansive mapping and understanding of policing within medical settings. As a primary provider of healthcare for marginalized and medically vulnerable patients, the VA provides multiple lessons for decoupling policing and healthcare, and for disentangling policing from other institutional contexts. I argue care providers have been coopted into policing work and police have become enmeshed in clinical decision making. Even with reasonable justifications for embedding police within medical centers, institutions

Bullying: Educating Nurses Towards Shared Responsibility, 32 CONTEMP. NURSE 147, 149 (2009).

313. Braithwaite, *supra* note 307, at 1740–44 (framing the benefits to community members and observers include reparative bonds and healing of relationships).

314. *See* Elizabeth Weill-Greenberg, *Chicago Lawmakers Push to Build Team of Emergency Responders Who Aren't Police*, APPEAL (Sept. 28, 2020), https://theappeal.org/chicago-public-mental-healthcare-system-emergency-responder-program [https://perma.cc/ 4VH5-6ZU6].

must consider the attendant costs to patient privacy, autonomy over care decisions, stigma, medical bias, and police violence.

This Article analyzes two primary features of embedded healthcare policing. It broadens the lens of mass criminalization to include patient management, workplace violence prevention, and threat assessment policies. It offers a more comprehensive understanding of the ways these intersecting threads operate to mark veteran patients as deviant, threatening, and necessary to control. It complements the emerging work of criminal procedure scholars and scholars looking at the regulatory nature of health and welfare systems as comprehensive processes that enact violence upon Black people and forms the basis of an approach to assist scholars and activists in the understanding of the institutional dynamics and overlap between care, worker safety, and policing.

This Article's analysis of embedded healthcare policing within the VA has broader implications. The imbrication and path dependency of police and care complicate the solution of more funding for healthcare. The consequences of overusing police within health delivery settings provides a vivid account of the need to recalibrate the roles of police in our society. In addition, other institutions with embedded police (such as K-12 education, universities, or mass transit) can draw lessons and consider the ways reliance on police influences interpretations of law and internal policy. This Article provides another account of law enforcement and surveillance in the lives of a marginalized group: veterans of the U.S. military with disabilities.