THE STATE OF NEW HAMPSHIRE

SUPREME COURT

2020 TERM

NO. 2020-0454

Jane Doe

v.

Commissioner of the New Hampshire Department Health and Human Services

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Rule 7 Mandatory Appeal

BRIEF OF *AMICUS CURIAE*

NEW HAMPSHIRE HOSPITAL ASSOCIATION, ALICE PECK DAY MEMORIAL HOSPITAL, ANDROSCOGGIN VALLEY HOSPITAL. CATHOLIC MEDICAL CENTER, CHESHIRE MEDICAL CENTER, CONCORD HOSPITAL, COTTAGE HOSPITAL, ELLIOT HOSPITAL, FRISBIE MEMORIAL HOSPITAL, HCA HEALTH SERVICES OF NEW HAMPSHIRE (PARKLAND MEDICAL CENTER AND PORTSMOUTH REGIONAL HOSPITAL), HUGGINS HOSPITAL, LITTLETON HOSPITAL ASSOCIATION (LITTLETON REGIONAL HEALTHCARE), LRGHEALTHCARE (FRANKLIN REGIONAL HOSPITAL AND LAKES REGION GENERAL HOSPITAL), MARY HITCHCOCK MEMORIAL HOSPITAL, MONADNOCK COMMUNITY HOSPITAL, NEW LONDOND HOSPITAL, SOUTHERN NEW HAMPSHIRE MEDICAL CENTER, SPEARE MEMORIAL HOSPITAL, ST. JOSEPH HOSPITAL, UPPER CONNECTICUT VALLEY HOSPITAL, VALLEY REGIONAL HOSPITAL, AND WEEKS MEDICAL CENTER

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QUESTION PRESENTED

Whether the trial court correctly held that a person detained because of an involuntary emergency admission certificate pursuant to RSA 135-C is entitled to a probable cause hearing within three days of execution of the certificate.

SUMMARY OF THE ARGUMENT

In November 2018, John Doe filed a complaint in federal court for himself and other similarly situated persons who are or would be subjects of involuntary emergency admission ("IEA") certificates. The federal complaint raises the same challenge to the New Hampshire Department of Health and Human Services' ("DHHS") interpretation and administration of RSA 135-C that is presented in this appeal. John Doe argues in the federal case and Jane Doe argues here that RSA 135-C requires that they receive a probable cause hearing within three days of the execution of an IEA certificate at a hospital emergency room department ("ED").

Amicus curiae, the New Hampshire Hospital Association and twenty-three acute care hospitals (collectively, the "Hospitals"), intervened in the federal case. While supporting John Doe's interpretation of RSA 135-C, the Hospitals also challenge DHHS's practice requiring that a Hospital hold an IEA patient in its ED for days or weeks until DHHS informs the Hospital that the person may be transported to New Hampshire Hospital ("NHH") or another designated receiving facility (collectively "DRF").

During the last two years, DHHS has failed to persuade the federal court that the IEA process does not involve state action. DHHS separately failed to persuade the federal court that the involvement of the Hospitals and law enforcement in the IEA process renders the Commissioner's supervision of the process insufficient for John Doe and the Hospitals to challenge DHHS's conduct in federal court. DHHS now urges this Court to adopt the reading of RSA 135-C rejected by the federal court and by the trial court in Jane Doe's case by placing a different spin on its earlier arguments. By isolating words and phrases in RSA 135-C, applying

dictionary definitions, and parsing verb tenses, DHHS argues that such effort produces the agency's interpretation of the statutory scheme.

DHHS's effort fails because it contradicts the plain language of the statutes in the context of the entire statutory scheme and the legislature's intent in enacting RSA 135-C. The legislature's intent and the policy to be advanced regarding RSA 135-C and IEAs are easily discerned from three plain provisions: (1) "[t]he [IEA] of a person shall be to the state mental health services system under the supervision of the commissioner[,]" RSA 135-C:28, I; (2) the admission occurs upon the execution of an IEA certificate by a physician or APRN qualified by a DRF under the supervision of the Commissioner, *id.*; and (3) upon completion of the IEA certificate, the patient is to be delivered immediately to a DRF, RSA 135-C:29, I. The provisions neither are ambiguous nor require a dictionary or grammarian for interpretation in the context of the entire statutory scheme.

Because the statutory scheme is unambiguous, and ambiguity was not raised with the trial court, this Court need not examine the legislative history of RSA 135-C or DHHS's administrative rules. To the extent that this Court considers such materials, however, they do not support DHHS's strained interpretation of RSA 135-C.

This Court, like the federal court and the superior court in the instant appeal, should reject DHHS's interpretation of RSA 135-C.

ARGUMENT

I. The trial court correctly found that the State is required to provide an IEA patient with a probable cause hearing within three days of execution of the IEA certificate.

DHHS challenges the trial court's interpretation of the statutory scheme created in RSA 135-C. When this Court conducts its de novo interpretation of a statute, it "look[s] first to the statute's language, and if possible, construe[s] the language according to its plain and ordinary

meaning." *State v. Balch*, 167 N.H. 329, 332 (2015). The Court reads words and phrases "in the context of the entire statutory scheme ... to apply statutes in light of the legislature's intent in enacting them, and in light of the policy sought to be advanced by the entire statutory scheme." *Id.*

The legislature's intent and the policy to be advanced regarding RSA 135-C and IEAs are easily discerned. There are three plain provisions in the statutory scheme that DHHS attempts to rewrite by isolating words and phrases, resorting to dictionary definitions and parsing verb tenses. The statutory provisions are: (1) "[t]he involuntary emergency admission of a person shall be to the state mental health services system under the supervision of the commissioner[,]" RSA 135-C:28, I; (2) the admission occurs upon the execution of an IEA certificate by a physician or APRN who is approved by a DRF under the supervision of the Commissioner, *id.*; and (3) upon completion of the IEA certificate, the patient is to be delivered immediately to a DRF, RSA 135-C:29, I. The provisions are unambiguous, and therefore, neither a dictionary nor a grammarian is necessary for their interpretation in the context of the entire statutory scheme.

A. The IEA process.

Pursuant to RSA 135-C, DHHS must "establish, maintain, implement, and coordinate a system of mental health services under this chapter ...." RSA 135-C:3. DHHS may directly operate and administer facilities and programs to provide services to persons with mental health problems or it may contract with others for such purposes. *Id.* Among such facilities supervised by the Commissioner are DRFs, including NHH, "for the care, custody, and treatment of persons subject to involuntary admissions." RSA 135-C:26.

A DRF may be established to serve nonemergency involuntary admission persons or to receive IEA patients. RSA-135-C:26, II(a)-(c). If established to receive IEA patients, a DRF may receive them "beginning

with initial custody and continuing through the day following the probable cause hearing ...." *Id.*

DHHS, however, does not allow the IEA process to commence at a DRF. According to DHHS, because "NHH does not provide walk-in emergency or crisis services ... [t]he IEA process begins with a visit to a local hospital [ED] or CMHC, and the completion of an IEA Petition requesting admission to [NHH]." Hospitals' Appendix ("HA") 4.[1] Unlike NHH, as a condition of their licenses, the Hospitals are required to "operate an emergency department offering emergency services to all individuals regardless of ability to pay 24 hours every day, 7 days a week." RSA 151:2-g.

DHHS informs people that an ED doctor "will perform a medical evaluation, and a psychiatrist or a mental health clinician will perform a psychiatric/mental health evaluation." HA4. "If the doctor determines that an involuntary inpatient admission to NHH is appropriate, the [ED] will make arrangements with the NHH Admitting Department for the person to be transported to NHH." *Id.*

Once an IEA certificate is completed the Hospitals contact DHHS or its agent, most often via facsimile, to arrange for the transport to a DRF. *See* HA8-31.[2] DHHS, however, frequently informs the Hospital that the IEA patient cannot be transported to a DRF at that time. *Id.* Thereafter, the Hospital usually checks with DHHS daily until DHHS allows the transport. *Id.* Between May 8 and June 8, 2020, for example, DHHS's waitlist[3] showed an average of 16 IEA patients remained in Hospital EDs daily

[1] HA4-7 are printed copies of the involuntary admission and IEA pages on DHHS's website, https://www.dhhs.nh.gov/dcbcs/nhh/eligibility.htm. "CMHC" stands for "Community Mental Health Center. HA4.

[2] HA8-31 are affidavits that were filed with the federal court in *Doe v. Commissioner*, No. 18-cv-1039-JD.

[3] Stated simply, the waitlist is the daily number of people for whom IEA certificates have been signed but who remain in EDs awaiting transport to a DRF.

rather than being transported immediately to a DRF. HA32-46. When DHHS fails to transport an IEA patient from an ED to a DRF within three days, DHHS requires that the Hospital renew the IEA certificate every three days. HA48.[4]

B. An IEA admission is complete and the person becomes part of the State mental health system upon execution of an IEA certificate.

The preceding process is the only statutory process for an IEA admission. In sum, DHHS instructs people to bring prospective IEA patients to Hospital EDs. The Hospital is required by RSA 151:2-g to perform a psychiatric/mental health evaluation. If an IEA is warranted and a Hospital physician or APRN who has been qualified by a DRF signs an IEA certificate, the patient becomes part of "the state mental health system under the supervision of the Commissioner." RSA 135-C:28, I. Once part of the state mental health system under the control of the Commissioner, the IEA patient's admission to a DRF is complete. *Doe v. Commissioner*, No. 18-cv-1039-JD, 2020 LEXIS 75759 *26-27 (D.N.H. April 30, 2020) ("Certification is the mandatory first step in the admission process, which changes the legal status of the IEA-certified person.").

Unlike DHHS's strained interpretation of RSA 135-C, admission to a DRF upon completion of an IEA certificate is supported by "the context of the entire statutory scheme … and in light of the policy sought to be advanced by the entire statutory scheme." *See Balch*, 167 N.H. at 332. At a Hospital ED, a medical professional authorized by DHHS conducts an examination to determine whether the person meets the criteria of RSA 135-C:27, including whether the person presents a danger to himself or

[4] HA47-48 are the cover and another page of a training provided to the Hospitals by DHHS. DHHS's "best practices" for IEAs includes: "Make sure pages 5, 6, and 7 are re-executed every 3 days for patients holding in the ER. Add chronological numbers to the added pages….8,9,10…11,12,13 etc." HA48. Pages 5-7 are the mental and physical examination required for an IEA certificate.

others. RSA 135-C:28, I. If the medical professional finds the criteria are satisfied, she completes an IEA certificate, a State of New Hampshire form, the Hospital notifies DHHS, and DHHS informs the Hospital of the DRF to which the IEA patient is to be transported. Having been admitted to the State mental health system by virtue of the IEA certificate, "a law enforcement officer shall … take custody of the person to be admitted and shall immediately deliver such person to the [DRF] identified in the certificate." RSA 135-C:29, I.

The statutory scheme creates one continuous procedure for a single admission to "the state mental health system under the supervision of the Commissioner[,]" RSA 135-C:28, I, "[u]pon completion of an [IEA] certificate." RSA 135-C:29, I. The directive that a person subject to an IEA certificate be transported immediately to a DRF is consistent with a DRF being established to receive IEA patients "beginning with initial custody and continuing through the day following the probable cause hearing …." RSA-135-C:26, II(a). The lack of alternative statutory procedures also demonstrates the admission of the person to DHHS and the commencement of state custody upon the execution of the IEA certificate:

> The statute does not provide any procedure for holding a person indefinitely pending delivery to a [DRF]. There also is no statutory requirement for re-examination, re-evaluation or re-certification of the person when that person is delivered to a [DRF], which underscores the conclusion that admission to the mental health services system has already occurred before delivery, that is, at the time of certification.

Doe v. Commissioner, No. 18-cv-1039-JD, 2020 LEXIS 75759 *23.

DHHS's culling of words and phrases from RSA 135-C and its parsing of dictionary definitions and verb tenses to urge a different understanding of the statutes is belied by DHHS's own common and

ordinary explanation of the IEA process. DHHS's website describes the process as a single admission to the State mental health system:

> Most admissions to NHH are through the Involuntary Emergency Admission (IEA) process (pursuant to NH state law, RSA 135-C:27-33). ...
>
> The IEA process begins with a visit to a local hospital [ED] or CMHC, and the completion of an IEA Petition requesting admission to [NHH]. ...
>
> A doctor at the [ED] or CMHC will perform a medical evaluation, and a psychiatrist or a mental health clinician will perform a psychiatric/mental health evaluation. The results of the evaluations must be included with the Petition.
>
> If the doctor determines that an involuntary inpatient admission to NHH is appropriate, the Emergency Department will make arrangements with the NHH Admitting Department for the person to be transported to NHH. Because NHH has a limited bed capacity, the person may have to wait at the Emergency Department or CMHC until a bed at NHH becomes available.

HA4. DHHS, therefore, publicly acknowledges that it is a DHHS-qualified Hospital physician who "determines that an involuntary inpatient admission to NHH is appropriate." *Id.* DHHS also describes to the public the plain language of, and policy behind, RSA 135-C – as part of this single admission process, upon the completion of an IEA certificate a person is admitted to the State mental health system, is taken into State custody, and should be immediately transported to a DRF.

C. DHHS's construction of RSA 135-C ignores that persons are to be transported to a DRF immediately following execution of an IEA certificate.

DHHS's brief lacks a single acknowledgment that RSA 135-C:29, I provides: "[u]pon completion of an involuntary emergency admission certificate under RSA 135-C:28, a law enforcement officer shall ... take

custody of the person to be admitted and shall immediately deliver such person to the receiving facility identified in the certificate."[5] Rewriting RSA 135-C by omitting that a person subject to an IEA certificate is immediately taken into custody and transported to a DRF is essential (and fatal) to DHHS's arguments.

DHHS's concept of separate admissions to a Hospital and a DRF is unnecessary when the statutory requirement to immediately transport an IEA patient to a DRF is recognized. Delivery of immediate oral notice and written notice within twelve hours of the person's statutory rights at a DRF, RSA 135-C:30, is easily understood in the context of the person's immediate delivery to a DRF. Commencement of state custody and conducting probable cause hearings at a DRF within three days of the IEA certificate also is consistent with immediate transport to a DRF. DHHS's definition of "IEA admission" in its administrative rules remains appropriate in the context of a person being admitted to the State's mental health system upon execution of an IEA certificate and immediately transported to a DRF. *See* He-M 613.02(l) ("[IEA] means admission to a receiving facility on an involuntary, emergency basis, pursuant to RSA 135-C:27-33 ....").

DHHS's argument that "[n]o provision of RSA chapter 135-C contemplates that the completion of an IEA certificate alone places a patient within state custody," Brief, p. 28, illustrates the flaw in the State's statutory argument. DHHS argues that a person is not in state custody "until a law enforcement officer takes that patient into custody for delivery to a receiving facility." *Id.* DHHS, however, ignores that RSA 135-C:29, I requires that the patient be taken into custody by law enforcement and

[5] DHHS acknowledges only that "RSA 135-C governs transport of the person 'to be admitted' to the receiving facility identified in the IEA petition and certificate[,]" Brief, p. 18, and that "the hospitals have contended in the federal litigation that the Department must immediately remove a patient from a private hospital ED upon completion of an IEA certificate[,]" Brief, p. 34.

immediately delivered to a DRF "[u]pon completion of an involuntary emergency admission certificate." There is no reasonable reading of RSA 135-C:29, I and the acknowledgment that the person has become part of the State mental health system under the supervision of the Commissioner in RSA 135-C:28, I, that leads to a rational conclusion other than the person is admitted to a DRF upon completion of an IEA certificate.

The plain language of RSA 135-C:29-a, I also demonstrates that an IEA patient is in state custody upon completion of the IEA certificate. The statute provides that an IEA certificate may be rescinded and the patient "released" "before custody of the person is accepted by a law enforcement officer pursuant to RSA 135-C:29" under certain conditions. RSA 135-C:29-a, I. The legislature's choice of the word "released" plainly means freedom from custody. Similarly, "accept[ance]" of custody denotes that the IEA patient will be "in custody" for the law enforcement officer to "accept."

DHHS's reliance on *Mass. Gen. Hosp. v. C.R.*, 484 Mass. 472 (2020) is misplaced. Massachusetts' legislative scheme is entirely different from RSA 135-C. G. L. c. 123, § 12(a)[6] expressly allows any mental health professional qualified by the Department of Mental Health ("DMH") or a clinical social worker to restrain or authorize the restraint of a person for whom the medical professional has reason to believe that hospitalization is necessary to avoid the likelihood of serious harm. *Mass. Gen. Hosp.*, 484 Mass. at 477-78. There is no maximum length of time for this initial detention. The purpose of the initial detention is maintain the person's safety while the medical professional "'appl[ies] for the hospitalization of such person for a [three]-day period at a public facility or at a private

[6] HA174-75

facility authorized for such purposes by [DMH].'" *Id.* at 478 (quoting G. L. c. 123, § 12(a)).

The three-day period and other deadlines established in the Massachusetts statutory scheme do not commence to run until the "patient has been transported to the facility for admission." *Id.* at 479. The three-day period referenced in G. L. c. 123, § 12(a) and created in G. L. c. 123, § 12(b) "provides a facility with the appropriate time frame to assess and monitor a patient, and to determine whether commitment pursuant to a court order is appropriate for that patient." *Mass. Gen. Hosp.*, 484 Mass. at 480; *see also* HA174-75. The commitment or admission of a person to a psychiatric facility, however, requires a more exacting standard: "a physician qualified and designated to admit patients to a psychiatric facility must determine 'that failure to hospitalize such person *would create a likelihood* of serious harm by reason of mental illness' (emphasis added)." *Id* at 482 (quoting G. L. c. 123, § 12(b). "In sum, G. L. c. 123, § 12 (a) and (b), reflects distinct phases that should not be collapsed into one." *Mass. Gen. Hosp.*, 484 Mass. at 482.

Unlike Massachusetts' distinct two-step evaluative process with express directives regarding state custody, RSA 135-C provides that a person is admitted to the State mental health system and is to be transported to a DRF immediately upon execution of an IEA certificate. Unlike RSA 135-C, Massachusetts authorizes initial custody at a private facility. Massachusetts has a lower standard for the initial custody period and a higher standard for hospitalization following a comprehensive three-day evaluation period. Unlike Massachusetts, RSA 135-C does not contain a provision for a separate psychiatric evaluation upon arrival at a DRF. Massachusetts expressly provides that the three-day evaluation period and other deadlines in the statutory scheme do not commence to run until the person physically arrives at a qualified psychiatric facility.

The second substantial distinguishing aspect between *Mass. Gen. Hosp.* and psychiatric boarding in New Hampshire is each state's respective response to the crisis. In 2019, the Massachusetts Commissioners of Insurance, Mental Health, and Public Health collectively created an "expedited psychiatric inpatient admission protocol (EPIA)" that "impos[es] numerous deadlines during the ED boarding process." *Mass. Gen. Hosp.*, 484 Mass. at 485. The Massachusetts legislature also was actively considering an amendment to G. L. c. 123, § 12(a) that "would put a forty-eight hour cap on the amount of time patients younger than twenty-two years old may spend in an ED before admission to a facility[]" at the time *Mass. Gen. Hosp.* was decided. *Id.* at 487.

By comparison, there has not been any change to DHHS's IEA admission process since the federal case, *Doe v. Commissioner*, No. 18-cv-1039-JD, was filed more than two years ago. Rather than amending RSA 135-C to ameliorate the psychiatric boarding crisis, in February 2019, the New Hampshire legislature enacted RSA 151:2-h, which states "No later than 30 days following the first decision on the merits in *Doe v. NH Department of Health and Human Services*, et al. #1:18-CV-01039, or a court-approved agreement of all parties in the case, the commissioner of the department of health and human services shall initiate emergency rulemaking consistent with either the first decision on the merits or the court-approved agreement. The commissioner shall adopt such rules within 90 days of initiating rulemaking." HA173. Thus, the legislature allowed DHHS to delay initiation of the rulemaking process to address the crisis until after prompted to do so through the federal court litigation.

In February 2019, the legislature also authorized funds to renovate existing State hospital facilities or to add or expand DRFs, and to provide some reimbursement to hospitals for ED boarding. SB 11 (2019), HA49-52. Despite the appropriation, the first significant renovation or expansion

that resulted in increased capacity for IEA patients did not occur until September 2020, more than 19 months after the authorization of funds and more than 4 months after the federal court denied DHHS's motions to dismiss the plaintiffs' and Hospitals' amended complaints. *Compare* DA73[7] with HA53-54.[8]

DHHS's attempt to distinguish the constitutional issues present, but undecided in *Mass. Gen. Hosp.*, is equally unavailing. DHHS's argument that the federal and superior courts adopted an "atextual construction" of RSA 135-C is dependent on ignoring the requirement to immediately transport a person to a DRF upon the execution of an IEA certificate. *See* Brief, p.31. DHHS is correct, however, that the legislature would have expressly authorized the Hospitals to detain a person pursuant to an IEA certificate if such was intended by RSA 135-C. There is no such provision in the statutory scheme. The legislature's intent is plain - upon completion of an IEA certificate a person is admitted to the State mental health system, becomes in State custody, and should be immediately transported to a DRF.

D. DHHS cannot avoid its statutory obligations by declaring its system lacks facilities or staff.

DHHS argues that it can avoid its obligation to accept IEA patients immediately into a DRF if the need exceeds the DHHS created and staffed capacity. DHHS rests its position on RSA 135-C:13, which reads in part, "Admission to the state mental health services system and access to treatment and other services within the system shall be contingent upon the availability of appropriations." DHHS does not inform this Court, however, that the sentence of the statute on which it relies sunsets effective July 1, 2021. DA366-67. Accordingly, the dubious proposition on which

[7] "DA__" refers to the appendix filed with DHHS's brief.

[8] HA53-55 is a copy of DHHS's motion to extend time to respond to the Hospitals' motion for preliminary injunction. At paragraph 2, DHHS advises the federal court on August 28, 2020 that additional capacity for IEA patients may "come online over the next few months."

DHHS bases its argument that a statutory provision affords it the authority to refuse IEA patients expires in a few months. Particularly in light of the 2019 passage of RSA 151:2-h ("No later than 30 days following the first decision on the merits in *Doe v. NH Department of Health and Human Services*, et al. #1:18-CV-01039, or a court-approved agreement of all parties in the case, the commissioner of the department of health and human services shall initiate emergency rulemaking consistent with either the first decision on the merits or the court-approved agreement.), HA173, the legislature's extension of the statute is at best uncertain and DHHS's reliance on such uncertainty is unpersuasive.

The history of RSA 135-C:13 further undermines DHHS's argument. The sentence on which DHHS relies was first added to RSA 135-C:13 by way of HB 191 in 2011. HA58. When the legislature added the sentence, however, it simultaneously adopted a version of section 13 without this sentence, which would become effective in two years (in July 2013). Every two years since, except for in 2021, the legislature has repeated this process – adopting a version of section 13 with the sentence referring to the availability of appropriations with a corresponding version omitting that sentence two years later. HA60. If the legislature intended to afford DHHS the discretion to turn away IEA patients, it would have permanently inserted this sentence. The biennial extension of the sunset provision is strong evidence of the legislature's unwillingness to adopt firmly a policy of allowing appropriations to compromise IEA patients' rights and its acknowledgment that DHHS is responsible to care for all IEA patients. The legislature has effectively afforded DHHS ten years to solve the IEA boarding problem and DHHS has failed to do so. Notably, while the legislature enacted RSA 151:2-h in 2019, as of this filing, no legislator has introduced a bill to perpetuate, or even extend past July 1, 2021, the sentence on which DHHS relies.

Additional examination of the legislative history buttresses the conclusion that the availability of appropriations was not intended to limit the services to be afforded to IEA patients. The House Committee on Health and Human Services' Statement of Intent for HB 636 (2013), which extended the appropriations sentence of RSA 135-C:13 until 2015, expressed that it was intended to allow providers the ability to triage, but to always provide services to those needing emergency care, such as IEA patients:

> Prior law required that all clients be seen immediately which was not possible as the agencies faced shrinking financial resources. Those individuals who are severely mentally ill and in crisis will be seen right away but others will go on a waiting list that will prioritize the order in which they will be seen.

HA62. The legislature plainly intended for IEA patients to receive specialized care immediately rather than awaiting such care in an ED.

DHHS's argument faces another significant obstacle: it did not present to the superior court any evidence of a lack of appropriations to care for IEA patients. With respect to Ms. Doe's specific case, about which DHHS says very little in its opening brief, there is but a passing reference by the superior court to the effect that a bed was not available for her. DHHS, however, makes a much broader argument to this Court about its obligation to care for IEA patients generally, and for that, the record below is insufficiently developed as to service capacity, lack of service capacity, or the "availability of appropriations." With all due respect, this Court should not make a finding impacting the entire State mental health system without a detailed factual inquiry into DHHS's use of monies that have been appropriated to it or its efforts to secure appropriations to meet the needs of the IEA patients that it fails to transport immediately from Hospital EDs to a DRF.

DHHS's claim that Jane Doe's case requires it to secure "unlimited resources" is hyperbole. The resources necessary to service IEA patients are finite (as opposed to infinite). According to NAMI-NH, the average number of IEA patients boarded in hospital EDs during the first three quarters of 2018 was 48.67. DA41. Between November 1 and December 31, 2018, the period immediately before the Hospitals intervened in the federal case, the number of IEA patients boarded daily in New Hampshire's hospitals ranged from a low of fourteen to a high of forty-seven. The average number of IEA patients boarded during this period was thirty. DA44-45.

That pre-pandemic range represents the need DHHS is failing to meet, to the prejudice of the IEA patients and the Hospitals. Rather than attempting to quantify the actual cost to meet the need, DHHS urges this Court to assume it is beyond reach. A ruling against DHHS will not cause the level of disruption DHHS portrays. A finding for DHHS, on the other hand, denies specialized psychological care to IEA patients and erodes their liberty interests while also continuing to force the Hospitals to expend resources to sustain indefinitely these patients who are by definition severely mentally ill and a danger to themselves and/or others.

One cannot reasonably read the statutory scheme and conclude that the legislature intended to imbue in DHHS the discretion to cause IEA patients to remain in limbo indefinitely within Hospital EDs.[9] Budgetary constraints must give way to the constitutional rights of the IEA patients and the Hospitals that are forced to board them until DHHS accepts its responsibility. The legislature has determined that caring for our mentally

[9] The superior court specifically referred to the involuntary boarding in the Hospitals' EDs in this way and the description is apt as IEA patients are stuck in a no-man's-land until DHHS accepts them into a DRF. Sept. 21, 2020 Tr. of Hrg. before Super. Ct. pg. 9 ("THE COURT: What's the person's status if they're in limbo between the certificate being completed and the fact that there's no receiving facility available? What's – they're not - -it's not an emergency admission, what is it?").

ill citizens is an essential state function and delegated that responsibility to the Commissioner specifically. *See* RSA 135-C:1, I ("The purpose of this chapter is to enable [DHHS] to: (a) Establish, maintain, and coordinate a comprehensive, effective, and efficient system of services for persons with mental illness... (c) Prevent mentally ill persons from harming themselves or others."); RSA 135-C:1, II ("It is the policy of this state to provide to persons who are severely mentally disabled adequate and humane care...."); RSA 135-C:3 ("The department shall establish, maintain, implement, and coordinate a system of mental health services under this chapter ... [which] shall be supervised by the commissioner."); RSA 135-C:28, I ("The involuntary emergency admission of a person shall be to the state mental health services system under the supervision of the commissioner.").[10]

It is axiomatic that the State's appropriation power must yield to the constitutional rights of IEA patients and the Hospitals. Otherwise, states could simply use the budgetary process to dissolve the constitution. The argument implied by DHHS is that the State can deny IEA patients due process and simultaneously violate the Hospitals' rights to avoid raising taxes, cutting other expenses, or re-prioritizing appropriated funds to serve IEA patients. A similar argument was rejected in *Ehrlich v. Perez*, 908 A.2d 1220 (Md. 2006), where Maryland failed to appropriate funds for the state's medical assistance program for resident alien children and pregnant women who immigrated to the United States after August 22, 1996 (while providing such benefits to citizens and other resident aliens who arrived

[10] *See also* testimony of John Wallace of the Division of Mental Health, HB 226 (1986), which was the adoption of RSA 135-C, House Journal pg. 22 ("It is critical that those persons that now have a right to services in the community, we are obligated to serve them, they have a right to services get effective treatment. This is the heart of our system and if we cannot regulate that system and assure that those services are run properly then we will not have a mental health system."), DA268-70.

before that date). Maryland's highest court rejected the State's argument that the equal protection guarantees of the Maryland constitution do not apply to the budget appropriation process. *Id.* at 1247 ("[W]e reject the argument because the executive and legislative budget authority is subject to the constitutional limitations of the Declaration of Rights."). The Maryland Court foreclosed the practice of adopting budgets, rather than passing laws, as a means to violate constitutional rights. *Id.*

The same principle, that a state's appropriations must be sufficient to meet constitutional standards, has been recognized in other contexts, such as appropriating funds to provide adequate counsel for indigent criminal defendants. *See Kerr v. Parsons*, 378 P.3d 1, 9 (N.M. 2016) ("While we note the Legislature's broad power to appropriate funds and to affix limitations on those appropriations, we also recognize that some limitations on funding for the provision of indigent defense could be so severe as to create a presumption of ineffective assistance of counsel in particular cases.") (internal citation omitted). DHHS's argument also would fail under the logic expressed in *Robinson v. Crown Cork & Seal Co.*, 335 S.W.3d 126, 159 (Tex. 2010) where the Texas Supreme Court held that the constitutional protection against retroactive laws places a check on a state's budget process. *Id.* ("While it is axiomatic that the Legislature, through budgeting and lawmaking, has primacy in setting State policy, that power, though unrivaled, is not unlimited. One constraint is the Texas Constitution's Bill of Rights, including article I, section 16's prohibition against retroactive laws.").

Indeed, this Court has recognized that budget-making must meet certain minimums, including the constitutional requirement to provide an adequate education, *Claremont Sch. Dist. v. Governor*, 138 N.H. 183 (1993) (discussing the State's obligation to fund the adequate education mandated by the constitution), and the requirement to adequately pay for

the cost of providing counsel to indigent criminal defendants. *State v. Robinson*, 123 N.H. 665, 669 (1983) ("The right to counsel, as guaranteed by the sixth amendment and part I, article 15 of our own constitution, would be meaningless if counsel for an indigent defendant is denied the use of the working tools essential to the establishment of a tenable defense because there are no funds to pay for these items."). The same principle applies here. It would be a significant departure from existing law to hold, as DHHS suggests, that a lack of appropriations can justify violating an IEA patient's right to due process or the unreasonable seizure or a taking of the Hospitals' property without just compensation.

DHHS's argument would set a precedent with significant negative consequences. Imagine if the Department of Corrections ("Corrections") refused to accept convicted felons because there were insufficient funds to create and staff the prison system. Instead, Corrections advised the courts in which the defendants were sentenced or the county houses of corrections in which they were detained pre-trial to hold the convicts until space became available in the state prison system. The Commissioner does the equivalent here by directing the Hospitals to hold those enrolled in the state mental health system following the execution of an IEA certificate until DHHS advises otherwise. The legislature explicitly directed the Commissioner to care for those with such severe mental illness that they are a danger to themselves and/or others. The care to be afforded must, as a matter of law, satisfy constitutional requirements and avoid the harms suffered by IEA patients and the Hospitals.

DHHS's reliance on *In re Strandell*, 132 N.H. 110 (1989) is misplaced. The *Strandell* Court did not face the same constitutional challenges that are raised by Ms. Doe and the Hospitals.[11] *Id.* at 112

[11] DHHS's arguments on appeal are broad and not limited to Ms. Doe and her single writ of habeas corpus. Moreover, in its motion to dismiss, DHHS frequently references the federal

(declining to consider whether the petitioner had a right to habilitative services grounded in the due process clause of the fourteenth amendment to the United States Constitution). Left with just a statutory interpretation, this Court ultimately denied Ms. Strandell's challenge to a waitlist imposed due to fiscal constraints. There is, however, a fundamental difference between a person waiting months to be accepted into a facility of his choosing versus being detained against one's will in a Hospital ED without receiving due process, while also forcing a Hospital to house and care for the patient indefinitely. The consideration of the propriety of a waitlist in *Strandell* is not as significant as it is here because the stakes in *Strandell*, while important, are not as pressing as those in Ms. Doe's circumstance.

DHHS's decision to frame its opening brief to discuss the IEA system generally and not focus on Ms. Doe erodes the utility of the *Strandell* opinion. In *Strandell*, this Court rejected Ms. Strandell's characterization of the Division of Mental Health and Developmental Service's decision to put her on a waitlist as an "implied repeal" of the statutory service guarantees to which she was entitled and indicated it did so because the shortfall of appropriations "did not substantively repeal that statutory program." *Id.* at 114. Here, in contrast, DHHS argues broadly that it has the authority to force dozens of IEA patients each day to linger in EDs. Whereas Ms. Strandell challenged her placement on a waiting list to get into the facility of her choice, DHHS's argument here has broader substantive implications for the State's mental health system. As this Court noted, an appropriations bill neither creates nor modifies any rights; appropriations bills are merely "a means only to the enforcement of law, the maintenance of good order, and the life of the state government." *Id.* at

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litigation and advises the trial court of positions it has taken in the federal litigation. DA92. The Hospitals' Intervenor Complaint was submitted to the trial court. DA28-57. The trial court also expressly "agreed with the federal court's analysis" in *Doe v. Commissioner*, No. 18-cv-1039-JD.

114-15 (quotation omitted). In other words, the system must function as the legislature directed and as the constitution requires regardless of whether or how the legislature appropriates funds to DHHS.[12]

The waitlist regulation challenged in *Strandell* also was very different from DHHS's regulations for IEA patients. *Strandell*'s waitlist regulation constituted a thoroughly detailed mechanism for dealing with excess need by placing applicants into prioritized categories, requiring periodic review of each person's status, and mandating follow-up to determine facility availability. None of that detail is present in DHHS's IEA patient system. In the Hospitals' experience, they must make phone calls each day to DHHS to attempt to discern when a particular IEA patient might be transported out of the ED. HA8-31 (affidavits from the Hospitals).

Moreover, the existence of a regulation setting forth ***how*** to deal with excess need is not a legislative grant to permit excess need to compound on itself. The fact that the Commissioner requires DRFs to accept IEA patients unless a DRF has no open bed space (He-M 405.06 (b)) is not an endorsement for the system to allow IEA patients to remain in the Hospitals' EDs. Additionally, because DHHS's regulations for the IEA system point back to the statutory scheme, He-M 405.06 (a) (requiring that involuntary admissions "be made according to the procedures for IEAs under RSA 135-C:27-54."),[13] its argument comes full circle and falls apart when read in context with the entire statute.

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[12] Several years after *Strandell*, a class action complaint was filed in the United States District Court for the District of New Hampshire as the by-product of an investigation by the United States into the adequacy of the State's mental health system, including the services Ms. Strandell sought and for which she had to wait. That case resulted in a class action settlement in which DHHS agreed to make material changes to the State's mental health system. *See Amanda D. v. Hassan*, Civ. No. 1:12-cv-53-SM (D.N.H) (the settlement agreement is available at https://drcnh.org/wp-content/uploads/2019/01/Settlement_Agreement.pdf (last visited Jan. 14, 2021)).

[13] When read in context, it is plain that the section of rules found at He-M 405 is aimed at regulating DRFs and has little to do with IEA patients themselves or the Hospitals. These rules are, therefore, of very limited utility to this Court when deciding the issues presented by Ms. Doe.

II. The IEA statutes, RSA 135-C:27-34, are not ambiguous and the Court should not defer to DHHS's interpretation.

A. The statutory scheme is not ambiguous.

There is nothing ambiguous about the legislature's directive that each IEA patient be transported "immediately" from a Hospital's ED "upon completion of an involuntary emergency admission certificate." RSA 135-C:29. If an IEA patient is transported immediately, as the law explicitly requires, the statute straightforwardly dictates that a probable cause hearing take place within three days, thereby affording due process to the IEA patient and avoiding the prejudice suffered by the Hospitals. There is no need to perseverate over the meaning of "admitted" if the IEA patient is moved from an ED to a DRF without delay. It is only because DHHS routinely violates RSA 135-C:29, I by failing to transport IEA patients immediately to a DRF that the purported ambiguity exists. When read as a whole and in context, there is no ambiguity in the statute. *Ford v. N.H. Dep't of Transp.*, 163 N.H. 284, 293 (2012) ("However, we cannot read these statutes in isolation, but must read them in context.").

This Court's interpretation of the statutory scheme begins with the plain and ordinary meaning of the words used, with the overall goal to "apply statutes in light of the legislature's intent in enacting them, and in light of the policy sought to be advanced by the entire statutory scheme." *Appeal of Morrissey*, 165 N.H. 87, 92 (2013) (citing *Carlisle v. Frisbie Mem. Hosp.*, 152 N.H. 762, 773 (2005)). The policy to be advanced is to place IEA patients under the supervision and care of DHHS and to get them to a DRF as quickly as possible while affording them adequate due process to ensure none are held against their will without sufficient justification. The policy is achieved through the only reasonable construction of the statute; that is, the signing of an IEA certificate admits a person into the State's mental health system, the person is transported

immediately to one of the Commissioner's facilities, and the IEA patient is checked-into (or, "admitted") into the Commissioner's facility to receive the care and due process the legislature mandated.

DHHS's construction of "admission" as not occurring until an IEA patient physically crosses the threshold into a DRF undermines the legislature's policy because it creates a limbo status in which patients are held in Hospital EDs indefinitely without due process. This limbo status results in an IEA patient being detained by a Hospital without statutory authority, an unauthorized detention of indeterminant duration without due process, and the State taking at least a portion of the Hospital's ED and utilizing the Hospital's personnel until DHHS decides to receive the IEA patient. Consequently, DHHS's construction cannot prevail because it violates the constitutional rights of IEA patients and the Hospitals.

DHHS misplaces its reliance on the single reference "to be admitted" in RSA 135-C:29, I ("Upon completion of an [IEA] certificate under RSA 135-C:28, a law enforcement officer shall … take custody of the person to be admitted and shall immediately deliver such person to the [DRF] identified in the certificate.") as signifying that a person is not admitted to the State mental health system and in state custody upon the execution of an IEA certificate. RSA 135-C:31 provides rights to IEA patients at a time when DHHS does not dispute the person already has been received or "admitted" to a DRF. RSA 135-C:31, I ("*Within 3 days after an involuntary emergency admission* … there shall be a probable cause hearing in the district court having jurisdiction to determine *if there was probable cause for involuntary emergency admission.*"). Yet, when referring to the person's right to continue or waive the probable cause hearing, the statute uses the phrase "the person to be admitted." The use of the phrase "to be admitted" epitomizes the reason this Court does not construe words and phrases in isolation. *See Balch*, 167 N.H. at 332.

Standing alone the phrase is susceptible to an atextual interpretation. As part of a complete statutory scheme, however, the phrase is placed in context instead of afforded enhanced significance inconsistent with the policy behind the statute.[14] DHHS's strained construction goes too far and should be rejected.

B. Even if the statute is ambiguous, DHHS's construction should be rejected.

Despite the clarity of the statute, as a fallback position, DHHS suggests that *if* the statute is ambiguous, this Court should defer to DHHS's construction. DHHS's contention fails for at least two reasons. DHHS failed to raise this ambiguity argument before the superior court thereby depriving the trial court the opportunity to consider it. Nowhere in the pleadings provided with DHHS's appendix or in the transcript of the hearing on DHHS's Motion to Dismiss in Ms. Doe's matter will this Court find DHHS's argument that the statute is ambiguous.[15] DHHS's failure to raise the ambiguity argument below justifies this Court's rejection of the argument without further consideration. *In re Adam M.*, 148 N.H. 83, 86, (2002); *N.H. Dep't of Corr. v. Butland*, 147 N.H. 676, 679 (2002).

Even if this Court considers DHHS's argument that the statute is ambiguous, this Court need not adopt DHHS's interpretation. While this

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[14] Additional uses of the phrase "to be admitted" do not advance DHHS's argument. RSA 135-C:28, I ("The physician, PA, or APRN must find that the person to be admitted meets the criteria of RSA 135-C:27."); RSA 135-C: 28, II ("Upon request for involuntary emergency admission by a petitioner, if the person sought to be admitted refuses to consent....").

[15] Before the federal district court, DHHS characterized RSA 135-C as ***unambiguous***. *See, e.g.*, Memorandum of Law in Support of Commissioner Jeffery A. Meyer's Motion to Dismiss the Amended Intervenor Complaint, Civil No. 1:18-cv-01039-JD (D.N.H, filed Sept. 16, 2019) at 9 ("Rather, RSA 135-C ***unambiguously*** specifies that, once law enforcement takes custody of a person subject to an IEA petition and certificate, and delivers him to the appropriate designated receiving facility, he received a due process-based probable cause hearing within three days of his admission to that facility.") (emphasis added), HA73; Transcript of Apr. 2, 2020 Mot. Hear., Civil No. 1:18-cv-1039-JD (D.N.H.) at 46 (Attorney Garland stated, "And then the third point, and it's a related point I'd make with respect to that, is that we [DHHS] obviously believe that the statute is ***unambiguous*** as well,... We believe our reading is correct, we believe our reading is unambiguous that is based on ***unambiguous*** text and structure....") (emphasis added), HA144.

Court at times defers to an agency charged with administration of a law, that deference is not absolute. *Appeal of Town of Seabrook*, 163 N.H. 635, 644 (2012). This Court, and not DHHS, is the final arbiter of legislative intent and this Court is not bound by DHHS's interpretation, no matter how long the agency has held that view. *Id.* This Court "will not defer to an agency's interpretation if it clearly conflicts with the express statutory language, or if it is plainly incorrect. *Id.* (citing *Appeal of Stanton*, 147 N.H. 724, 728 (2002) and *Appeal of Levesque*, 136 N.H. 211, 213 (1992)); *see also Appeal of Morrissey*, 165 N.H. 87, 91 (2013). As explained above, DHHS's construction is contrary to the intent of the scheme and results in harm to IEA patients and the Hospitals, so it should be rejected.

DHHS overstates its authority by suggesting that its own historical rule-making should buttress its statutory interpretation. The legislature may authorize an agency to adopt rules to aid the successful execution of some general statutory provision, but the agency may only "fill in details to effectuate the purpose of the statute." *In re Appeal of N.H. DOT*, 152 N.H. 565, 571 (2005) (citing *State v. Normand*, 76 N.H. 541, 546 (1913); *Ferretti v. Jackson*, 88 N.H. 296, 298 (1936)); *Kimball v. N.H. Bd. of Accountancy*, 118 N.H. 567, 568 (1978)); *see also Ron L. Beaulieu & Co. v. N.H. Bd. of Accountancy*, 172 N.H. 284, 289 (2019); *Appeal of Mays*, 161 N.H. 470, 473 (2011). DHHS, however, does not have the authority to contravene RSA 135-C and its purpose. *In re Appeal of N.H. DOT*, 152 N.H. at 571 (Administrative officials, however, "do not possess the power to contravene a statute," and cannot "add to, detract from, or in any way modify statutory law.") (quoting *Appeal of Anderson*, 147 N.H. 181, 183 (2001) and *Kimball v. N.H. Bd. of Accountancy*, 118 N.H. 567, 568 (1978)).

This Court bears the ultimate responsibility "to insure that another will is not substituted for that of the legislature when, out of necessity, it delegates certain limited powers." *In re Appeal of N.H. DOT*, 152 N.H.

565, 571 (2005). This Court does not afford unfettered deference to an agency's rules, *id.* at 574, and deference is not warranted here. The Commissioner cannot adopt rules that deny the "immediate" transport of IEA patients from the Hospitals' EDs or that undercut the due process the legislature afforded IEA patients.

C. The legislative history does not advance DHHS's argument.

Because the statute is not ambiguous, there is no reason to delve into the legislative history. *See In re Lyon & Lyon*, 166 N.H. 315, 318 (2014) ("When the language of a statute is plain and unambiguous, we do not look beyond it for further indications of legislative intent.") (citing *Smith v. City of Franklin*, 159 N.H. 585, 588 (2010)). Even so, the legislative history does not aid DHHS in escaping its obligations to IEA patients like Ms. Doe. DHHS contends that its construction of "admission" is correct because the agency interpreted the prior version of the statute, RSA 135-B:19-22, to tie "admission" to physical presence. The legislature, however, did not use the words "physical presence" in the statutory scheme, HA178-80,[16] and the phrase's absence is notable. *U.S. EEOC v. Fred Fuller Oil Co.*, 168 N.H. 606, 613 (2016) ("We presume the legislature knew the meaning of the words it chose, and that it used those words advisedly.") (citing *Roberts v. Town of Windham*, 165 N.H. 186, 190 (2013)).

DHHS's argument also ignores that the phrase regarding physical presence was removed from its administrative rules after the legislature replaced RSA-B:19-25 with RSA 135-C:27-34. Compare DA111, 122, and 134 with DA142, 152, 164, 180, 193, 209, and 221. RSA 135-B involved a different statutory scheme that included an "Emergency Diagnostic Detention" period of up to 30 days before a petition to the probate court authorizing the detention was required. RSA 135-B:23. The replacement

[16] HA178-80 sets forth copies of RSA 135-B:19-25.

of RSA 135-B:19-25 with RSA 135-C:27-34 providing for "Involuntary Emergency Admission" and enrollment in the State mental health system upon the execution of an IEA certificate, RSA 135-C: 135-C:28, I , and the elimination of the "physical presence" sentence from DHHS's administrative rules is compelling evidence that neither the legislature nor DHHS intended for physical presence to be the touchstone of admission to a DRF. *See* Gagne v. Garrison Hill Greenhouses, 99 N.H. 292, 297-98 (1954) (elimination of sentence from definition of "employee" in worker's compensation statute "points strongly to a purpose not to include" eliminated matter in new statutory definition); *see also Bach v. N.H. Dep't of Safety*, 169 N.H. 87, 92 (2016) ("We use the same principles of construction when interpreting both statutes and administrative rules.").

On page 42 of DHHS's opening brief, it cites to the May 4, 2010 testimony of Attorney Michael Skibbie, who testified on behalf of the Disability Rights Center. According to DHHS, Attorney Skibbie's testimony somehow conveys an "understanding that an IEA is an admission to a state facility." *Id.* The characterization of Attorney Skibbie's testimony is wrong. First, the 2010 public hearing includes no mention of psychiatric boarding in Hospital EDs[17] or when a person becomes admitted to a DRF.[18] *See* DA311-331. Second, to the extent any testimony of Attorney Skibbie is reflective of what the ***legislature*** intended, Attorney Skibbie later made very clear his understanding that DHHS was required to transport IEA patients immediately from an ED to a DRF. In 2018, he testified:

[17] The lack of mention of psychiatric boarding in 2010 is not surprising. The data relied upon in the federal case to demonstrate the increase in psychiatric boarding commences in 2013. DA41-42. The lack of discussion about psychiatric boarding, however, renders unreliable all 2010 testimony urged by DHHS as supportive of its position.

[18] The bill before the legislature amended RSA 135-C:32 to exclude weekends from the calculation of the 10-day period that an IEA may extend before a hearing must be held in the probate court. DA316.

> Regarding Section 3 [of the bill], the system is designed to work that a person in a psychiatric crisis would be examined by a health professional, the statute commands they be received by a designated receiving [facility]. Then a series of time limits apply after this action.

SB 590 (2018), HA155. Thus, Attorney Skibbie's relevant testimony is consistent with finding that the admission to a state facility occurs upon the execution of an IEA certificate when the person is admitted to the State mental health system and is to be transported to a DRF.

In 2002, Representative J.P. Manning testified before the House Judiciary Committee in connection with HB 1311 (2002), which addressed the annulment of certain records relating to IEAs. Implicit in his testimony is a requirement for a transfer to "a state facility" to occur immediately, an event which, if it actually occurred, neutralizes most of DHHS's argument in this case. Representative Manning testified:

> First, a person fills out a petition to have a person IEA'd, then a physician needs to sign the petition, then the person is held at a state facility for three days. On that third day, a hearing must be held to determine if at the time the petition was signed, the person met the qualifications to be IEA'd.

HA, pp. 158.

In 2017, the legislature adopted HB 400, which required the Commissioner to develop a plan "with recommendations to ensure timely protection of the statutory and due process rights of patients subject to the [IEA] process of RSA 135- C who are awaiting transfer to a [DRF]. The recommendations shall provide for judicial review on a schedule consistent with the statutorily required schedule for persons who have been admitted to a [DRF]." HA163 (112:3). If DHHS is correct that IEA patients boarded in the Hospitals' EDs are not under the care of the Commissioner and have not been "admitted" to a DRF, why would the legislature direct the Commissioner to study and solve this crisis? The legislature's directive

to the Commissioner confirms its intention that IEA patients are part of the Commissioner's mental health system once the IEA certificate is signed.

DHHS's so-called "10-Year Mental Health Plan" that resulted from the 2017 work (which continued into 2018 and was presented to the Senate Committee on Health and Human Services) included a recommendation to eliminate ED boarding of IEA patients in hospitals. DA167-69. If IEA patients in Hospital EDs are not part of the State system, why would this recommendation be necessary? The Commissioner also asked the legislature to amend statutes pertaining to licensing hospitals to require that hospitals implement probable cause hearings within 72 hours of the signing of an IEA certificate. DA168-69. If "admission" did not occur until transportation to a DRF, this requested modification (which did not occur) would be unnecessary. The fact that the Commissioner requested this change, however, confirms that "admission" to the State's mental health system occurs when the IEA certificate is signed and before the IEA patient is transported to a DRF, otherwise there would be no concern for a probable cause hearing at that juncture. That the legislature has not acted on the Commissioner's request to shift the burden to private hospitals is ample proof that it is DHHS that is responsible for the very process DHHS seeks to avoid in this case.

The legislative history does not support DHHS's attempt to rewrite the statute to its liking.

CONCLUSION

In the context of the entire statutory scheme, the plain language of RSA 135-C reveals the legislature's intent and the policy to be advanced regarding involuntary emergency admissions. Rather than spending weeks in a state of legal limbo, the execution of an IEA certificate at a hospital emergency department means that the IEA patient has become enrolled in the State mental health system under the custody and control of the

Commissioner and is to be transported immediately to a designated receiving facility. For those reasons, the superior court order dismissing the State's Motion to Dismiss should be affirmed.

Oral Argument

The Hospitals request 15 minutes for oral argument before the full Court and has a motion requesting oral argument pursuant to New Hampshire Supreme Court Rule 30(4).

Respectfully submitted,

NEW HAMPSHIRE HOSPITAL ASSOCIATION, ALICE PECK DAY MEMORIAL HOSPITAL, ANDROSCOGGIN VALLEY HOSPITAL. CATHOLIC MEDICAL CENTER, CHESHIRE MEDICAL CENTER, CONCORD HOSPITAL, COTTAGE HOSPITAL, ELLIOT HOSPITAL, FRISBIE MEMORIAL HOSPITAL, HCA HEALTH SERVICES OF NEW HAMPSHIRE (PARKLAND MEDICAL CENTER AND PORTSMOUTH REGIONAL HOSPITAL), HUGGINS HOSPITAL, LITTLETON HOSPITAL ASSOCIATION (LITTLETON REGIONAL HEALTHCARE), LRGHEALTHCARE (FRANKLIN REGIONAL HOSPITAL AND LAKES REGION GENERAL HOSPITAL), MARY HITCHCOCK MEMORIAL HOSPITAL, MONADNOCK COMMUNITY HOSPITAL, NEW LONDOND HOSPITAL, SOUTHERN NEW HAMPSHIRE MEDICAL CENTER, SPEARE MEMORIAL HOSPITAL, ST. JOSEPH HOSPITAL, UPPER CONNECTICUT VALLEY HOSPITAL, VALLEY REGIONAL HOSPITAL, and WEEKS MEDICAL CENTER

By their counsel,

Dated: February 1, 2021 By: /s/ Michael D. Ramsdell

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CERTIFICATE OF SERVICE

On February 1, 2021, this brief, which complies with Supreme Court Rule 16(11) because it contains 9500 words, excluding the table of contents, table of citations, and addenda, was forwarded to Solicitor General Daniel E. Will, Senior Assistant Attorney General Anthony J. Galdieri, Assistant Attorney General Samuel R.V. Garland, and Gary N. Apfel, Esquire through the Court's electronic filing system.

/s/ Michael D. Ramsdell
Michael D. Ramsdell