State of New Hampshire
Supreme Court

NO. 2020-0454

2021 TERM
JANUARY SESSION

Jane Doe

v.

Commissioner of the New Hampshire Department of Health and Human Services

RULE 7 APPEAL OF FINAL DECISION OF THE MERRIMACK COUNTY SUPERIOR COURT

Brief of *Amicus Curiae*, NAMI New Hampshire
(National Alliance on Mental Illness)

By: Joshua L. Gordon, Esq.
NH Bar ID No. 9046
Law Office of Joshua L. Gordon
75 South Main St. #7
Concord, NH 03301
(603) 226-4225 www.AppealsLawyer.net

Kenneth Norton, Exec.Dir.
NAMI NH
85 North State St.
Concord, NH 03301
603-225-5359 info@naminh.org

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Federal Cases

New Hampshire Cases

New Hampshire Statutes

Secondary Authority

STATEMENT OF INTEREST OF *AMICUS CURIAE*

NAMI NH is the New Hampshire chapter of the National Alliance on Mental Illness. Its mission is to improve the lives of all people affected by mental illness and suicide. NAMI NH envisions a future where people affected by mental illness have hope, help, and health – where they are able to access supports and evidence-based treatments necessary for recovery, to enjoy a lifespan not cut short by suicide or co-occurring conditions, and to reach their full potential, living in communities free from discrimination.

NAMI NH is not a treatment provider. Rather, it is a grassroots coalition of people living with mental illness, their families, service providers, and other key stakeholders. While it has professional paid staff, NAMI NH is dependent on a cadre of trained volunteers, most of whom have "lived experience" with mental illness, either themselves or with a family member or loved one.

NAMI NH offers statewide programs and activities to furnish education and training. It provides advocacy and empowerment at the individual level, the family level, and the systems level, by offering its members, volunteers, and stakeholders training and graduated opportunities in advocacy and leadership skills.

NAMI NH has over 35 years of service to New Hampshire children, transition age youth, adults, and seniors. Last year, it provided support, education, and advocacy to over 33,000 individuals. In 2019, NAMI NH was the recipient of the Nonprofit Impact Award from the NH Center for Nonprofits.

NAMI NH is submitting this *amicus curiae* brief with the intent to provide a historical context for ongoing concerns about emergency department boarding, and to describe the real-world impact that boarding and the commensurate denial of care and treatment has on those people who are directly

impacted. NAMI NH wishes to emphasize that the boarding problem should not be considered in a vacuum. It is directly related to the long-term failure of the State, hospitals, and the health care system generally, to develop a comprehensive system of community-based services for people with serious mental illnesses, including inadequate numbers of inpatient psychiatric beds for those who need that level of care and treatment.

BRIEF OF *AMICUS CURIAE*

"Psychiatric boarding" is "the practice in which admitted patients are held in hallways or other emergency department … areas until inpatient beds become available." David Bender &a., *A Literature Review: Psychiatric Boarding*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Oct. 29, 2008), *NAMI Appx*.[1] at 3, <http://aspe.hhs. gov/daltcp/reports/2008/psybdlr.htm>, *cited in* James A. McClure IV, *Psychiatric Boarding in New Hampshire: Violation of A Statutory Right to Treatment*, 14 U.N.H.L. REV. 197, 226 (2016). Hospital emergency room boarding is detrimental to both the patients boarded, and the medical system.

Due to lack of capacity, there are no facilities available to hospitals to transfer those patients who need mental health care, in order to avoid harm to themselves or others. Even though the law requires a hearing within three days of involuntary admission, hospitals routinely redo Involuntary Emergency Admission (IEA) petitions at three-day intervals, having the effect of delaying hearings for weeks.

Consequently, emergency department boarding – during which patients' liberties are suspended for lengthy periods, and their mental health suffers – is distressingly common in New Hampshire.

[1]An appendix was filed with the appellant's brief, cited herein as "*HHS Appx.*" A separate appendix is being filed with this brief, cited herein as "*NAMI Appx*."

I. Legal and Legislative History

A. Background

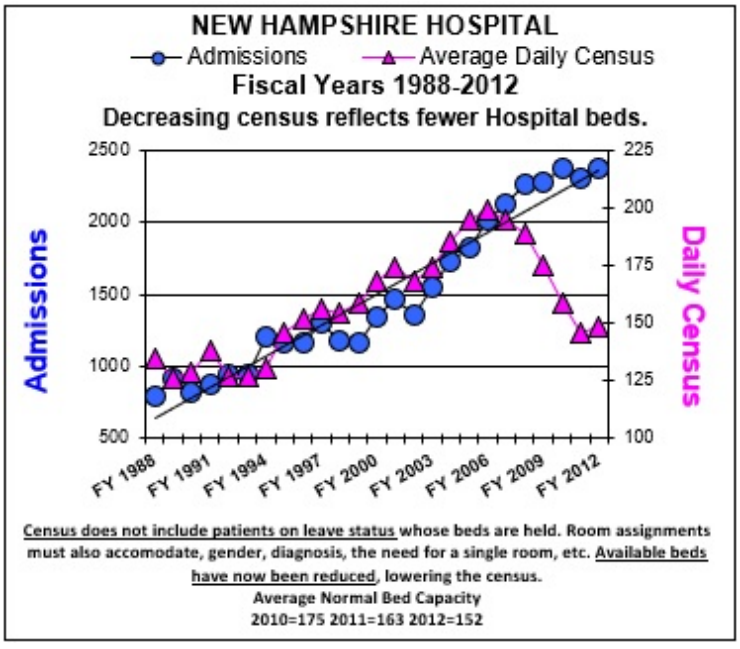
In 1957 the population of New Hampshire was 750,000 and the census of adults living on the State Hospital Grounds in Concord reached its peak of 2,700 adults. Today, state population is 1.3 million, but the adult population of the Acute Psychiatric Service in Concord (APS or "State Hospital") is just 174.

This dramatic change is a result of the 1963 Community Mental Health Act, which began the process of shifting the focus of care away from large institutions toward community-based systems. Deinstitutionalization gained momentum in New Hampshire after a 1982 legislative study known as the "Nardi Wheelock Report" laid out a vision and roadmap for comprehensive community based mental health services. By the late 1980s, New Hampshire's mental health system was rated among the top three in the country. E. Fuller Torrey, Sidney E. Wolfe, & Laurie M. Flynn, *Care of the Seriously Mentally Ill: A Rating of State Programs* (Public Citizen Research Group and National Alliance for the Mentally Ill) (3rd ed. 1989).

A significant factor in New Hampshire's success was the 1990 opening of the APS, a state-of-the-art psychiatric hospital facility on the grounds of the State Hospital in Concord. Several projections determined the size of the new facility and the anticipated future need for inpatient psychiatric care. First, it was projected that New Hampshire would continue to build out a comprehensive community-based system of mental health care, which would reduce the need for inpatient admissions, as well as allow successful discharge into the community of the remaining long-term patients at the New Hampshire Hospital. Second, it was projected that there would be a number of regional Designated Receiving Facilities (DRF), typically local hospitals, which would accept involuntary patients on a short-term basis, thus keeping them close to their families, natural support systems, and local treatment providers.

Unfortunately, neither projection was fully realized. The new APS hospital opened with a significant part of its census consisting of long-term patients transferred directly from the old state hospital facility. Entering the new century, New Hampshire's community-based mental health system was not being adequately funded and was beginning to decline. While some new DRFs were opened, New Hampshire never achieved the number planned, and some, including Androscoggin Valley Hospital, closed. Funding for Community Mental Health Centers (CMHC), hospitals, the New Hampshire Hospital, and other providers, had decreased, creating significant gaps in the community-based system of care.

In 2005, the New Hampshire legislature created the Mental Health Commission to develop a comprehensive state mental health plan. In 2008, the Commission issued a 10-year plan. *Addressing the Critical Mental Health Needs of NH's Citizens A Strategy for Restoration* (Aug. 2008), *NAMI Appx*. at 33, <www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>. Due to an economic recession and other factors, the report's recommendations were not funded or enacted, and New Hampshire's mental health system continued to decline. In 2011, this culminated in the closure of the Philbrook Children's Center, which had provided inpatient psychiatric treatment for children on the grounds of the State Hospital, leading to the transfer of the



children's unit to the APS building, and the loss of over 40 adult beds.

The chart above, provided by the New Hampshire Department of Health and Human Services, tracks both hospital admissions (circles) and daily census (triangles). It shows that from 1998 through about 2008, they were aligned, but starting around 2008, a large annual gap started developing between the two, thus resulting in a sharp drop-off of available beds at New Hampshire Hospital.

By 2011, mental health services in New Hampshire had deteriorated to such an extent that the United States Department of Justice Civil Rights Division (USDOJ) initiated an investigation. In April 2011, the Justice Department issued a report to the New Hampshire Attorney General, concluding that New Hampshire was not in compliance with federal law. USDOJ, *United States' Investigation of the New Hampshire Mental Health System Pursuant to the Americans With Disabilities Act* (Apr. 7, 2011), *NAMI Appx*. at 52, <www.justice.gov/sites/default/files/crt/legacy/2011/04/13/New_Hampshire_MH_findlet_04-07-11.pdf>. As set forth by the United States Supreme Court, *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), the law requires that individuals with disabilities, including mental illness, receive supports and services in the most integrated setting appropriate to their needs. The report cited loss of inpatient capacity, increased New Hampshire Hospital admissions, and inadequate community supports to prevent hospitalizations. USDOJ made recommendations that, if implemented, would move New Hampshire into compliance with the federal requirements.

The New Hampshire Department of Health and Human Services (NHDHHS) disputed the findings, LETTER FROM NHDHHS to USDOJ (Dec. 6, 2011), *NAMI Appx*. at 80, <drcnh.org/wp-content/uploads/2019/01/DHHS_Letter_to_ USDOJ.pdf>, and New Hampshire made little effort to move forward with the steps recommended by USDOJ.

As a result, in February 2012, legal advocates, led by the New Hampshire Disabilities Rights Center, filed suit in the New Hampshire Federal District Court, on behalf of plaintiffs seeking mental health treatment, which the USDOJ joined. *See Kenneth R. ex rel. Tri-Cty. CAP, Inc./GS v. Hassan*, 293 F.R.D. 254, 258 (D.N.H. 2013). After a class was certified, settlement discussions began, and a settlement agreement was approved by the federal court, which remains in effect today. *Amanda D. &a. v. United States &a.,* N.H. Fed. Dist.Ct. No. 1:12-CV-53-SM, Class Action Settlement Agreement (Feb. 12, 2014), *NAMI Appx*. at 85, <www.justice.gov/sites/default/files/crt/legacy/2014/02/19/nh-ada_agreement_2-12-14.pdf>.

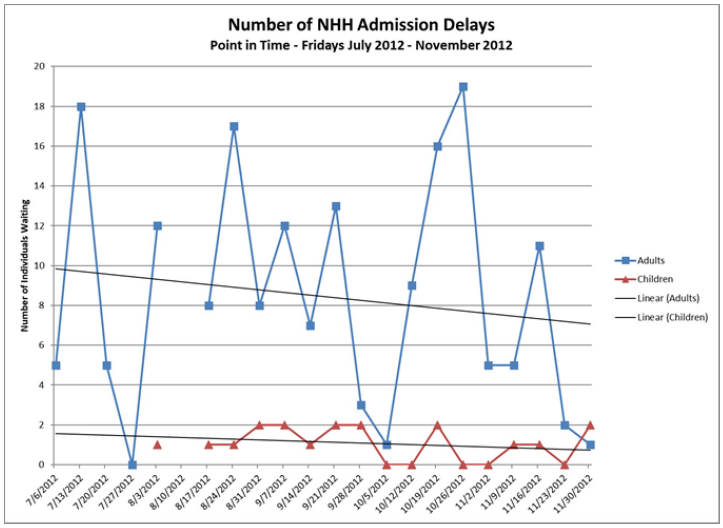
The agreement provided for the establishment and enhancement of many needed community supports and services, including supported housing, supported employment, mobile crisis response teams (in Concord, Manchester, and Nashua), and establishing Assertive Community Treatment teams (multi-disciplinary teams that provide 24/7 comprehensive support including crisis response) within each Community Mental Health Center. The agreement also appointed an independent expert reviewer who files biannual reports with the court. *See New Hampshire Community Mental Health Agreement, Expert Reviewer Report Number Twelve* (Aug. 18, 2020), *NAMI Appx*. at 117, <drcnh.org/issue-areas/mental-health/mental-health-agreement/>.

B. Emergency Department Boarding Began Around 2012

While "additional pressure on emergency departments" is mentioned in the USDOJ report, emergency department boarding was not specifically called out in the report, the original class action suit, nor in the settlement agreement. This is because until about 2012, individuals who met the criteria for Involuntary Emergency Admission (IEA) under RSA 135-C were routinely *immediately* transferred to the New Hampshire Hospital or a DRF. Thus, rarely, if ever, did individuals fail to receive a due process hearing within three business days, as specified in RSA 135-C:31.

The lack of capacity and failings of New Hampshire's community mental health system, combined with the loss of beds from the 2011 closure of the Philbrook Children's Center and resultant transfer of its child patients to the APS, created what is now an emergency department boarding crisis. Starting at that time, individuals experiencing a mental health crisis – who are examined and certified in accordance with RSA 135-C to have a likelihood of danger to themselves or others – began to be boarded in emergency departments with minimal, if any, treatment while awaiting an inpatient psychiatric bed.

When boarding first began in 2012, patients were held for a few hours in emergency departments, prior to their transfer to an inpatient setting. By the end of 2012, boarding had stretched to days, with an increasing number of people detained.



At that time, as seen in the chart above, the average daily number of adults (squares) boarded in emergency rooms was around 8, and number of children (triangles) was between one and two.

In January 2013, NAMI NH met with the governor, followed by a press conference where it was joined by others[2] to publicly explain these numbers and the nature of the crisis.

C. Number of Boarded Patients Has Increased

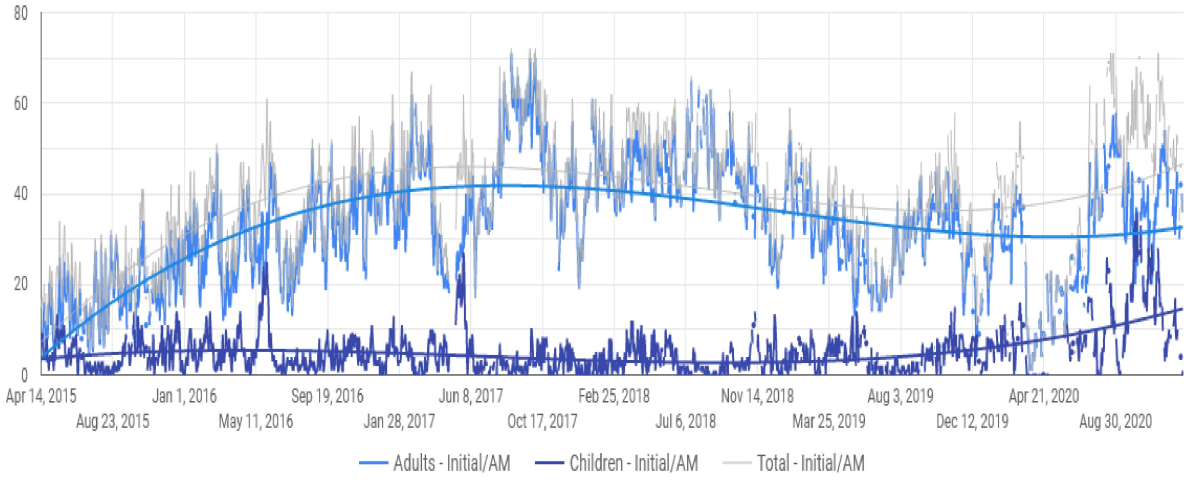
In the years that followed, the numbers climbed steadily.

Data provided by the NHDHHS, and tabulated by NAMI NH, shows cumulative daily numbers of people waiting for an inpatient bed at New Hampshire Hospital or a DRF, between April 2015 and December 2020. In the chart on the following page, the dark line represents children, gray represents adults, and the upper line is combined adults and children. Before 2020, the year 2017 was the worst boarding year with a peak of 27 children waiting on May 27, 2017 and 71 adults on August 21, 2017 (there were no children waiting that day). Sadly, 2020 exceeded those numbers, with 36 children on several days during October and into the first week of January 2021, and the number of children and adults combined exceeding the previous single day high of 71 on multiple days.

[2]Participants included: New Hampshire Community Behavioral Health Association, New Hampshire Medical Society, New Hampshire Psychiatric Society, New Hampshire Hospital Association, New Hampshire American College of Emergency Physicians, New Hampshire Suicide Prevention Council, New Hampshire National Association of Social Workers, New Hampshire Emergency Nurses Association, UNH Cooperative Extension Service, New Hampshire Alcohol and Other Drug Service Providers Association, New Hampshire Psychological Association, New Hampshire Alcohol and Drug Abuse Counselors Association, New Hampshire Association of Counties – Superintendents of Corrections, New Hampshire Sheriff's Association, New Hampshire Association of Chiefs of Police, New Hampshire Academy of Family Physicians, Granite State Federation of Families, and Monadnock Peer Support Agency.

New Hampshire Hospital Admission Waiting List Count
Compiled by NAMI New Hampshire

Apr 14, 2015 — Dec 31, 2020



Dates with the greatest number of adults waiting for beds at NHH

	Date	Adults - Ini...
1.	Aug 21, 2017	71
2.	Sep 24, 2017	70
3.	Oct 4, 2017	70

Select date ranç

Dates with the greatest number of children waiting for beds at NHH

	Date	Children - Init...
1.	Oct 8, 2020	36
2.	Oct 5, 2020	34
3.	Oct 15, 2020	33

Greatest number of adults waiting at one time for beds at NHH

71

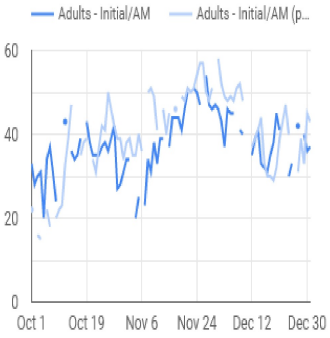
Greatest number of children waiting at one time for beds at NHH

36

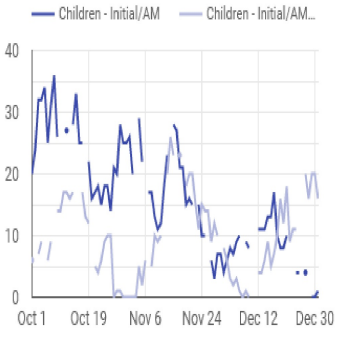
Greatest total number of individuals (adults & children) waiting at one time for beds at NHH

72

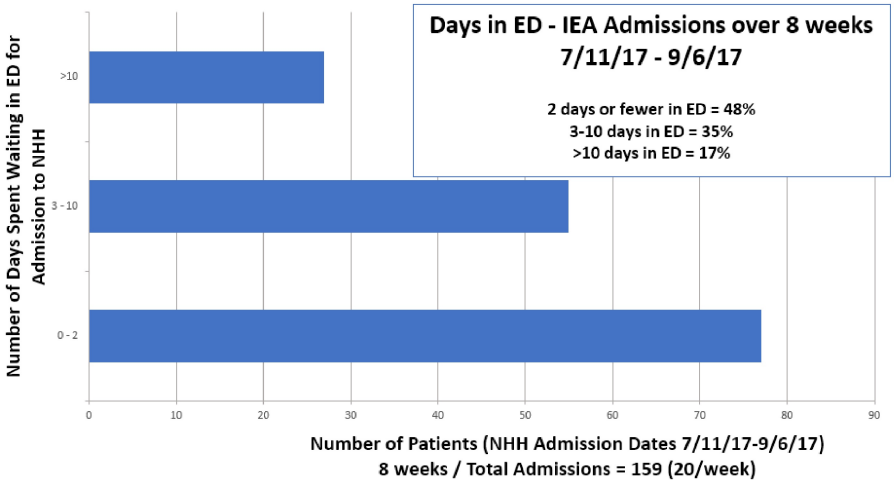
Adult daily wait list count from the most recently completed quarter compared to the prior quarter



Child daily wait list count from the most recently completed quarter compared to the prior quarter



While there is a daily DRF wait list that contains the number of people waiting, it is unclear how long they have been waiting. NAMI NH has often heard from boarded individuals or their families that at times the wait has exceeded three weeks before transfer to an appropriate mental health facility.



The only data NAMI NH is aware of, specific to wait times and durations, appears as a chart (above) compiled by New Hampshire Hospital Interim CEO Don Shumway and presented at the New Hampshire Hospital Association Annual Meeting in September 2017.

The Shumway data covered the previous eight-week period, and indicated that 52% of individuals were waiting more than three days before admission. Of those, 17% were waiting more than 10 days. The average wait was 6 days. To keep this in context, it is important to consider that, given current judicial review arrangements, however long they had waited before transfer, it would be an additional three days before receiving their due process hearing. This is a considerable amount of time to be detained without a hearing, and without adequate care and treatment.

A key piece of data specific to the issue of due process is the contrast between the number of admissions and hearings, and the number of times probable cause was found or not found. Data provided by the New Hampshire

District Court indicates that from 2013 to 2016, there were 8,323 admissions. *See* DISTRICT COURT DATA (Regarding Involuntary Emergency Admissions), *NAMI Appx*. at 212. There was no probable cause found in 389 of those, which amounts to 4.67 percent of the cases. This means that people were being detained – sometimes for weeks – when almost 5 percent of the cases were found to have no probable cause for detention.

Another significant factor in emergency department boarding, which directly impacts wait times and the data, is the "back door problem." This refers to the number of people in New Hampshire Hospital or another DRF facility who no longer meet the criteria for needing hospital levels of care, but who are unable to be discharged due to the lack of comprehensive community-based supports to allow them to successfully transition back to the community. Simply stated, delays in discharging people leads to admission delays for people in crisis. The inability to discharge people is the result of inadequate community based systems of care. There is no ongoing data which tracks the number of people ready for discharge, although it has been reported to equal the number of people being boarded.

D. Efforts to Address Delayed Due Process Hearings

Concerned by the increasing wait times and subsequent delays in due process hearings for persons boarded, an interlocutory appeal to this Court was filed in 2016 by Edwin Kelly, Administrative Judge of the New Hampshire District Court. INTERLOCUTORY TRANSFER STATEMENT, *In the Matter of TD &a.*, Conc.Dist.Ct. No. 429-2016-EA-1256, 57, 58 (Nov. 17, 2016), *NAMI Appx*. at 214. That case presented the circumstances of three individuals whose probable cause hearings had all been held on the same particular day, and for whom probable cause was found in each. Judge Kelly noted that on the day of the probable cause hearings, these individuals had been detained in emergency departments for 17, 19, and 20 days, respectively. One of them had repeatedly asked to be released. Each had numerous successive IEA certificates completed on them every three days, presumably as a way to circumvent the due process requirements and restart the RSA 135-C three-day clock. The State requested dismissal on mootness. This Court's rejection of the appeal, ORDER (declining appeal), *In the Matter of TD &a.,* Conc.Dist.Ct. No. 2016-0618 (Dec. 8, 2016), *NAMI Appx*. at 225, was a disappointment to individuals, families, providers, and advocates, who had been attempting to address the burgeoning crisis.

In 2017, the New Hampshire Senate held hearings, resulting in legislation requiring the NHDHHS to meet with key stakeholders, and develop a plan to provide timely hearings for individuals detained in hospital emergency departments while waiting for space in a DRF. The law also required NHDHHS to create a new ten year plan. 2017 LAWS § 112:3.

NHDHHS complied, with the participation of NAMI NH and other stakeholders, and proposed the development of a system of video hearings to be piloted at four hospitals. NAMI NH supported this plan as a good faith effort to meet the due process rights of individuals being detained because of a mental health crisis. NHDHHS, *Report on Involuntary Emergency Admissions* (Aug. 31,

2017), *NAMI Appx*. at 226, <www.gencourt.state.nh.us/statstudcomm/committees/72/documents/Involuntary%20Emergency%20Admission%20Plan%208.31.17.pdf>.

By November 2017, however, plans to move forward with the pilot program unraveled. Hospitals cited lack of staff, as well as security and liability concerns as rationale. In December 2017, NHDHHS issued a letter to the legislature indicating it would not further implement the plan. NHDHHS, *Supplemental Report on IEA Hearings in Non-Designated Receiving Facilities* (Dec. 21, 2017), *NAMI Appx*. at 235, <mediad.publicbroadcasting.net/p/nhpr/files/201804/report_on_iea_hearings_in_non-drfs_december_2017__2_.pdf>.

In 2018, there was a *habeas corpus* petition filed in Merrimack County Superior Court on behalf of a John Doe, and a hearing was held that afternoon. Doe had voluntarily admitted himself to an inpatient psychiatric unit. He decided to leave after becoming dissatisfied with his course of treatment, only to have the hospital file an IEA petition alleging he was a danger to himself. The hospital then filed successive IEA petitions every three days, presumably to circumvent the need for a due process hearing. After having been involuntarily held for ten days, Doe sought immediate release. The court (*Richard McNamara*, J.) issued a decision in favor of Doe, concluding that

> [A]fter 3 days, Petitioner must be released or provided the hearing provided by statue. Concord Hospital may not simply file a new Petition for IEA certificate or "renew" the pending Certificate after the initial Petition expires.

ORDER, *Doe v. Concord Hospital,* Merr.Super.Ct. No. 217-2018-CV-00448, (Aug. 9, 2018), *HHS Appx*. at 83. By the time the decision was issued, Doe had been released, mooting the case. ORDER, *Doe v. Concord Hospital,* Merr. Super.Ct. No. 217-2018-CV-00448 (Sept. 6, 2018), *NAMI Appx*. at 242.

Given these truncated proceedings, in November 2018, the New Hampshire Civil Liberties Union filed suit in the New Hampshire Federal

District Court, which resulted in an order (*Joseph DiClerico*, J.) upholding the right of detained persons in a mental health crisis to judicial review of detention within three days after the detention. ORDER, *Doe v. Comm'r, New Hampshire Dep't of Health & Human Servs*. N.H. Fed. Dist.Ct. No. CV 18-CV-1039-JD, 2020 WL 2079310 (Apr. 30, 2020), *HHS Appx*. at 73.

In 2019, after extensive stakeholder and public input, NHDHHS issued a new ten-year mental health plan. NHDHHS, *New Hampshire 10-Year Mental Health Plan* (Jan. 2019), *NAMI Appx*. at 251, <www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>. Among its goals was to "[s]tabilize and support individuals experiencing mental health crises and acute psychiatric episodes while reducing avoidable inpatient stays." The report says that

> [t]he most immediate way to reduce wait times in [emergency departments] is to enhance services that divert avoidable hospitalizations, support transitions to the community, reduce readmissions, and facilitate outflow from inpatient settings.

Id. at 29.

The plan also contained fourteen immediate recommendations. With strong bi-partisan support, in 2019 the legislature enacted a number of them, including transferring the children's Philbrook unit from the New Hampshire Hospital to Hampstead Hospital. It also mandated that NHDHHS initiate emergency rulemaking for compliance with involuntary admission requirements, following the decision on the merits in the federal *Doe* case. 2019 LAWS 41:1, et seq., SB11, *NAMI Appx*. at 307, <gencourt.state.nh.us/bill_Status/billText.aspx?sy=2019&id=1000&txtFormat=html>.

The veto and budget impasse, which continued into the fall of 2019, delayed immediate enactment of these legislative initiatives, and they were further delayed by the pandemic. Some are only now beginning to come on-line in January 2021, although NHDHHS as not yet begun the emergency rulemaking the Legislature envisaged.

E. Pandemic Has Exacerbated the Boarding Problem

The pandemic has had a further negative impact on the already significant problem of emergency department boarding. The planned transfer of the Philbrook Children's Center to Hampstead Hospital took place the week of March 20, 2020, around the same time the Governor declared a pandemic emergency. The New Hampshire Hospital immediately began taking adults being boarded in emergency departments, resulting in a waiting list of zero for a day or two. However, as the pandemic took hold in New Hampshire, it became increasingly difficult to discharge people from inpatient settings. Residential programs reduced their census to achieve social distancing, closed, or stopped taking referrals entirely. Homeless shelters also decreased their capacity. People from out of state, now working from home, began to rent or purchase property in New Hampshire, putting additional pressure on the supply of affordable housing.

Numerous reports have identified increased stress, anxiety and depression in individuals across all ages due to the pandemic. Before the pandemic, New Hampshire's Community Mental Health Centers were reporting workforce shortages with over two hundred clinical vacancies statewide. NH Community Behavioral Health Association, *New Hampshire Health Care Workforce Coalition Sign On Letter* (Jan. 31, 2019), *NAMI Appx*. at 310, <nhcbha.org/new-hampshire-health-care-workforce-coalition-sign-on-letter/>. The pandemic has exacerbated these problems.

In addition, the COVID-19 virus itself presented further complications. With emergency departments serving as one of the front lines for treating COVID-infected patients, boarded individuals in mental health crises stand at high risk for being exposed. Additionally, concerns arose about the possibility that these individuals may carry COVID into inpatient settings once admitted. New Hampshire Hospital and other DRFs, which are experiencing workforce

shortages due to their staff having COVID or needing to quarantine due to exposure to COVID, have thus been forced at times to reduce their census due to workforce shortages and so they can isolate COVID-positive patients.

II. Harm Caused by Emergency Room Boarding

A. Emergency Room Boarding Harms Individuals

It is difficult to clearly assess and document the human tragedy of emergency department boarding. This tragedy is born of illegality and injustices that have occurred on a daily basis for over eight years. Conservatively estimating that there are 2,000 involuntary admissions to New Hampshire Hospital and DRFs per year, and that fifty percent of these initiated in emergency departments where patients were boarded for more than 24 hours, then the number individuals who did not receive a timely probable cause hearing would be around 8,000.

An unknown number of people who were being boarded ended up being arrested or jailed. These are individuals who entered hospital emergency departments to receive emergency mental health treatment, and whose conditions deteriorated while being boarded and subsequently became assaultive. They ended up in the criminal justice system. Two examples of this involved a patient who charged with choking a nurse in Lebanon, Valley News, *Patient Charged with Choking DHMC Nurse* (Nov. 25, 2019), <www.vnews.com/Woman-charged-with-choking-DHMC-employee-30711648>, and a patient who attacked hospital workers in Manchester. WMUR, *Hospital Workers Attacked by Patient in Manchester* (July 9, 2013), *NAMI Appx*. at 318, <www.wmur.com/article/hospital-workers-attacked-by-patient-in-manchester/5182913#>.

Some of these assaults have been serious, resulting in permanent injury and disability for hospital staff. While assaultive behavior has long been an issue for hospital staff and security, the potential for assaultive behaviors increases when people experiencing severe psychiatric symptoms are allowed to languish for days or weeks in emergency departments with worsening symptoms and little treatment.

It is also difficult to determine the stifling effect that boarding has had on those seeking help for mental health care. National estimates indicate "[n]early 60% of adults with a mental illness did not receive mental health services in the previous year." NAMI, *Mental Health Facts in America*, *NAMI Appx*. at 322, <www.nami.org/nami/media/nami-media/infographics/generalmhfacts.pdf>.

Obviously, complex factors contribute to this. While media coverage of emergency department boarding has been important in building awareness and consensus to address this public health issue, it has likely resulted in people who need help for a mental health crisis not seeking care. NAMI NH has received posts to its social media from individuals who have been boarded, indicating they will never go to an emergency room again, and others indicating they would rather go to jail or die by suicide than be boarded again. A recent comment from a family member to NAMI NH's twice weekly posts regarding emergency department boarding stated, "My son was discharged for no beds and committed suicide 2 days after they kicked him out. … We need more help for the youth with mental [illness]."

Perhaps the best descriptions of emergency department boarding come from people who have experienced it themselves. A hand-written note by one women who was boarded for 20 days – in crayon because it was the only writing tool allowed – described her experience as follows: "This place is pure hell, degrading, condescending, soul busting, treats mentally ill like children with no dignity at all, punitive – if you don't do what we say we will put you in solitary + take away your phone, food, etc., in lock-down you have to have 2 people + there is rarely if ever 2 staff, no water, no food, no fun." NHPR, *Woman Detained In Hospital For Weeks Joins Lawsuit Against New Hampshire* (Oct. 22, 2019), *NAMI Appx*. at 323, <npr.org/2019/10/22/771854639/woman-detained-in-hospital-for-weeks-joins-lawsuit-against-new-hampshire>.

Another example comes from former long time Concord Monitor Journalist Anne Marie Timmins, who in 2013 courageously and publicly described her own experience with being boarded in the Concord Hospital Emergency Department. She noted that had she not had private insurance, she likely would have been there much longer.

> Those 13 hours, I believe, worsened my condition.… And Yellow Pod is considered a model when compared with the waiting space in other emergency rooms across the state. … There was no bed, only a hard rubber chair. The door was locked. I couldn't see the nurse's station. The noise of the TV, which was behind Plexiglas was so distressing, my husband asked it be turned off. I don't think there was a bathroom. There was no food or water easily available.… That night, it got worse before it got better. And I regretted being honest about needing help.

WBUR, *A N.H. Reporter Chronicles Her Own Mental Health Struggles* (Apr. 5, 2013), *NAMI Appx*. at 329, <www.wbur.org/hereandnow/2013/04/05/mental-health-new-hampshire>.

Emergency Department Boarding is also extremely distressing for family members, who see their loved ones suffering and their mental status deteriorating due to lack of treatment. They report being infuriated by the inhumane conditions, and helpless to do anything while their loved ones wait days and sometimes weeks, not knowing when their loved one will be chosen to fill the next vacancy at New Hampshire Hospital or a DRF.

B. Emergency Room Boarding Violates Medical Ethics

Emergency room boarding is ethically wrong because the standard of medical care is to "do no harm." Boarding, however, puts hospitals, mental health centers, and their staff, in the untenable position of failing to meet standards of care for patients.

Patients are often held in windowless rooms, denied access to cell phone communications, and left alone with their thoughts, for long periods of time. Others are held on gurneys in hallways. This results in withholding effective treatment and therapy that can alleviate suffering and distressing symptoms, including psychosis, severe mood disturbance, or anxiety and suicidal thoughts. Research, common sense, and experience dictate that the sooner an individual in an acute mental health crisis receives treatment, the better both short and long-term outcomes will be. Delays in treatment decrease not only the time for someone to recover but also the opportunity for maximum response.

Holding people in emergency departments, where they are unable to access critical treatment, as many individuals have described to NAMI NH, is traumatizing. Boarding, and failing to effectively treat a mental health crisis has resulted in numerous incidents of aggressive behavior, causing serious injuries to providers, and sometimes patients themselves, and in some cases has resulted in the patient being arrested for assault.

Because emergency departments are high stimulation environments. They are inherently unsafe places for people who may have high levels of impulsivity or impaired judgment, and who have just been certified as posing a likelihood of danger to themselves or others.

Boarding also increases the potential of emergency staff liability for detaining people against their will under questionable authority, and consumes resources that may delay treatment for other people in need of emergency care for their acute medical conditions.

C. Emergency Room Boarding is Morally Wrong

Individuals in New Hampshire who are experiencing a mental health crisis should be afforded the same type of patient centered treatment as someone experiencing a physical health crisis, but are not. Hospitals, emergency departments, health insurance companies, and other key care providers do not categorically delay other essential treatments – such as for cancer, heart disease, stroke or any other life threatening non-mental health illness.

The practice of holding individuals in emergency rooms is neither evidence based nor humane. And while it is morally wrong to do this to any person in a health crisis, it is unconscionable that we do this to children in a mental health crisis.

While hospitals and health care systems in New Hampshire provide capacity to meet all other serious medical conditions, a hold over from the days of asylums and institutionalization is the presumption that care of people with serious mental illness should be segregated from all other health care, and that responsibility for people with serious mental illness rests almost exclusively with the State. Despite the crisis in mental health care during the last decade, however, hospitals in New Hampshire have made minimal efforts to increase capacity for people in mental health crises, and some have closed or reduced capacity.

D. Emergency Room Boarding is Economically Inefficient

Emergency room boarding is economically inefficient because other than intensive care units, emergency departments are the costliest of all hospital services. Up until 2019, care for an person in a mental health crisis held in an emergency department (other than the initial evaluation) was uncompensated, as there were no official codes which would allow hospitals to bill for "boarding," or stays in an emergency department longer than a few hours. This

has forced hospitals to raise rates for other services to recover these costs.

Additionally, increased use of law enforcement, and diverting people with mental illness to the criminal justice system when an emergency department cannot handle an aggressive patient, shifts costs to counties and municipalities.

E. Emergency Room Boarding is Unlawful

Finally, as will be fully explained by other parties, NAMI NH believes that emergency department boarding violates the law.

Holding individuals who meet the criteria for involuntary admission violates RSA 135-C:29, which requires that "[u]pon completion of an involuntary emergency admission certificate, … a law enforcement officer *shall* … *immediately* deliver such person to the receiving facility identified in the certificate." *Id.* (emphasis added).

In addition, successive IEAs on three-day intervals, as a way to avoid due process hearings, violates RSA 135-C:31, which requires that "[w]ithin 3 days after an involuntary emergency admission … there shall be a probable cause hearing in the district court … to determine if there was probable cause for involuntary emergency admission."

CONCLUSION & REMEDY

From the outset of this crisis, and in personal conversations, NAMI NH's Executive Director and Board Members have met with two successive Governors, three Attorney Generals, and three Commissioners of the Department of Health and Human Services, to urge an immediate end to this practice. NAMI NH's position on these issues has remained unchanged.

First and foremost, people who are in a mental health crisis and meet the criteria of posing a likelihood of danger to themselves or others, as described in RSA 135-C, should have *immediate* access to inpatient psychiatric care and treatment. It would be hard for anyone to argue that the legislative intent of RSA 135-C differs from that.

The factors that have led to emergency department boarding in New Hampshire and across the country are complex and include a long history of well documented discrimination toward people with serious mental illness, including discrimination in insurance coverage, reimbursement rates, housing, and adequate systems of care. The pendulum swing from the late 1950s of unnecessarily hospitalizing hundreds of people for long periods of time has now swung so far the other way that people who have been evaluated, and been determined to be a danger to themselves or others, are unable to get a timely inpatient admission. Recently, on the afternoon of January 17, 2021, New Hampshire set a new record high of eighty four individuals – fifty nine adults and twenty five children – being boarded in emergency departments, plus two waiting in jail. Many of these people will be waiting weeks for an admission.

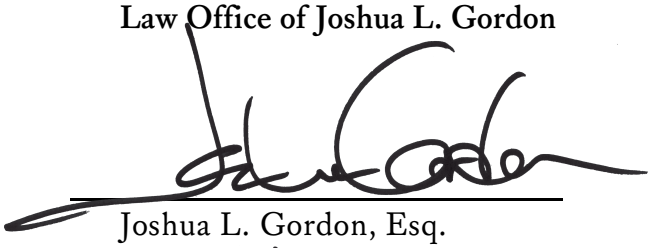
NAMI NH is not aware of any situation in our legal system, as a state or nationally, where civilly detained individuals can be detained against their will for weeks without some type of due process hearing. Briefs before this Court will amplify in great detail the statutory framework established for treatment of people with mental illness whose condition warrants their involuntary detention

because they are found to be a danger to themselves or to others. A fair reading of the relevant statutes suggest that the legislature has expressed its intent that a patient held in involuntary custody for that reason is indeed entitled within three days to a judicial review of that finding. The statutes also contemplate that a patient subject to such a finding will immediately be transferred to a center providing expert psychiatric care, a "Designated Receiving Facility," and that judicial review of the finding supporting the detention, accompanied by standard due process safeguards, will be held within three days of the time the patient arrives at that facility. It is up to this Court to recognize and rectify this grave injustice.

NAMI NH asks this Court to confirm a proposition that we believe is self-evident: that RSA 135-C:31 requires that a patient involuntarily held in custody is entitled to a judicial hearing, with due process safeguards specified by the statute, of the finding on the basis of which s/he is detained. NAMI NH also respectfully cautions the Court that it would not be in the public interest to force release of patients who are, in fact, a danger to themselves or to others. Any relief provided by this Court should be prospective, so that those bound by the Court's order will have adequate time to assure that dangerous patients are not released on a technicality.

Respectfully submitted,

NAMI NH
By its Attorney,
Law Office of Joshua L. Gordon



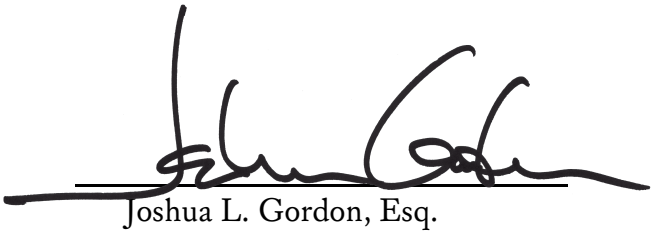
Dated: January 31, 2021

Joshua L. Gordon, Esq.
Law Office of Joshua L. Gordon
(603) 226-4225 www.AppealsLawyer.net
75 South Main St. #7
Concord, NH 03301
NH Bar ID No. 9046

CERTIFICATIONS

I hereby certify that this brief contains no more than 9,500 words, exclusive of those portions which are exempted.

I further certify that on January 31, 2021, copies of the foregoing is being forwarded to Gary N. Apfel, Esq.; and to Anthony J. Galdieri, Esq., Office of the Attorney General.



Dated: January 31, 2021

Joshua L. Gordon, Esq.