March 31, 2026

Honorable Michael Rodrigues
Chair, Senate Ways and Means
State House, Room 212
Boston, MA 02133

Honorable Joanne Comerford
Vice Chair, Senate Ways and Means
State House, Room 410
Boston, MA 02133

Dear Chair Rodrigues, Vice Chair Comerford, and members of Senate Ways and Means:

Re: Opposition to increased penalties section of S.1718, *An Act requiring health care employers to develop and implement programs to prevent workplace violence*

On behalf of the Mental Health Legal Advisors Committee (MHLAC), the Center for Public Representation (CPR), the Committee for Public Counsel Services (CPCS), the Disability Law Center (DLC), the Disability Policy Consortium (DPC), the Massachusetts Association for Mental Health (MAMH), the Massachusetts Association of Criminal Defense Lawyers (MACDL), the National Alliance on Mental Illness (NAMI) of Massachusetts, and Roots Up, I write to express our deep concern with section 3 of S.1718, *An Act requiring health care employers to develop and implement programs to prevent workplace violence.* Our organizations strongly support efforts to protect and empower health care providers. They perform critical and challenging work. However, section 3, which increases penalties for certain offenses, should not be part of a strategy to keep health care workers safe. It is neither effective nor fair to people in custodial care.

Section 3 would turn lesser offenses from misdemeanors into felonies, such that even minor infractions could result in long sentences and substantial fines.

Section 3 would increase the penalties for assault and assault & battery on health care providers in a wide range of institutional and community-based services.[1] Section 3 states that an assault or assault & battery on a provider may be punished by either no more than 5 years in prison or between 90 days and 2.5 years

[1] Per the bill's language, Section 3 applies to health care providers in health care facilities which includes hospitals, the DOC contracted facility in Plymouth, state acute care or non-acute care facility, continuing care facilities or group homes operated, funded or overseen by the Department of Public Health, the Department of Mental Health, and the Department of Developmental Services except certain facilities including nursing homes, rest home, mobile clinic, home health agency, adult day health, hospital, surgical center, dialysis, outpatient PT or speech, and temporary nursing agencies).

in jail or a house of correction, or a fine between $500 and $5000.[2] Under this scheme, even minor actions such as a threat of harm to someone, blurted out in a moment of frustration or fear, or while experiencing symptoms of a medical condition or disability, could theoretically result in a 5-year prison sentence or a $5000 fine.[3]

Existing penalties for assault and assault & battery, particularly on health care providers, are substantial.

Current law provides significant penalties for assaults. An assault or an assault & battery is punishable, pursuant to G. L. c. 265, § 13A, by up to 2.5 years in jail and/or a fine of up to $1000. Further, assault & battery with serious bodily injury is a felony, with penalties of up to 2.5 years in jail or 5 years in state prison and/or a fine of not less than $500 and not more than $5000. Under current law, the upper limits of punishment, in cases of serious bodily harm, are largely comparable to those proposed in section 3 of S.1718.

Further, pursuant to G. L. c. 265, § 13I, assault or assault & battery on an emergency medical technician, ambulance operator, or health care provider, as defined in G. L. c. 111, § 1,[4] is punishable by not less than 90 days nor more than 2.5 years in jail or a house of correction and a fine of not more than $5000, or both. Thus, for key types of health care providers, these crimes presently may result in the imposition of jail time (including a minimum period of detention) and a potentially substantial (felony-level) fine.

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[2] The House version of this bill, H.4767 (previously H.2655), passed the House in November 2025. It contains similar problematic language regarding penalties. Section 5 provides that an assault or an assault & battery on a health care provider resulting in bodily injury may be punished by either no more than 5 years in prison or 2.5 years in jail or a house of correction or a fine between $500 and $5000, or any combination of a fine and imprisonment. Further, an assault or an assault & battery of a health care provider resulting in *serious* bodily injury, may result in imprisonment for up to ten years.

[3] Studies suggest that increasing criminal penalties has no impact on assault rates or other targeted illegal activities. *See, e.g.,* Menendez & Weatherburn, Does The Threat of Longer Prison Terms Reduce the Incidence of Assault?, 49 J. of Criminology (Mar. 2015), Does the threat of longer prison terms reduce the incidence of assault? - Patricia Menéndez, Don James Weatherburn, 2016 (no evidence found that threat of mandatory minimum prison terms to address alcohol-related violence had any effect on the incident of assault in New South Wales); Shepherd, Criminal Deterrence as a Public Health Strategy, 358 The Lancet 1717 (Nov. 2001), Criminal deterrence as a public health strategy - ScienceDirect (duration of imprisonment seems to have little effect on deterring offenders not to injure others); Elvik & Christensen, The Deterrent Effect of Increasing Fixed Penalties for Traffic Offences: The Norwegian Experience, 38 J. of Safety Research 689 (Nov. 2007), The deterrent effect of increasing fixed penalties for traffic offences: The Norwegian experience - ScienceDirect (increase in rates of fixed penalties for common traffic violations in Norway between 1995 and 2004 found no effect on speeding in general); *see also* Apel, Sanctions, Perception, and Crime: Implications for Criminal Deterrence, 29 J. of Quantitative Criminology 67 (2013), Sanctions, Perceptions, and Crime: Implications for Criminal Deterrence | Journal of Quantitative Criminology | Springer Nature Link (research concerning the accuracy of risk perceptions suggests that the average citizen does a reasonable job of knowing what criminal penalties are statutorily allowed, but a poor job of estimating the probability and magnitude of the penalties).

[4] G. L. c. 111, § 1 defines health care provider broadly to include, among others, doctors, registered nurses, social workers, psychologists, interns, fellows, residents, hospital/clinic/nursing home employees and public hospital employees.

Higher penalties will not protect health care workers, and focusing on such punishments detracts from other more effective solutions.
Increasing penalties on individuals in care and custody will not protect workers. In many instances, workplace crises are triggered by trauma and/or fear. Crises may even be the result of coercion or physical force by workers. A patient or resident may act to defend their freedom and bodily autonomy. In such situations, higher penalties will likely not have a deterrent effect. And for people who act with deliberation and inflict bodily harm, existing law provides punishments on par with those in section 3.

Rather than increase penalties, healthcare facilities should train staff on how to gather information regarding patients, identify patient stressors, and de-escalate crisis situations. Such training should include evidenced-based practices including trauma-informed care, safety and crisis prevention planning, positive behavior support plans, and strategies to reduce and eliminate the use of restraint.[5] Focusing on restraint reduction is particularly important as the use of physical holds and mechanical restraints are a common source of patient and provider injury. When such injuries occur, they should be seen as treatment failures, warranting a re-examination of the system of care broadly, and the use of restraint as an intervention specifically.

Higher penalties will hinder the habilitation and recovery of people in state care and custody.
Higher penalties will propel people currently in state care and custody into the criminal legal system, some for long periods of time. Such carceral confinements will interfere with their habilitation, treatment, and recovery.

Moreover, for many service recipients, particularly those served in the community by the Department of Public Health, the Department of Mental Health, or the Department of Developmental Services, or their vendors, stays in carceral settings would be particularly damaging. Carceral confinement will likely hinder the social goals of personal growth and community integration. Further, criminal convictions recorded on CORIs will thwart access to employment, housing, schooling, volunteer positions, community placement, and social contacts – all important factors in pursuing a productive life.

While proponents of this bill may argue that the increased penalties will only affect individuals who formed intent to commit the offenses, providers may file charges lacking certainty that the individual had formed intent or even knowing that the individual had not intended their actions.[6] And, while not all such charges will result in conviction and/or incarceration, being charged with a crime is itself traumatic and stigmatizing.

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[5] *See, e.g.,* Kaur & McNamara, Patient Restraint and Seclusion, StatPearls (Jan. 2026), https://www.ncbi.nlm.nih.gov/books/NBK565873/.

[6] *See, e.g.,* Susan Stefan, Q & A – Criminal Prosecution of Institutional Residents by Staff, Mass Legal Services (July 1, 2003), https://www.masslegalservices.org/content/q-criminal-prosecution-institutional-residents-staff (citing patient suits against hospitals for damages as a result of the hospital criminally charging patients for behavioral resulting from their mental condition "regardless of whether the patient had the capacity to form the requisite criminal intent").

Higher penalties would exacerbate the current crisis of forensically-involved patients filling our DMH inpatient psychiatric units and would jeopardize state policy initiatives to divert people from the criminal legal system.
Currently, DMH-operated, continuing-care inpatient units are filled with forensic patients yet to be found competent to stand trial. These DMH units are therefore largely unable to accept discharge-ready, non-forensic patients from acute care psychiatric units. Further, this backlog of patients waiting in acute care units for discharge prevents psychiatric patients from leaving emergency departments (EDs), exacerbating ED boarding in the Commonwealth.

Higher penalties on assaults will overwhelm an already burdened Massachusetts mental health system with an influx of even more people needing evaluation for competency to stand trial and/or hospitalization upon a finding of incompetence. The state should not compound the current crisis by increasing the numbers of individuals entering our criminal legal system, requiring forensic evaluations, and needing ongoing inpatient care pending a determination of competency.

Moreover, increasing the maximum sentence extends the point at which people found not competent are generally able to have their cases dismissed pursuant to state law– at half the maximum sentence. This change means that, but for exceptional circumstances where defense counsel can satisfy the court that the defendant will never regain competency, everyone charged under the new law – even for an assault with no unwanted physical contact – would be saddled with an open criminal matter for 2.5 years. This period is double the time that, under current assault and battery law, a person found incompetent to stand trial could be detained or hospitalized prior to dismissal.

Finally, the imposition of higher penalties, which would drive people into the criminal legal system, is in direct conflict with other state policy initiatives intended to divert people, particularly people with disabilities, from involvement in that system.

Increasing penalties places patients and residents at risk.
Increased penalties will give providers dangerous power over patients and residents in their custody and care. In custodial settings, staff are empowered to put hands on people as intervention, putting patients at risk of physical and psychological harm. This bill could inhibit patients from speaking out about inappropriate or illegal interactions resulting in harm, due to fear that a worker could retaliate by filing charges with potentially severe penalties.

For all these reasons, we urge you to remove Section 3 from this bill and, should this bill go to Conference Committee, also reject Section 5 of H.4767.

Thank you for your consideration.

Sincerely,

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