

# NEW HAMPSHIRE MENTAL HEALTH SENTINEL EVENT REVIEW

REPORT  
January 2014



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The staff at the Department of Justice for copying and mailing surveys, and for collating this report.

## Introduction

On November 4, 2013, Governor Hassan created the sentinel review team to consider certain specific issues in the context of two events that occurred at the Elliot Hospital, and the experience of other facilities with patients awaiting care in hospital emergency departments (EDs). Our review was conducted consistent with the DHHS sentinel event policy\* and in response to Commissioner Toumpas's similar request.

In her directive to us, the governor posed a series of questions, concluding with "What action steps are necessary to minimize risk of harm to patients and staff at all of New Hampshire's health care facilities?"

It was not the team's task to conduct criminal or civil investigations, or to determine responsibility for any sentinel events. Nor did we consider litigation in which the state is involved dealing with mental health issues. Our responsibility was to gather information upon which to base responses to the governor's broad concerns and to seek answers to the questions she posed. In the process, we learned that the components of our mental health system are interwoven into an intricate mosaic.

While the reasons for a single event or for the increasing need for mental health services in New Hampshire are diverse and many, we found near universal agreement as to their contributing causes. Not surprisingly, a lack of public and private resources topped the list, along with increased substance abuse, a serious economic downturn, unemployment, and our general approach to treatment of the mentally ill.

Because the professionals are in general agreement about the causes of the current mental health crisis and much of what should be done to address it, answering Governor Hassan's questions may not have been as difficult as it will be to implement public and private policies needed to respond to them.

The information we received from hospital and mental health professionals gave us a picture of a mental health care system in serious decline. Yet, there was optimism among those with whom we talked that people of high motivation and firm determination could achieve the necessary changes everyone hopes will come.

We share that enthusiasm.

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\*While this report is public, **Policy Number:** DHHS Policy: PR 10-01, **VIII E. Confidentiality**, provides: **Pursuant to RSA 126-A:4, IV, any and all records of or prepared solely for the Sentinel Event Review shall be confidential.**

## Sentinel Events

A Sentinel Event is defined by DHHS Policy: PR 10-01, **III Definitions:**

“Sentinel event” means an unexpected occurrence involving the death or serious physical or psychological injury, or risk thereof, signaling the need for immediate investigation and response, or other serious event including, but not limited to the following:

1. An unanticipated death or permanent loss of function, not related to the natural course of an individual’s illness or underlying condition, resulting from such causes including, but not limited to, a medication error, an unauthorized departure or abduction from a facility providing care, or a delay or failure to provide services.
2. Homicide or suicide.
3. Sexual assault or rape.
4. Abuse resulting in physical harm or mental anguish that seriously jeopardizes a person’s health.
5. Neglect as a result of the failure to provide the services necessary to avoid physical or psychological injury that seriously jeopardizes a person’s health.
6. High profile events which may involve media coverage and/or police involvement.

According to a February 2013 report of the Foundation for Healthy Communities, in 2012 the acute care hospitals in New Hampshire with emergency departments (EDs) collected several data elements regarding people who were medically cleared in the (ED) but in need of an in-patient psychiatric admission. Fifteen hospitals submitted data, for a minimum of 8 weeks, during the last quarter of 2012.

Nearly 1 out of 3 people waited more than 24 hours in a hospital (ED) for mental health treatment. The average waiting time was 2.5 days among this group of patients.

More than half of all patients recommended for an Involuntary Emergency Admission for psychiatric care waited more than 24 hours in a hospital ED.

The primary diagnosis for more than 1 out of 5 patients was reported as suicidal and about one third reported major depression.

More than 3 out of 4 patients required constant observation while waiting in the ED and almost half of the patients required special security.

New Hampshire Hospital in Concord was the single most frequently identified destination following a visit to an emergency department among patients studied.

In 2012 there were one hundred and ninety six reported sentinel events at New Hampshire acute care facilities.

In 2013 there were two hundred and twenty-eight reported sentinel events.

Twenty-one of those events occurred during the month of July. One such event occurred at the Elliott Hospital on Monday, July 8, 2013 when Ansel Kinglocke, who had been held in the emergency department for three days over the July 4<sup>th</sup> weekend, waiting to be involuntarily admitted to the New Hampshire Hospital, attacked two hospital employees. The first employee had been assigned to watch him and another patient. Kinglocke stole that employee's key card, then attacked a nurse who came to check on the commotion. Both Elliott employees suffered critical injuries. Kinglocke is said to have been cooperative until the attack.

During the month of October there were eighteen reported sentinel events. One occurred at the Elliott Hospital on October 16, 2013. Fernando Ornelas, waiting to be admitted involuntarily to the New Hampshire Hospital, became agitated, disrupted other patients and began punching a security officer in the head as the officer walked him back to his room. The officer then exchanged punches with Ornelas in an effort to restrain him. Along with the help of at least two security guards and a Manchester police officer, the security officer eventually subdued Ornelas using pepper spray.

The representatives of nearly every hospital with whom we met described similar events or close calls. Some were considered serious enough to report, others were not.

As one survey responder noted, "Simply stated, patients requiring involuntary emergency admission represent a risk to staff and other patients when they are forced to board in an emergency room....There must be additional capacity, whether arrived at by adding beds or increasing efficiency, or creating satellite campuses of NH Hospital to treat patients closer to the communities to which they are connected."

## Some Lessons Learned from the Elliott Events and Experiences of other Emergency Departments

- Rooms in emergency departments are most suitable for short visits.
- There are insufficient psychiatric care rooms in most hospitals to serve the needs of the seriously mentally ill, whether there voluntarily or involuntarily.
- Psychiatric patients in our state wait too long in emergency departments to receive the care they need.
- Because emergency departments serve people with every type of health issue, they are not well equipped to handle patients who become violent.
- Not every member of the staff in emergency departments is trained to deal with mentally ill patients.
- Predicting the risk of unexpected violent outbursts in all mentally ill patients is not possible.
- An increasing problem of acute substance abuse co-occurring with mental illness adds to the difficulty of providing appropriate treatment to patients.
- The medical response to mental illness is much different from the response to other health problems such as chest pain, sprains or pneumonia.
- The process of patient discharge from psychiatric inpatient units back into the community may be lengthy and may take weeks to accomplish.
- Medicaid requires patients to see a psychiatrist or psychiatric nurse practitioner, and at some community mental health centers that process takes months to occur.
- Hospitals find mental health care is not economically viable because of the relatively low economic status and lack of insurance of patients arriving at emergency departments.
- If there are no emergency department procedures in place to stabilize the mentally ill patient promptly, the risk of an unexpected violent event increases while the patient waits to be transferred to a voluntary or involuntary psychiatric hospital unit.

## Governor Hassan's Concerns

### 1. What Acuity of Patients Can and Should be Treated in the State's Continuum of Mental Health Facilities, Including Community Based Services, The Cypress Center, Designated Receiving Facilities, and New Hampshire Hospital?

The acuity of a person's psychiatric symptoms, along with the likelihood of being a potential danger to themselves or others as a result of mental illness, determines the appropriate level of psychiatric intervention. Individuals presenting with significant psychiatric symptoms and capable of maintaining their safety can be managed in an outpatient community setting, as long as assessment and treatment is provided promptly.

Rapid access of patients to their treating clinician frequently addresses clinical issues without needing more rigorous intervention. More emergent situations can be handled by local Assertive Community Treatment (ACT) teams, with possible short-term admission to a local Acute Psychiatric Residential Treatment Center (APRTC) such as Cypress Center, for rapid stabilization and return home. Upon discharge from the APRTC, an appointment with the patient's primary psychiatric provider needs to be scheduled with a minimum one week wait time, to ensure effective continuity of psychiatric care.

If an emergency department visit becomes necessary, the patient's stay can be minimized with care provided by well trained staff that understands the needs of psychiatric patients in crisis, diverting a possible voluntary or involuntary inpatient admission. Clear communication between emergency department and local community mental health center emergency services staff regarding the patient's immediate clinical requirements leads to effective, patient centered decisions, hopefully averting more restrictive interventions.

An admission to a psychiatric hospital inpatient unit should be considered as a last resort, and an involuntary admission to a Designated Receiving Facility (DRF), with New Hampshire Hospital being the largest in the state, is the most restrictive intervention. Voluntary psychiatric hospital admissions are initiated for patients who desire and need a higher level of treatment and observation that outpatient services can provide.

Involuntary psychiatric admissions to a DRF are reserved for patients who are deemed a danger to themselves or to others as a result of mental illness, and who frequently have poor insight into their need for treatment. Inpatient admissions can be facilitated locally with more voluntary and DRF bed availability in the patient's community, allowing increasing family involvement in the patient's care and psychiatric treatment by clinicians who likely are knowledgeable regarding the patient's clinical and treatment history.

## 2. What is the Methodology and System for Triageing Psychiatric Emergencies to Ensure Patients are Receiving the Appropriate Level Of Care? Is the Triage System Working? Can it and Should it be Improved?

Patients presenting in crisis to emergency departments are typically brought by family, friends, or the local police. A triage nurse conducts an initial assessment of the patient's psychiatric and medical needs based on the patient's complaints. If psychiatric symptoms are the main issue, their acuity is determined based on the patient's clinical presentation, agitation, and whether they are at risk of harming themselves or others.

Some emergency departments have developed specialized psychiatric holding rooms where patients stay awaiting further assessment and disposition. The availability and quality of these specialized rooms vary, and some emergency departments do not have them. Emergency departments have sitters or security staff who stay with psychiatric patients at all times. The training these sitters and staff obtain regarding crisis intervention techniques vary between institutions.

The great majority of emergency departments contract with the local community mental health center (CMHC) emergency services clinicians to conduct psychiatric assessments of patients in psychiatric crisis. These CMHC clinicians determine what level of psychiatric intervention is most appropriate, based on the patient's clinical presentation. For instance, whether to send the patient home, to set up an outpatient appointment, to admit to a voluntary psychiatric bed, or to admit to a DRF, based upon the patient's clinical presentation.

Communication between the emergency department and CMHC staff varies, mostly due to the existing relationship between the hospital and the local CMHC. Emergency department clinicians have differing levels of comfort in treating psychiatric patients in crisis; access to psychiatrists for consultation varies regionally.

While the triage process has generally worked for the majority of psychiatric patients, there are differences in the overall treatment patients get, depending on the emergency department that receives them. This is based on how the emergency department is set up to care for psychiatric patients; the effectiveness of the training the emergency department and hospital security staff obtain in treating and interacting with psychiatric patients; the communication and institutional relationship that exists between the hospital and the CMHC; and availability of aftercare options for psychiatric patients.

### 3. Are Patients who Experience Acute Psychiatric Distress at Hospital Emergency Rooms Usually Receiving Treatment in the Community?

The percentage of patients arriving at hospitals who are, or have been treated in the community before admission to emergency departments varies greatly from hospital to hospital.

Community treatment and resources available to the mentally ill going to hospital emergency departments for care usually depend upon where the hospital is located. For example, facilities located in tourist areas assess and treat many itinerant patients, with consequent limited information on their past treatment history.

One of the small critical access hospitals in a “rurally isolated medically underserved area,” found the use of video conferencing worked for some psychiatric patients but not for all.

All hospitals report that when acute episodes occur, outpatient case workers bring individuals to hospital emergency departments because it has become increasingly more difficult to get patients into community outpatient treatment, and then, too often not in time to prevent an acute psychiatric episode.

Comments from hospital and community representatives were diverse. One rural Critical Access Hospital representative responding to the survey noted, “Primary care practitioners are burdened to attempt to manage many of these patients – often far beyond their training skills and comfort zone,” and another one replied, “The majority of our patients are non-compliant with their treatment plans or lack the resources for continued out-patient care.”

#### 4. What Environmental/Clinical Circumstances are Leading to the Rise In the Number of Patients Experiencing Acute Psychiatric Distress In the Emergency Room?

The increasing number of mentally ill seeking services in emergency departments makes it difficult for hospitals to accommodate the number of medical patients they are able to serve, and significantly affects the environment within the emergency departments. Treating those suffering from emergent medical conditions results in the acutely mentally ill being kept in rooms for long periods of time, sometimes with only minimal treatment. Longer patient emergency room hospital stays further exacerbate conditions within emergency departments.

Another significant contributing factor is that many mentally ill patients brought to hospital emergency rooms are sicker and untreated as a result of a co-occurring substance abuse issue. Patients frequently have no place to go for assessment and treatment of their addiction due to either nonexistent or limited access to detoxification or substance abuse rehabilitation facilities. Co-occurring substance abuse tends to exacerbate the symptoms of mental illness and make it more difficult for hospital emergency departments to address.

In addition, transfer to the NHH cannot occur until the patient is medically detoxified because NHH is not staffed or equipped to address the medical complications that may develop with licit or illicit substance withdrawal.

Most with whom we met believe there is a correlation between the increased use of emergency rooms and the down-turn in the economy. They see the increasing number of psychiatric emergency department visits corresponding with the nation's 2008 economic crisis. Many felt that the loss of jobs, shortage of housing, lack of insurance, erosion of the family unit, and financial instability contribute to the increased use of emergency rooms, especially among those suffering from mental illness.

The lack of safe, affordable and adequate housing for the mentally ill is a significant environmental circumstance also contributing to acute psychiatric distress. Homelessness is troublesome and has been a chronic and difficult societal issue.

There is a frequent disconnect between the hospitals, the regional mental health centers and other community based providers. Making matters worse has been the elimination of liaison positions between NHH and the CMHCs, potentially leading to longer periods of hospitalization.

There is also a shortage of beds for treatment of the mentally ill. The total number of in-patient psychiatric beds in New Hampshire decreased 27% from 526 beds in 2005 to 384 beds in 2013.

The general lack of a comprehensive range of mental health services to meet the needs of our mentally ill citizens.

## 5. What Level of Training is Provided to Emergency Room Staff Regarding Treatment of Acute Psychiatric Distress, Including Management of their Behavioral Manifestations?

Hospital emergency department personnel mainly include doctors and other health care providers, nurses, social workers, and security staff. Hospitals also hire former police and correctional officers to fill security positions in EDs when needed.

It is not unusual for acutely mentally ill patients to exhibit severe and aggressive behavior. Sometimes that behavior appears random and, at other times, it is a logical extension of their present condition. In either case, it is critical that all hospital staff be adequately trained to anticipate this behavior and to minimize the risk of harm to patients and staff alike.

Not all hospitals recognize the same need for additional specialized training in addressing the needs of the mentally ill. For those who do, their focus is often upon training security staff and not clinicians.

Training programs such as the Management of Aggressive Behavior (MOAB) are common but not universal. Some hospitals train their security staff in other forms of non-violent intervention and de-escalation. A few hospitals extend this training to their nursing staff. Non-violent training programs like MOAB are well established but may benefit from review and reevaluation. Clearly, specialized training can provide tools to reduce the risk of escalation and the potential for injury to patients and staff.

Just training security staff in methods of non-violent intervention, however, is not enough. Clinical staff should also be trained in the diagnosis and treatment of mental illness. While a psychiatrist on staff twenty-four hours a day, seven days a week may not be necessary in every hospital, emergency room staff, medical doctors, nurses and other clinicians alike should be trained to recognize the symptoms of mental illness and to competently assess and treat patient's immediate psychiatric needs.

A comprehensive approach to providing a full spectrum of emergency department training for staff and first responders should help significantly reduce violence and the potential for harm to everyone involved.

## 6. Why Has the Waiting Time for Transfers to the Appropriate Level of Care Increased?

The comments of one hospital chief operating officer summarize the general observations of other hospital and mental health center representatives.

A number of State fiscal and program policy decisions combined with Legislative actions, changes in State demographics and demand patterns, shifts in health care trends and changes in how behavioral health services are organized and provided have had a combined impact that has significantly contributed to the current behavioral health crisis in NH Hospital emergency rooms. Demand for services has grown, the original plan to develop regional inpatient treatment capacity was never implemented and available community based group home and hospital beds have diminished. Funding cuts and inadequate Medicaid rates in the face of inflationary cost increases, increased demand for treatment and reduced group home and psychiatric beds have resulted in a system that is saturated and unable to function as intended.

Demand for services has grown at the same time available treatment options have been reduced, leaving emergency departments the only alternative for a growing number of patients in need of acute psychiatric care.

Without available, needed community treatment, more patients are becoming sicker before being seen by a clinician.

Lack of personal and community resources result in patients going back to the streets, often returning to emergency departments in a worsened psychiatric condition.

There is a shortage of psychiatrists in New Hampshire.

There is a general concern that psychiatrists do not receive compensation for consultations with primary care providers.

Costs of care and insurance have increased, making private in-patient treatment at available facilities out of reach of those most in need. With the downturn in the economy, more and more people have lost insurance coverage, or have limited finances to pay for treatment or medications.

Increasing lengths of stays of patients at the New Hampshire Hospital because of limited community resources and/or legal issues contribute to longer delays in admitting mentally ill patients to New Hampshire Hospital from hospital emergency departments.

## 7. What Action Steps are Necessary to Minimize Risk of Harm To Patients and Staff at Health Care Facilities?

To minimize risk of harm to patients and staff at health care facilities, there are some immediate, short range and long range action steps to consider that also address what many have called a mental health crisis. They involve seeking ways to:

1. Enhance community based psychiatric care available to mentally ill individuals, offsetting potential future emergency department visits.
2. Expand community based treatment following discharge from facilities.
3. Reduce time spent by psychiatric patients in emergency departments.
4. Improve communication, cooperation and exchange of ideas among facilities and community mental health centers.
5. Provide more voluntary and designated receiving facility beds for psychiatric patients requiring in-patient care.
6. Encourage the private sector to share responsibility for change.
7. Encourage business, industry, and communities to provide financial support to improve mental health services for our citizens.
8. Provide the state and private resources required to fully treat the mentally ill.
9. Procure reasonable federal reimbursement for mental health services.
10. Remove some burdensome federal restrictions relating to psychiatric care provided by psychiatric advanced practice registered nurses.
11. Improve coordination of discharge planning between hospitals and community mental health centers.
12. Review emergency department security training and procedures to determine whether the programs and techniques currently in use are effective.
13. Accept the idea, as one professional noted that, "A healthy population enables growth, productivity, and helps create an economic environment that will sustain New Hampshire's future wellbeing."

## **A. IMMEDIATE ACTION**

1. Ask each hospital to develop a plan to expand the number of beds, based upon their particular need, which are dedicated to Designated Receiving Facilities, and/or voluntary use for acute treatment of psychiatric patients who come to Emergency Departments.
2. Ask hospitals to establish a telephonic or web based Cooperative Call Center for the central assignment of critical patients to available beds statewide when none are available at the New Hampshire Hospital or other DRF. The hospitals would share the management and cost of such a center. The system would provide for fair and equal distribution of patients to each hospital, on a case by case basis, that takes into consideration geography and other agreed upon criteria.
3. Ask for a new interpretation of, or waiver from, the Medicaid rules that prohibit or restrict psychiatric APRN care, deleting the mandate that all psychiatric treatment plans be approved only by a psychiatrist, thus allowing psychiatric APRN's the ability to develop and implement psychiatric treatment plans independently.
4. Find ways for Medicaid to provide reimbursement for psychiatric care on the same basis as that of Medicare.
5. Explore ways to reduce the time per client that prescribing clinicians spend seeking authorizations for psychiatric medications.
6. Recognize and address the lack of crisis options for children and adolescents seeking psychiatric services, resulting in emergency room visits and at times unnecessary inpatient psychiatric hospitalizations.
7. Intensify education of emergency department physicians regarding treatment options for psychiatric patients they encounter, focusing on improvement of psychiatric symptoms with the goal of discharge from the emergency department rather than holding them until an inpatient admission is achieved.
8. Consider adopting uniform training standards for everyone working in emergency departments, to include all clinical and security staff dealing directly with psychiatric patients.
9. Encourage police departments to participate in the Crisis Intervention Training program, which provides instruction to police officers on effective ways to interact with the mentally ill.
10. Create uniform protocols for managing psychiatric patients in emergency rooms.
11. Review the current Involuntary Emergency Admission statute to determine ways of addressing issues regarding evaluation of patients in hospital emergency departments awaiting admission to a DRF.
12. Weigh the benefit to the delivery of mental health care that would occur with an expansion of Medicaid.

## **B. SHORT RANGE ACTION**

### Enact a Tax Exempt Trust Fund

1. Establish “The New Hampshire Mental Health Trust,” supported by public appropriation and private funding.
2. Provide for management of the trust, including how the funds will be spent, by a non-partisan, broad based, independent board.
3. Challenge business, industry, communities and the state to contribute to the Mental Health Trust Fund on a regular basis.
4. Resolve and make clear that the trust fund is not intended to supplant state appropriations for mental health care.

### Implement the Current State Budget

According to the governor, implementing the budget will expand access to acute care beds, add a new designated receiving facility, add community residence beds, provide subsidies for housing and support services, add ten Assertive Community Treatment Teams to assist people in crisis, and increase other community support services.

### Engage in Community Programming

1. Provide additional affordable community housing.
2. Allow Mental Health Centers more flexibility for supported housing programs.
3. Create more Assertive Community Treatment teams.
4. Fund a position for each community mental health center, to provide a direct liaison with New Hampshire Hospital and other hospitals having DRF beds.
5. Find ways to improve assessment and treatment for individuals with co-occurring substance abuse and mental illness.
6. Enhance vocational rehabilitation and supported employment opportunities.

## C. LONG RANGE ACTION

1. Continue to review, revise if necessary, and carry out the state's 10-year plan.
2. Rethink the value of group homes as a component of housing options for individuals with mental illness. Determine whether they can be a valuable part of a continuum of housing services available to patients as they transition to independent living. If necessary, redesign and restructure the model.
3. Find ways to treat together the co-occurring disorders of mental illness and substance abuse effectively. Recognize and understand the role each may play in violent conduct.
4. Investigate the potential to develop a statewide data system for sharing of information between New Hampshire Hospital and community mental health centers.
5. Address the absence of parity in medical and psychiatric care.
6. Encourage the hiring of more psychiatrically trained physicians to care for hospitalized patients.
7. Eliminate waiting times for patients to access mental health services upon discharge from hospitals.
8. Consider ways to cut the length of stays at New Hampshire Hospital and to use resources in the community to help keep patients in their homes.
9. Develop and fund day treatment centers and Partial Hospitalization Programs.
10. Open more statewide Acute Psychiatric Residential Treatment Centers such as the Cypress Center in Manchester.
11. Consider the viability and effectiveness of video conferencing for some psychiatric patients.
12. Promote better public understanding and education about mental disease.

As one professional put it:

We need to bring mental disease out from the shadows and into the light of day for us to realize that some of our citizens have real need, a need that they wish they did not have.

## Conclusion

As with all critical situations, it is not one decision, cut or policy shift that creates turmoil in a system. It is evident that there have been many individual occurrences over the years that have gradually abraded the inpatient, residential and community based services in our behavioral health care system. Difficult economic times have given leadership poor choices in provision of services for people with mental illness. Short term cuts in services of this magnitude have an eventual cost to all citizens of our State, and with emergency departments providing the last resort of care to so many, the time for payment is now.

A survey response of one hospital chief operating officer.

The ultimate goal of any action should be to design a system that is effective in providing timely and needed psychiatric services in the patient's community, minimizing the need for costly inpatient stays that frequently are distant from the patient's home. Rapid access of patients to their treating clinician locally can mitigate the need for more intensive intervention. More emergent situations may be handled by local ACT teams, with possible short-term admission to local Acute Psychiatric Residential Treatment Centers for rapid stabilization and prompt return home.

Supported stable housing that is affordable, group home options, and sustainable employment can all lead to improved stability in the patient's day-to-day existence, with increasing self-sufficiency, adherence to treatment, and overall improvement in mental and physical health.

If an emergency room visit is necessary, the stay may be minimized with care provided by well trained staff that understands the needs of psychiatric patients in crisis, diverting a possible voluntary or involuntary inpatient admission. Inpatient admissions can be facilitated locally with more voluntary and DRF beds in the patient's community, allowing for increased family involvement in the patient's care.

It is clear that the mental health problems our state faces cannot be ignored or minimized without grave consequences. They must be confronted and changes made. Continuing to pursue policies of the past will not accomplish the task.

The demand upon public and private resources is great, and will continue. We must, nevertheless, demonstrate the commitment and determination to effectively care for our mentally ill citizens, and in the process we can go a long way to relieve the strain on hospital emergency departments

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## Appendix

### Office of New Hampshire Governor Maggie Hassan

For Immediate Release:  
Monday, November 4, 2013

Governor Hassan Launches Review of  
Mental Health Services in Manchester

*Team Led by Supreme Court Justice Nadeau to Review Incidents  
at Elliot Hospital, Triaging of Patients for Mental Health Services*

CONCORD – Governor Maggie Hassan announced today that she has asked former Supreme Court Justice Joseph Nadeau to lead a Sentinel Event Review team to address concerns raised by recent incidents in Manchester involving patients with acute mental illness, as well as the ongoing strains caused by mental health patients awaiting care in emergency rooms.

Justice Nadeau, who currently chairs the state’s Board of Mental Health Practice, will lead the review with the support of Dr. Alexander P. de Nesnera, from the Geisel School of Medicine and the Associate Medical Director of the New Hampshire Hospital, and Senior Assistant Attorney General Michael Brown.

“New Hampshire is moving ahead with implementing the state’s 10-year mental health plan in an effort to address one of our most pressing public health challenges: the need to restore our mental health system,” Governor Hassan said. “The Department recently opened new beds at the State Hospital and opened a designated receiving facility (DRF) in Franklin, NH. It is also working to expand Assertive Community Treatment Teams throughout the state, making more emergency services beds available and expanding community mental health services.

“However, even some of these changes do not appear to be alleviating the wait for beds or the crisis in our emergency rooms. The recent incidents involving patients at the Elliot Health System raise serious concerns and questions about how we are using our existing mental health beds and resources,” Gov. Hassan said.

The review team will look at the individual incidents at Elliot Hospital as well as the broader questions raised by the incidents, such as which resources (i.e. community treatment, designated receiving facility beds, State Hospital beds) are being used for varying levels of acuity, how psychiatric emergencies are triaged, what level of training is provided to staff of local hospital emergency rooms regarding treatment of acute psychiatric distress, and what steps are necessary to minimize the risk of harm to patients and staff.

“We can all agree that our mental health system is deeply strained,” Governor Hassan said. “We recognize that we will not address all of our challenges at once, and that the significant investment we are making in this biennium is the beginning of the process. But we must continually address and consider what is happening on the ground in our communities, and this review will be an important step in those efforts.”

Governor Hassan sent a letter to Health and Human Services Commissioner Nicholas Toumpas confirming the planned review. The Governor’s full letter can be found below:

Dear Commissioner Toumpas:

We share a concern for the care and treatment of our New Hampshire citizens suffering from acute mental illness. New Hampshire is moving ahead with implementing the state's 10-year mental health plan in an effort to address one of our most pressing public health challenges: the need to restore our mental health system. The safety of the public and the health and well-being of individual citizens depend upon our efforts, as well as the efforts of our mental health professionals.

The Department recently opened new beds at the State Hospital and opened a designated receiving facility (DRF) in Franklin, NH. It is also working to expand Assertive Community Treatment Teams throughout the state, making more emergency services beds available and expanding community mental health services. However, even these changes do not appear to be alleviating the wait for beds or the crisis in our emergency rooms.

The recent incidents involving patients at the Elliot Health System raise serious concerns and questions about how we are using our existing mental health beds and resources.

To help review these questions, I have asked former Supreme Court Justice Joseph Nadeau to lead a Sentinel Event Review team that will look at both these individual incidents, but also the broader questions they raise. Justice Nadeau will be supported in this effort by Dr. Alexander P. de Nesnera, from the Geisel School of Medicine and the Associate Medical Director of the New Hampshire Hospital, and Senior Assistant Attorney General Michael Brown.

I am directing the review team to consider the following issues concerning both the patient incidents at the Elliot DRF and the patients awaiting care in other emergency rooms:

- 1) What acuity of patients can and should be treated in the state's continuum of mental health facilities, including community-based services, the Cypress Center, Designated Receiving Facilities, and New Hampshire Hospital?
- 2) What is our methodology and system for triaging psychiatric emergencies to ensure patients are receiving the appropriate level of care? Is the triage system working? Can it and should it be improved?
- 3) Are any of the patients who are experiencing acute psychiatric distress at local hospital emergency rooms currently receiving treatment in the community?
- 4) What environmental/clinical circumstances are leading to the rise in the number of patients experiencing acute psychiatric distress in our emergency rooms?
- 5) What level of training is provided to staff of local hospital emergency rooms regarding treatment of acute psychiatric distress, including management of the range of behavioral manifestations that such patients can exhibit?
- 6) Why has the waiting time for transfers to appropriate level of care increased?
- 7) What action steps are necessary to minimize risk of harm to patients and staff at all of New Hampshire's health care facilities?

We can all agree that our mental health system is deeply strained. We recognize that we will not address all of our challenges at once, and that the significant investment we are making in this biennium is the beginning of the process. But we must continually address and consider what is happening on the ground in our communities, and this review will be an important step in those efforts.



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Dear Judge Nadeau, Dr. de Nesnera, Attorney Brown and Assistant Director Langley:

Pursuant to RSA 126-A: 4, IV and the Department of Health and Human Services' Sentinel Event Policy, 10-01, eff. September 2010, with this letter I am appointing Judge Nadeau, Dr. de Nesnera and Attorney Brown as a Sentinel Event Review Team to review the events that occurred at Elliot Hospital. One event involved Angel Kinglocke on July 8, 2013, and the other involved Fern Ornelas on October 15, 2013. I am also appointing Assistant Director Diane Langley as the Sentinel Team Liaison and Consultant.

Governor Hassan has recommended that I empanel a review team to consider the following issues as they relate to both the patient incidents and other patients awaiting care in other emergency rooms:

- 1) What acuity of patients can and should be treated in the State's continuum of mental health facilities, including community-based services, the Cypress Center, Designated Receiving Facilities and New Hampshire Hospital?
- 2) What is our methodology and system for triaging psychiatric emergencies to ensure patients are receiving the appropriate level of care? Is the triage system working? Can it and should it be improved?
- 3) Are any of the patients who are experiencing acute psychiatric distress at local hospital emergency rooms currently receiving treatment in the community?
- 4) What environmental/clinical circumstances are leading to the rise in the number of patients experiencing acute psychiatric distress in our emergency rooms?
- 5) What level of training is provided to staff of local hospital emergency rooms regarding treatment of acute psychiatric distress, including management of the range of behavioral manifestations that such patients can exhibit?

The Honorable Joseph P. Nadeau  
Alexander de Nesnera, M.D.  
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- 6) Why has the waiting time for transfers to appropriate level of care increased?
- 7) What action steps are necessary to minimize risk of harm to patients and staff at all of New Hampshire's health care facilities?

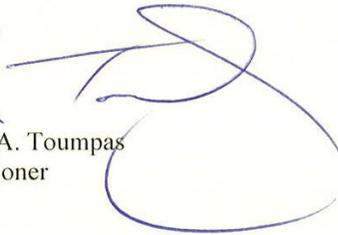
In conducting this sentinel review, you are reminded that quality assurance reviews such as this are privileged and confidential by law.

Lastly, I want to thank you in advance for being willing to take the time out of your busy schedules to conduct this important review on behalf of the Department and State of New Hampshire.

Sincerely,



Nicholas A. Toumpas  
Commissioner



## HOSPITAL SENTINEL EVENT REVIEW SURVEY

We would appreciate your comments upon the general study questions posed to us by the governor, in the context of your experiences. Please answer each one with a few sentences. Thank you.

1. What acuity of patients can and should be treated in your hospital?
2. What is your methodology and system for triaging psychiatric emergencies to ensure patients are receiving the appropriate level of care?  
Is the triage system working? Can it and should it be improved?
3. Are the patients who experience acute psychiatric distress at your hospital emergency room usually receiving treatment in the community?
4. What environmental/clinical circumstances do you believe are leading to the rise in the number of patients experiencing acute psychiatric distress in the emergency room?
5. What level of training is provided to your emergency room staff regarding treatment of acute psychiatric distress, including management of their behavioral manifestations?
6. Why do you think that the waiting time for transfers to the appropriate level of care increased?
7. What action steps do you believe are necessary to minimize risk of harm to patients and staff at your health care facility?

THIS EMAIL FROM STEVE AHNEN TO NHHA MEMBER HOSPITAL CHIEF EXECUTIVE OFFICERS AND ADVOCACY TASK FORCE MEMBERS IS TYPICAL OF THE COOPERATION WE RECEIVED FROM HEALTH CARE PROFESSIONALS.

You should have recently received a copy of the attached letter and survey from Retired Supreme Court Associate Justice Joseph Nadeau in his role leading a Sentinel Review task force looking at the events that occurred earlier this year at the Elliot Hospital involving psychiatric patients awaiting a bed at New Hampshire Hospital. The review was requested by Governor Hassan and is being conducted with Dr. Alex deNesnera, Associate Medical Director at New Hampshire Hospital and an Associate Professor of Psychiatry at the Geisel School of Medicine at Dartmouth, and Attorney Michael Brown from the Attorney General's Office. As part of their charge, they have been asked to look not only incidents that occurred at the Elliot, but the broader issues facing our hospitals and mental health system.

I strongly encourage you to respond to Judge Nadeau's survey.

Over the past several weeks, Judge Nadeau and the Sentinel Review team have been meeting with hospitals, community mental health centers, law enforcement and others as part of their overall review. Shawn LaFrance, Foundation for Healthy Communities executive director, and I met with Judge Nadeau in December to share our perspectives and that of the broader statewide hospital community with them. We shared information with them from the report released earlier this year that was published by the Foundation regarding the growing crisis of patients in acute psychiatric crisis forced to wait in hospital emergency rooms for a bed to open up at New Hampshire Hospital. We were also able to discuss a number of efforts that are being undertaken by hospitals to help address this situation. But we stressed over and over that part of the solution is to create additional capacity NOW to alleviate the backlog of patients awaiting proper treatment. While we would all agree that community-based, outpatient treatments are best to help patients manage their illness and avoid an acute psychiatric crisis, there simply is insufficient capacity to address this situation now. We absolutely have to invest in both inpatient AND outpatient treatments. Failure to do so will only result in additional incidents like the ones that occurred this past year at the Elliot. In fact, while those incidents received high profile public attention, they were by no means the only incidents where hospital staff were threatened or injured.

This is an important opportunity to share with Judge Nadeau and the Sentinel Review team the impact that this growing crisis is having on your patients, their caregivers and your institutions. It is important that they understand the impact that this is having on staffing of units, management of patients awaiting a transfer to New Hampshire Hospital, the additional costs associated with all of this, and how it is affecting not only the dedicated staff who care for these patients, but all of your patients who you care for in your emergency rooms. In addition, the complex legal issues that confront you every day as these patients are forced to wait in your emergency rooms until they can be transferred to New Hampshire Hospital where they can receive the most appropriate treatment. Every one of you have a powerful and important story to tell.