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The Center for Public Policy and the Social Sciences

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—Celebrating 10 Years of Service to New Hampshire and Vermont—

**SECURE HOUSING AND TREATMENT OPTIONS FOR
THE NON-CRIMINAL MENTALLY ILL IN NEW
HAMPSHIRE**

Presented to the New Hampshire Commission on Involuntary
Commitment

PRS Policy Brief 1617-09
June 12, 2017

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This report was written by undergraduate students at Dartmouth College under the direction of professors in the Rockefeller Center. Policy Research Shop (PRS) students produce non-partisan policy analyses and present their findings in a non-advocacy manner. The PRS is fully endowed by the Dartmouth Class of 1964 through a class gift in celebration of its 50th Anniversary given to the Center. This endowment ensures that the Policy Research Shop will continue to produce high-quality, non-partisan policy research for policymakers in New Hampshire and Vermont. The PRS was previously funded by major grants from the U.S. Department of Education, Fund for the Improvement of Post-Secondary Education (FIPSE) and from the Ford Foundation and by initial seed grants from the Surdna Foundation and the Lintilhac Foundation. Since its inception in 2005, PRS students have invested more than 50,000 hours to produce more than 150 policy briefs for policymakers in New Hampshire and Vermont.



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TABLE OF CONTENTS

| | |
|--|-----------|
| EXECUTIVE SUMMARY | 1 |
| 1. INTRODUCTION | 1 |
| 2. PURPOSE STATEMENT | 2 |
| 3. BACKGROUND INFORMATION | 3 |
| 3.1 PSYCHIATRIC TREATMENT IN NEW HAMPSHIRE | 3 |
| 3.2 CURRENT PROCEDURE FOR CIVIL COMMITMENT AND TRANSFER TO THE SECURE PSYCHIATRIC UNIT | 3 |
| 3.3 PREVIOUS REFORM EFFORTS | 3 |
| 4. METHODOLOGY | 4 |
| 4.1 CONDUCT STATE-BY-STATE COMPARISONS | 4 |
| 4.2 EXAMINE REFORM OPTIONS THROUGH SELECTED CASE STUDIES | 5 |
| 4.3 INTERVIEWS WITH PSYCHIATRIC CAREGIVERS, MENTAL HEALTH ADVOCATES, AND POLICYMAKERS | 7 |
| 5. MAINTAINING THE STATUS QUO | 9 |
| 6. IMPROVING EXISTING FACILITIES | 10 |
| 6.1 CALIFORNIA CASE STUDY: IMPROVING EXISTING HOSPITAL SECURITY INFRASTRUCTURE | 10 |
| 6.2 IMPROVING EXISTING HOSPITAL SECURITY INFRASTRUCTURE IN NEW HAMPSHIRE | 12 |
| 7. CONSTRUCTING NEW SECURE FACILITIES | 13 |
| 7.1 OREGON CASE STUDY: THE CONSTRUCTION OF JUNCTION CITY HOSPITAL | 13 |
| 7.2 CONSTRUCTING NEW FACILITIES IN NEW HAMPSHIRE | 15 |
| 8. IMPLEMENTING ASSISTED OUTPATIENT TREATMENT | 16 |
| 8.1 OHIO CASE STUDY: ASSISTED OUTPATIENT TREATMENT | 16 |
| 8.2 IMPLEMENTING ASSISTED OUTPATIENT TREATMENT IN NEW HAMPSHIRE | 17 |
| 9. TRANSFERRING PATIENTS OUT-OF-STATE | 17 |
| 9.1 HAWAII CASE STUDY: TRANSFERRING PATIENTS TO OUT-OF-STATE FACILITIES | 18 |
| 9.2 LEGISLATION GOVERNING THE INTERSTATE TRANSFER OF PSYCHIATRIC PATIENTS | 19 |
| 9.3 POTENTIAL PUBLIC RECEIVING FACILITIES IN MASSACHUSETTS | 21 |
| 9.4 POTENTIAL PUBLIC RECEIVING FACILITIES IN MAINE | 22 |
| 9.5 POTENTIAL PUBLIC RECEIVING FACILITIES IN RHODE ISLAND | 23 |
| 9.6 POTENTIAL PUBLIC RECEIVING FACILITIES IN CONNECTICUT | 23 |
| 9.7 POTENTIAL PUBLIC RECEIVING FACILITIES IN NEW YORK | 24 |
| 9.8 IMPLEMENTING OUT-OF-STATE TRANSFER IN NEW HAMPSHIRE | 25 |
| 10. CONCLUSION | 26 |
| REFERENCES | 28 |



EXECUTIVE SUMMARY

New Hampshire currently houses mentally ill patients considered dangerous to themselves or others in the Secure Psychiatric Unit (SPU) of the New Hampshire State Prison for Men in Concord. Patients are transferred to the SPU from New Hampshire Hospital when the security level of the Hospital is deemed insufficient to meet the needs of a patient. This housing arrangement has recently come under examination because of the unique patient population, location of the unit, and questions about where patients would be best served. There have been several attempts to pass legislation that would place non-adjudicated mentally ill patients into another facility. This report was originally commissioned to inform discussion of HB 1541, but it will now seek to inform the Commission established by HB 208 to study involuntary commitment in New Hampshire. This report examines the costs and benefits of maintaining the status quo policy at the SPU, as well as the costs, benefits, and transition processes associated with the available alternatives, which include a) improving existing facilities, b) constructing new facilities, c) implementing assisted outpatient therapy, and d) transferring patients out of state.

1. INTRODUCTION

In 1986, the New Hampshire legislature drafted a policy that would allow the transfer of psychiatric patients in New Hampshire from the state hospital to the SPU in the State Prison for Men. Patients in the SPU are a cohort of criminal and non-criminal patients. The patients from the state prison are concurrently serving a sentence and undergoing psychiatric treatment. The patients that originate from the state hospital have not been convicted of a crime, but are undergoing treatment in the SPU because the security level in the state hospital was deemed insufficient to prevent harm.¹

New Hampshire created this policy partly out of concern for the safety of the hospital staff and the residents in neighborhoods surrounding the New Hampshire State Hospital, but also to ensure that the hospital would receive federal accreditation. Administrators believed that housing a potentially dangerous population could prevent the hospital from receiving a federal license, and thus from receiving Medicaid funds.²

Although the SPU itself is a medical facility, the American Corrections Association is the only organization that currently provides accreditation for its services. That accreditation expired in 2011. The 60 beds within the facility house patients ranging from sexually violent predators to those with developmental disabilities: Patients who have never been involved in the criminal justice system are housed with convicted criminals. The New Hampshire Hospital sends, on average, thirteen people per year to the facility, and non-adjudicated patients filled 16 of the beds in this unit as of March 2016.³ Patients have stayed in the SPU for anywhere from a few days to six years.⁴



In the 1966 case of *Lake v. Cameron*, the Federal Court of Appeals in Washington D.C. ruled that civil commitment must occur in the least restrictive setting that would benefit the patient.⁵ According to some policymakers and advocates, the location of the SPU within the New Hampshire State Prison for Men may be in violation of this and subsequent Supreme Court doctrine, making New Hampshire potentially vulnerable to legal action. Representative Renny Cushing, along with representatives from the New Hampshire branch of the American Friends Service Committee and the Treatment Advocacy Center, filed a complaint with the United States Department of Justice in August of 2016 to request a full investigation into the matter.⁶

The location of the SPU on prison grounds also presents some logistical difficulties for the state regarding funding and oversight. First, the SPU is not eligible to receive federal Medicaid funding because it cannot be certified as a hospital. Additionally, it lacks the oversight of a body with healthcare expertise. The Department of Corrections (DOC) is in charge of patients in the SPU, and no outside audits of performance have occurred in the last 30 years. In 2011 and 2014, a forensic psychiatrist reviewed the mental health care being received by inmates in New Hampshire, but the SPU was not included.⁷

2. PURPOSE STATEMENT

This report examines the status quo policy, the current care of non-adjudicated patients in the SPU, along with four main policy alternatives, including improving existing facilities, constructing new facilities, implementing assisted outpatient treatment, and transferring patients out-of-state. To examine the status quo, the report will present information on how patients are housed and the details of oversight in the SPU. For each alternative policy, the report presents case studies of implementation efforts in other states. Each case study also describes the costs and benefits of potential implementation in New Hampshire and explains the mechanisms of administration used by other states that could serve as potential models for New Hampshire.

Additionally, a set of 21 interviews with policymakers, mental health advocates, and medical professionals informs the analysis of both the status quo and each of the four alternatives, providing information on how each system works from the perspective of those administering it. The overall findings of the report may inform the decision-making process of the Commission established by HB 208 to study New Hampshire's involuntary commitment procedures generally and the SPU specifically.



3. BACKGROUND INFORMATION

3.1 Psychiatric Treatment in New Hampshire

A variety of treatment levels are available to mental health patients in New Hampshire, including partial hospitalization, inpatient care, and outpatient care, in both state and private hospitals. As of 2010, the state had 189 public psychiatric beds, down from 224 beds in 2005.⁸ New Hampshire is divided into ten regions, each maintaining its own Community Mental Health Center, a private full service clinic offering additional programs. Many of these regions also have Peer Support Agencies, which are private non-profit agencies equipped to provide non-medical mental health interventions. Both types of facilities are contracted by the Department of Health and Human Services (DHHS) Bureau of Behavioral Health. New Hampshire also has emergency mental health support services in place 24 hours a day, seven days a week for crisis situations. These services are accessed by dialing 911 or the statewide suicide hotline, or by visiting the local emergency room or community health center. New Hampshire is currently experiencing a statewide shortage of psychiatric beds at all levels of treatment.⁹

3.2 Current Procedure for Civil Commitment and Transfer to the Secure Psychiatric Unit

Involuntary, or civil, commitment laws in New Hampshire set the criteria for determining when the state can require psychiatric treatment for a patient. These laws may allow for assisted outpatient treatment (AOT) or commitment if the patient in question poses a danger to themselves or others.

According to the DHHS, the transfer process to the SPU begins when the treatment team of a patient determines that the patient cannot be managed safely at the current facility. Officials at the hospital and the medical director at the DOC review the determination. A transfer request can then be made and must be signed by the CEO of the New Hampshire Hospital, the commissioner of the DHHS, and the commissioner of the DOC. The patient is informed of the transfer and may request a hearing to contest it, to be decided by the DHHS Administrative Appeals Unit. If the transfer is approved, the patient is placed under the charge of the DOC but still considered a patient of the New Hampshire Hospital. The patient may be transferred back to the hospital, if approved by the medical director.¹⁰ In 2015, there were 51 transfers from NHH to the SPU, and 50 of these transfers were in emergency situations where patients are transferred immediately.¹¹

3.3 Previous Reform Efforts

In 2010, a Commission was established by HB 1602 to study the viability of the construction of an alternative facility to the SPU. After reviewing possible sources of



funding and potential legal liabilities of housing non-adjudicated psychiatric patients with those who have been adjudicated, the Commission recommended the establishment of a new secure psychiatric facility for both adjudicated and non-adjudicated patients who may pose a danger to themselves or others, at an estimated cost of roughly \$13 million.¹² Since the release of the report, no further action has been taken toward the construction of a new facility.

In February 2016, House Bill 1541 was introduced to the New Hampshire state legislature. It prohibits the placement of mentally ill individuals who have not been charged with or convicted of a crime in the SPU, and mandates their placement in other therapeutic facilities in or outside of the state. The bill was sent to a committee work session and was not reported out. In 2017, HB 208 passed and established a Commission with the purpose of exploring involuntary commitment procedures. Specifically, the bill requests that the Commission “[consider] the location and other factors regarding the secure psychiatric unit.”¹³

4. METHODOLOGY

4.1 Conduct State-by-State Comparisons

To understand how New Hampshire policy operates and determine what treatment options are available for non-adjudicated psychiatric patients, we conducted a systematic review of current practices and procedures in each of the fifty states. This included analyzing the relevant legislation governing civil commitment procedure for non-adjudicated patients, and exploring the features of available facilities in each state. More specifically, we asked the following questions:

- How many psychiatric beds are in each state?
- How many psychiatric patients are being treated in each state?
- By what methods are patients deemed to be potentially dangerous treated?
- How did that state choose the methods currently in use and make the transition to the current system?
- What security measures and administrative structures are in place in the facilities housing dangerous patients?

The research included an exploration of the psychiatric care provided to criminals and how it differs from the care given to patients who have not been involved in the justice system. We found relevant information on state agency websites, as well as in advocacy group reports on state mental health policy. Additional research involved systematically reviewing media reports about state psychiatric care, the current inpatient climate in the country as a whole, and specific reports on the facilities included in Section 9 on out-of-



state transfer. The goal of this approach was to place New Hampshire policy in a national and comparative context.

4.2 Examine Reform Options Through Selected Case Studies

Options for changing the current system include the improvement of existing state psychiatric facilities, the construction of a new facility, the implementation of assisted outpatient treatment (AOT), and the transfer of patients out-of-state. The state-by-state comparisons, the exploration of how other states have adapted their healthcare systems to care for potentially violent patients, and research on past efforts to change the New Hampshire state psychiatric system, produced this set of possible alternatives to treating non-adjudicated patients in the SPU. Specifically, a 2010 memorandum by the Committee formed pursuant to New Hampshire HB 1602 led to the exploration of constructing a new psychiatric facility in New Hampshire, renovations to existing facilities were considered as a less costly approach to reforming existing New Hampshire psychiatric care infrastructure, the option of transferring patients out-of-state was originally proposed in HB 1541, and AOT is encouraged as a mode of care for violent psychiatric patients by the Treatment Advocacy Center, and was included as a policy option following further research.

After determining the four policy options beyond the status quo, we selected model states not for their similarities to New Hampshire, but for their demonstrated excellence in a particular approach (see Table 1 below). We also explore whether and how these policies could be effectively enacted in New Hampshire, as the some of the states included in the case studies are quite different from the Granite State.

Research on the status quo in the Secure Psychiatric Unit was included in this report in order to present all perspectives on the current system. Understanding the current policy is key to deciding what, if any, changes should be made. Determining how patients are transferred to the SPU, in what situations these transfers may be necessary, and the type and structure of care patients receive while in the SPU informed this analysis. The case study utilized information from the New Hampshire Hospital and the State Prison for Men to provide an overview of how the system operates.

California and the Napa State Hospital were chosen to explore the possibility of renovating existing state psychiatric facilities to improve the security of both patients and employees. Napa State is notable for the depth and breadth of changes implemented. We examined the decision to renovate facilities, how the facilities were updated, the political actions required to bring about and support the renovations, and the success of the policy. Research on the state psychiatric hospital system provided important background information on oversight procedures. Tracking state bills authorizing budgetary measures and programmatic features of the renovation informed the legislative side of the case



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study. Interviews with the California Department of State Hospitals provided information on the cost of the renovations, the changes made to security programs and procedures, and the effectiveness of the changes. Research on the New Hampshire state psychiatric hospital was used to place the California recommendations in the context of the Granite State's smaller system.

The Oregon State Hospital system was chosen to study the option of constructing a new secure psychiatric facility because it recently built Junction City Hospital, a facility that collaborates with the existing state hospital in Salem to house state psychiatric patients deemed most potentially dangerous. In addition, the previous status quo in Oregon bears some similarity to New Hampshire, as it previously only had one small state psychiatric hospital. Interviews were conducted to gain insight into a typical patient day of care relative to the status quo in New Hampshire, and an examination of local media reports provided information on the economic impact of construction and community involvement with the new facility.

Summit County, Ohio was chosen to study the option of assisted outpatient treatment (AOT) after emerging from a survey of various states as having a particularly robust program, as well as a similar psychiatric patient population as New Hampshire in terms of type and severity of mental illnesses. The Summit County model comes highly recommended by The Treatment Advocacy Center and the legislation governing civil commitment in Ohio is similar to that in New Hampshire, suggesting that implementing such a program may be feasible. The case study investigates the current systems of AOT in both Summit County and New Hampshire, including the commitment process, number of patients served, types of mental illness treated, involvement of community partners, success rates, and costs.

The state of Hawaii was examined to explore the possibility of transferring psychiatric patients to out-of-state facilities because it is the only state on which information regarding out-of-state transfers could be readily located. Important aspects of this analysis addressed the decision-making process used to determine the cases in which transfer is appropriate, and the factors that went into the decision by the state to use a specific facility in South Carolina for its transfers. Our analysis also involved assessing the legislative framework, specifically the Interstate Compact on Mental Health, necessary to facilitate such transfers in Hawaii, New Hampshire, and other states that may be viable options for the relocation of the SPU patients. Further, we examined features of psychiatric facilities in New England that may be able to receive SPU transfers, including number of beds, security measures and procedures, services available, treatment costs, treatment durations, and admission wait-times. These facilities are located in Massachusetts, Maine, Rhode Island, Connecticut, and New York. Interviews with Hawaii state policymakers, Hawaii Department of Health administrators, and health officials from potential receiving states further informed this research.



Table 1: Policy Options and Primary State Case Studies

| Policy Option | Primary State Studied |
|---|------------------------------|
| Maintain the status quo/SPU | New Hampshire |
| Renovate existing psychiatric facilities | California |
| Construct a new secure psychiatric facility | Oregon |
| Develop an assisted outpatient treatment program | Ohio |
| Transfer violent patients to an out-of-state facility | Hawaii |

4.3 Interviews With Psychiatric Caregivers, Mental Health Advocates, and Policymakers

For an issue as complex as policy about psychiatric care, it is important to understand the perspectives of all stakeholders involved in the policymaking and implementation process. For this reason, interviews were conducted with medical professionals, outside advocates for reformed treatment of the mentally ill, and policymakers or administrators both in the state of New Hampshire and in the states discussed in the case study section of the report, which include California, Oregon, Ohio, and Hawaii.

The interviews were semi-structured and the questions were tailored to each interviewee according to his or her area of expertise. The goal of each interview was to learn more about both current policy in New Hampshire and each of the proposed policy alternatives to housing non-adjudicated patients in the Secure Psychiatric Unit. Interviews began with questions about the policy pursued in New Hampshire or in the state of residence of the interviewee, and proceeded to more specific questions about the experience of the interviewee with the implementation of the policy in question. A total of 42 experts were contacted, and a total of 21 experts were interviewed for this report.

Representative questions asked to the experts interviewed include:

For the New Hampshire State Hospital and the Secure Psychiatric Unit:

- How are the most dangerous patients committed, and how can they move to less restrictive care settings?
- Are existing New Hampshire State Hospital services equipped to handle the patients from the SPU? What supports or improvements may be necessary?
- What kind of administration is used in the SPU to communicate with New Hampshire Hospital and oversee patients?



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- How is the state hospital/SPU set up regarding housing patients at different treatment levels?

For the California Department of State Hospitals:

- What security measures were in place before the security changes were implemented at Napa State?
- How costly were the changes implemented?
- Have the changes been effective in reducing the incidence of violence? What measures have been most and least effective?
- How does the oversight of the hospital operate? Has it led to any revisions to hospital procedure in dealing with violent patients?

For Junction City Hospital, Oregon personnel:

- What security measures exist at JCH for patients considered dangerous to themselves or others?
- What was the economic impact of building JCH, specifically regarding jobs, community involvement, and financial commitment from the state?
- What is the cost of care for patients residing at JCH?
- What oversight exists for JCH? Has the facility received any type of evaluation or accreditation?

For Summit County, Ohio healthcare administrators, physicians, and mental health advocates:

- What is the current model of AOT that exists in Summit County? What prompted the county to develop its current model of AOT?
- How is it decided whether AOT is the most appropriate type of care for a patient?
- Are patients who may pose a danger to themselves or the community ever treated through AOT rather than in-patient care?
- What have been the successes of AOT so far in Summit County? What improvements, if any, could be made?

For Hawaii healthcare administrators and policymakers:

- What factors into the decision to transfer a patient from the state hospital to an out-of-state facility?
- What legal framework and administrative procedures were needed to transfer the patients?
- How does the cost of care in the Hawaii state hospital compare with the cost of care in the transfer facility?



- How is oversight of the process conducted? Does the state's responsibility for the patient continue after a transfer?

For potential New England transfer facilities (MA, ME, RI, CT, NY):

- Has the hospital ever admitted patients from out-of-state under the Interstate Compact on Mental Health? If so, under what circumstances?
- Does the hospital currently have waitlists? If so, how long and how long is the average wait?
- What is the approximate cost per day for the care of a secure patient?
- What safety training does psychiatric staff undergo? What physical security measures are in place?

5. MAINTAINING THE STATUS QUO

The SPU is a unique collaboration between the New Hampshire Department of Health and Human Services and the Department of Corrections. It exists within the New Hampshire State Prison for Men at Concord and has 65 beds for patients deemed too dangerous to be cared for elsewhere. Only patients who are involuntarily committed to New Hampshire Hospital (NHH) may be transferred to the SPU. An SPU official estimates these patients currently fill 6 to 10 of the beds at the SPU.¹⁴ The transfer of patients from NHH to the SPU, however, is not common. Alex de Nesnera, the interim Chief Medical Officer at NHH, reports that of the 2,000 patients seen each year, only 3 or 4 are transferred for treatment to the SPU.¹⁵ These patients are found, through a review process by an NHH care team, to be violent to a degree that they have become a danger to themselves or others and cannot be handled within the current level of security at NHH. Though NHH has a partially secure campus with police available to assist with dangerous patients, the cohabitation of patients in double occupancy rooms or more open spaces raises the risk of dangerous behavior.

The SPU contains six separate units. The six-bed infirmary unit is under constant observation and provides the most intensive level of care. Patients transferred from the NHH may be placed initially into this unit. Patients who progress beyond the infirmary unit for treatment move through the wards of the SPU, each with a decreasing level of security. The ten-bed E Ward houses patients who require a high level of supervision, but do not need to reside in the infirmary to receive treatment. F Ward contains twenty beds and less strict security measures that allow patients to move around. Open areas in F Ward, such as a television room, are monitored at all times by a campus officer. G and H Ward hold ten beds each and house patients who are stabilizing. In all wards, patients reside only in single cells due to health concerns. Civilly and criminally committed inmates may be housed in cells next to each other.¹⁶



The female population in the SPU constitutes an exception to the normal housing system. D Ward is a ten-bed female-only unit, which cohabitates civilly committed patients and any female patients who came from another corrections facility in New Hampshire following a mental health crisis. This ward houses females at all levels of care until they return to the sending corrections facility or to NHH.¹⁷

Because it is located within a prison, the SPU contains a higher level of security than the New Hampshire Hospital. The SPU is consistently monitored by the prison officers and security staff. Residents may be placed in physical restraints should violent behavior escalate. There are also locked doors and secure tiers, and each residence hallway and resident cell is locked.¹⁸ Regarding cost, treating patients in the SPU is less expensive than providing treatment in NHH. The cost of care per day in the SPU is \$270, while the cost of care per day at NHH is \$1,350 as of June 2016.¹⁹ To provide effective oversight, the DHHS and DOC collaborated to establish a memorandum of understanding to oversee patient care.²⁰

Though some parties may be interested in alternative housing arrangements to the SPU for non-criminal psychiatric patients because of the recent complaint to the DOJ, the lack of Medicaid funding for the facility, and the possibility that patients in the SPU would be better served in a therapeutic psychiatric setting, maintaining the status quo would not require additional expenditures or legislative changes.

6. IMPROVING EXISTING FACILITIES

The improvement of existing facilities is another policy alternative that we investigated, principally through the case study of California efforts to implement such a policy.

6.1 California Case Study: Improving Existing Hospital Security Infrastructure

The California state mental health system provides an informative example of improvements made to hospital security through physical and procedural measures. Prior to recent reforms, pre-existing security measures included a system of locked gates and doors, metal detectors, personal alarm devices for staff members that could sound an alarm to summon help inside the patient residential buildings, and staff safety training. Following the murder of one of its psychiatric technicians by a patient in her care, these measures were deemed insufficient. To improve safety, the Department of State Hospitals (DSH) updated risk assessment procedures for all hospitals, and Napa State Hospital, specifically, overhauled its physical security measures.

Napa State has 1,197 beds, and reported 1,800 physical assaults perpetrated by patients in 2015.²¹ The hospital houses patients who are civilly committed, judged incompetent to stand trial, or found not guilty by reason of insanity, and parolees with a mental disorder



related to their crime. Patients who are civilly committed make up about one-fifth of the total patient population of 1,255.²²

In 2014, the DSH developed the California State Hospital Violence Assessment and Treatment Guidelines (Cal-VAT), which provide a comprehensive guide to assessing the potential violence of patients and developing appropriate treatment plans. The guidelines are evidence-based, drawing on the results of clinical trials and the clinical experience of psychiatric professionals, and are designed to reduce violent incidents. Since implementation, assaults have seen an overall decline, though there has only been sufficient data collected to empirically demonstrate the effectiveness of some specific program components.²³ Additionally, a Risk Management Program consisting of standardized procedures is used to identify high-risk situations in which violence may occur and determine corrective measures.²⁴ Oversight of the hospital and revision to these programs is conducted by a Quality Council, a committee charged with providing oversight to the risk management and performance improvement processes.²⁵

Therapeutic Strategies and Interventions (TSI) guidelines designed to reduce aggression among patients, formerly known as Prevention and Management of Assaultive Behavior (PMAB), have also undergone revision.²⁶ According to the Illness Prevention and Treatment Plan released in 2015, TSI consists of a training course that integrates evidence-based input from the DSH Statewide Task Force and some of the work of the original PMAB taskforce. TSI lays out appropriate safety procedures for various types of DHS employees, including psychiatric technicians, the nursing team, and the off-unit clinical team.²⁷ For example, staff are taught de-escalation techniques such as moving away from a patient while working to verbally diffuse the situation.²⁸

Napa State also implemented several changes to hospital staffing and physical security measures. The availability and visibility of staff around the hospital were increased through a new system called the Ground Presence Team, which creates a consistent presence of supervisors throughout the hospital.²⁹ Changes to the staff training program and safety policy include specifically focusing on the transfer of patients between activities and the supervision of patients in the courtyard.³⁰ The pre-existing police presence was expanded to include a substation in the Secured Treatment Area, facilitating quicker responses to incidents should preventative measures fail. Other physical changes to the hospital include changes to the doors controlling patient movement and the installation of mirrors that allow staff to see around corners.³¹

In addition, a PDAS (Personal Duress Alarm System) was implemented at each of the five state hospitals at a cost of \$56 million. Every employee and contractor, a total of 10,380 people, was provided a personal alarm with a wireless activation device capable of identifying their location within three meters and notifying all nearby staff through an emergency alert message.³² Staff are required to wear the alarm at all times.³³



Improvements associated with the PDAS system include a reduction in police response times from 5-30 minutes to 1-3 minutes.³⁴

Evaluation of the new safety measures has been positive. Staff have given appreciative feedback on the system and reported incidents in which the improved response time following the implementation of PDAS meant a violent patient “was unable to continue an assault that could have resulted in more severe injuries or even a death.”³⁵ It is difficult, however, to demonstrate direct causality between specific new safety measures and the overall decline in assaults since 2012 because the DSH has not collected sufficient data.³⁶ This difficulty is compounded by the lack of data on incident response times before the implementation of the changes, as there is nothing to which new data on response times can be compared.³⁷

Further, the California State Legislature passed Assembly Bill 1340 in 2014, authorizing the Department of State Hospitals to establish and pilot enhanced treatment programs (ETPs) for patients at high risk of dangerous behavior that cannot be treated safely in a standard treatment environment.³⁸ These programs have not yet gone into effect, but three 13-bed enhanced treatment facilities at Atascadero State Hospital and one 10-bed facility at Patton Women’s State Hospital will serve patients who do not respond to standard modes of treatment, and will incorporate a placement evaluation system, an in-depth violence risk assessment, and regular re-evaluation of the appropriateness of continued participation of each patient.³⁹ The goal of the new facilities is to provide care for patients “at the highest level of risk for violence.”⁴⁰ The first unit is planned to open in June of 2018. The initial budget of \$7.9 million to implement the changes and new construction was approved for fiscal year 2017-18.⁴¹

Regarding oversight, the Clinical Operations Division of the Department of State Hospitals manages the development, evaluation, and maintenance of clinical standards.⁴² The division “supports a ground up change model where executive level decision making is based on input from unit staff at each facility.” Clinical Operations makes recommendations to the executive committee of the DSH, which includes the executive directors of each hospital, and the Director of the Department of State Hospitals and deputy directors, who then make policy changes. The administrative leaders of the hospital also meet regularly with the Safety Now Coalition, an employee group that includes labor representatives. These meetings provide a forum in which staff can voice safety concerns to further inform policy revisions.⁴³

6.2 Improving Existing Hospital Security Infrastructure in New Hampshire

New Hampshire has a significantly smaller population than California, and accordingly has far fewer beds in its one state hospital. The difference in scale between the two states, however, does not preclude the adoption California model. By scaling down the practices and policies, it may be possible to apply them to New Hampshire. Though Napa State has



been a forensic facility since the 1990s and the New Hampshire State Hospital currently has few provisions for violent patients, the policies implemented in California are applicable to New Hampshire because they can be adapted to fit a facility without pre-existing secure facilities.

To follow the California model, New Hampshire could create similarly secure facilities within its state hospital, end transfers of civilly committed patients to the SPU, and develop an oversight system. The Department of State Hospitals currently conducts the oversight of the hospital system in California. Created in 2012, the Department is different from the previous administrative system in that it emphasizes risk management through regular staff feedback and maintains close relationships with the management teams at each hospital. While the creation of an entirely new department to oversee the New Hampshire system may be unnecessary as there is only one state psychiatric hospital, the integrated and collaborative style of the California oversight system is nonetheless an applicable model that can be adapted for the DHHS.

It is also important to note that though California is in the process of constructing new facilities in which the ETPs will be implemented, it may also be possible to implement the program in an existing, renovated facility. New Hampshire could potentially adopt portions of the ETPs without building multiple entirely new facilities.

The costs associated with implementing these policies result from the research efforts necessitated, construction fees, and the hiring of additional staff. Laurie Harding, a former New Hampshire state legislator and registered nurse, explained in an interview that the greatest obstacle to implementing such a policy is the cost, which the New Hampshire state legislature is reluctant to fund.⁴⁴ In the case of the policy reforms made in California, however, the state constitution does not require the state to reimburse local agencies for the mandated costs. Despite its costliness, improving security at NHH would provide a clear policy alternative by equipping the New Hampshire with the resources necessary to house potentially violent patients outside of the SPU.

7. CONSTRUCTING NEW SECURE FACILITIES

The construction of new secure facilities is another policy alternative that we investigated, principally through the case study of Oregon efforts to implement such a policy.

7.1 Oregon Case Study: The Construction of Junction City Hospital

The Junction City Hospital is a newly constructed secure psychiatric facility in Oregon that opened in May 2015. Currently, three of the six units are operating and 75 beds are available. One hundred and seventy four beds in total can be made available by opening



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all units, which will occur on an as-needed basis. Because the population of Oregon is predicted to grow over the next few decades, the additional units are expected to be opened to support increased demand.⁴⁵ Along with the recently renovated main campus in Salem, Junction City is one of two hospitals in Oregon that house the state's most

severely ill psychiatric patients. These hospitals fall under the jurisdiction of the Oregon Health Authority (OHA) in the DHHS. Within the OHA, a board of nine citizens nominated by the Governor and confirmed by the Senate makes policy decisions and conducts oversight of all operations. Citizens serve on the board for four-year terms.⁴⁶

The Junction City hospital was an \$84 million project, with 298 staff and 42 vacancies at opening. As-yet unopened units will each require 42 additional staff members. The construction of the hospital, funded through bonds and certificates of participation, created approximately 400 jobs and resulted in the hiring of 41 subcontractors. The hospital intends to engage its community by offering learning opportunities and residencies in psychiatric health for nearby colleges and medical schools.⁴⁷ It also aims to return civilly committed patients to a less restrictive form of care, according to an agreement with the U.S. Department of Justice addressing compliance with the Olmstead Act.⁴⁸

The two state hospitals admit patients who are civilly committed, found not guilty by reason of insanity, or judged incompetent to stand trial. Although 60 percent of patients are criminally committed, the high level of security in the hospital can accommodate both adjudicated and non-adjudicated patients. Sally ports, secure double-door controlled entry and exit points from each unit, constitute an important security measure. Each staff member carries an ID badge to swipe for entry, and has his or her identification confirmed by camera. Patients also carry ID badges, but are not able to utilize sally ports and must be accompanied by a staff member. Some sally ports have counters to track traffic.⁴⁹

In the interest of safety, patients reside in single rooms upon entering the hospital. Patients may later reside in double occupancy rooms if they are moved to a less intensive level of care. When possible, patients who are admitted in the same fashion (civilly committed, guilty except for insanity, etc.) and who have the same privilege level (allowed to go on outings, have visits, etc.) are housed in the same unit. Patient rooms are not normally locked. Seclusion and restraint rooms, where patients can be isolated in a safe room and constantly observed by staff members and a psychiatrist, are utilized as a method of last resort.⁵⁰

Patients spend each day on the treatment mall, a campus-like setting offering a variety of classes. Each patient is part of his or her own treatment team, and in conjunction with



supervising doctors, chooses where to spend his or her time. Class subjects range from anger management to cooking classes.⁵¹

7.2 Constructing New Facilities in New Hampshire

The costs of following the example of Oregon are concentrated in the initial transition from the SPU to a new inpatient facility. Constructing a new facility with the requisite beds and medical treatment capabilities would incur substantial costs, as would including appropriate security measures, new food service equipment, and other patient services. The facility would also need to hire a new set of employees, as the SPU would retain its medical staff to care for adjudicated patients. Though a smaller facility would require fewer staff members, the wide variety of jobs, ranging from medical and technical to custodial, remains considerable. Costs of construction in New Hampshire are likely, however, to be lower than the costs incurred by Oregon, as the population of New Hampshire is one third of the size and would not require as large of a facility.

Some benefits of constructing a new facility stem from the potential positive economic impact of construction and hiring new staff. The community in which the hospital is placed could experience economic gains from hiring local contractors and the inward migration of skilled medical professionals. Additionally, an inpatient facility with hospital-level beds is eligible to receive Medicaid funding from the federal government. This could help offset the higher costs of providing treatment in a hospital as opposed to the SPU, which is currently built into the budget for patient care within the state general fund.

Additionally, the extra beds provided by a new facility would increase capacity to care for citizens experiencing mental illnesses in New Hampshire. The SPU is limited to 65 beds, some of which must be allocated to patients serving prison sentences. Should the facility reach capacity, the NHH would be forced to care for patients who may be violent with inadequate security measures. Dedicating a new facility to civilly committed patients would ensure that these patients are cared for under an appropriate level of security. Further, New Hampshire emergency rooms and hospital beds are currently at capacity, resulting in long wait times for psychiatric beds. This issue could be addressed by dedicating some beds in the new facility to treatment in a less secure setting.

Other potential benefits arise from what a new hospital could offer to the community: opportunities for students to gain valuable medical experience within the state rather than traveling to an out-of-state facility, and the ability of family members to see their loved ones outside of a prison setting rather than traveling or moving out-of-state.



8. IMPLEMENTING ASSISTED OUTPATIENT TREATMENT

The use of assisted outpatient treatment is another policy alternative that we investigated, principally through the case study of Ohio efforts to implement such a policy.

8.1 Ohio Case Study: Assisted Outpatient Treatment

Assisted outpatient treatment (AOT) is the court-mandated supervised treatment of patients with serious mental illnesses that takes place within the communities of the patients, rather than in an inpatient setting. In foundational studies of AOT, patient attendance at psychiatric appointments and treatment sessions improved and hospital recidivism decreased.⁵² The legal framework for AOT, often referred to as “involuntary outpatient treatment” or “outpatient commitment,” exists in 46 states, including New Hampshire. Two components of AOT differentiate it from other outpatient treatment models: court ordered commitment and enhanced community-based services. These enhanced services almost always include case management, therapy, and medication, and may sometimes include education or vocational training, supervised living, or substance abuse treatment.⁵³ While the commitment of a patient to AOT is determined by a unique set of factors in each state, the laws for involuntary commitment in New Hampshire are similar to those in Ohio.⁵⁴

In Summit County, Ohio, roughly seventy individuals are participating in AOT at any given time.⁵⁵ The county’s AOT model is distinguished by the close collaboration of all participating agencies. The Treatment Advocacy Center (TAC) explains, “AOT thrives in Summit County because judges, lawyers, mental health professionals, caseworkers, and law enforcement officers all recognize the clinical benefits of AOT and also share the same strong desire to see individuals with serious mental illness stay as functioning members of their communities.”⁵⁶ The strength of the program in Summit County is also attributable to advocacy by the National Alliance on Mental Illness (NAMI) Ohio and the TAC regarding the interpretation of civil commitment laws.⁵⁷

The process of committing a patient to AOT often begins with a petition following his or her release from inpatient care or prison. It is also possible for a patient who has not received inpatient care to be committed to AOT. In Summit County, all petitions for AOT are currently heard in the Probate Division of the Summit County Court of Common Pleas under Judge Stormer.⁵⁸ If the AOT is deemed an appropriate method of treatment, mental health professionals develop a plan that includes multiple community-based services. Although there are no specific psychiatric criteria that make a patient eligible for AOT, the majority of patients tend to be resistive to traditional treatment and exhibit severe mental illness, such as bi-polar disorder or schizophrenia. The average order for treatment is 90 days, but can be renewed.⁵⁹



8.2 Implementing Assisted Outpatient Treatment in New Hampshire

Both financially and structurally, Summit County is an accessible model for the implementation of AOT in New Hampshire. In Summit County, the AOT program requires that all ordered treatment for a patient be delivered by the community system. Almost all AOT patients are treated at one community support services agency. In New Hampshire, the ten pre-existing Community Mental Health Centers can be adapted to fit an AOT system. In addition, though New Hampshire has not set aside funding for AOT, the Summit County program has also thrived without receiving designated funding.

AOT is also relevant to New Hampshire given psychiatric bed and staff shortages. Implementing AOT could help mitigate these issues as it treats patients outside of a traditional inpatient setting. In addition, the AOT program in Ohio has successfully treated patients who have been deemed violent and prone to psychotic episodes.⁶⁰ A similar program in New Hampshire could, therefore, potentially address the needs of some individuals with severe mental illnesses currently being treated in the SPU.

A potential obstacle to implementing AOT in New Hampshire is the high level of coordination and involvement required by the variety of program actors. The success of the AOT model in Summit County depends on close collaboration between case managers, the Alcohol, Drug Addiction, and Mental Health Services Board, the supervisors at the Community Support Services center, and the probate courts.⁶¹ Because of mental healthcare staffing shortages in New Hampshire, such coordination and involvement may prove burdensome to the state.

Another possible difficulty in implementing AOT is the relatively weak enforcement mechanisms for patient noncompliance. AOT noncompliance may be met with reprimands, fines, or involuntary inpatient commitment. These measures, compared with those associated with noncompliance with other types of court orders, are less severe and more difficult to enforce, as AOT is not designed as a punitive program. Lastly, AOT carries the likely benefit of a lower cost to the state of New Hampshire than upgrading or constructing inpatient facilities while still diverting patients from the SPU.

9. TRANSFER OF PATIENTS OUT-OF-STATE

The transfer of patients to out of state facilities is another policy alternative that we investigated, both through the case study of Hawaii efforts to implement such a policy and by examining potential receiving facilities in states geographically proximate to New Hampshire.



9.1 Hawaii Case Study: Transferring Patients to Out-of-State Facilities

The Hawaii State Hospital (HSH) in Kaneohe, Oahu faces three issues that have spurred the transfer of some patients to secure facilities outside the state with the capacity to care for mentally ill patients who exhibit violent behavior. The first is overcrowding, an issue that affects many states, including New Hampshire, due to a nation-wide shortage of inpatient psychiatric beds. The second issue is insufficient treatment capabilities to

handle some complex psychiatric cases. The third is insufficient security measures to handle violent patients, which also affects the NHH.

In January 2006, a registered nurse at the HSH was assaulted by a mentally ill patient and suffered significant injury. This was not an isolated incident, and the inability to handle patients posing security threats led administrators to arrange for the transfer of several patients. Dr. Mark Fridovich, chief of the Adult Mental Health Division in the Hawaii Department of Health (DOH), also named insufficient treatment capabilities and cost as motivators in some transfer decisions. In some cases, it was less expensive to transfer a patient to an out-of-state facility that was better equipped to meet the needs of the patient.⁶²

In 2014, the Department of Health (DOH) relocated two men to the Columbia Regional Care Facility in South Carolina. The private facility was selected after it was determined to have the appropriate level of care, necessary specialty services, and a willingness to comply with state procurement law governing liability and insurance.⁶³ Former Hawaii State Senator Clayton Hee suggested that the decision to contract with Columbia Regional Care, as opposed to other state public and private facilities, may have also been based on cost concerns.⁶⁴ In the past, Hawaii has transferred patients with highly specialized needs to out-of-state facilities other than Columbia Regional Care that were best-suited to addressing those unique cases.⁶⁵

The transfer of these patients follows from Title 11 Chapter 94 Section 14 of the Hawaii Department of Mental Health code: “As changes occur in a patient’s physical or mental condition necessitating a different level of service or care which cannot be adequately provided by the facility, the patients are transferred promptly to a facility capable of providing an appropriate level of care.”⁶⁶ Additional legislative framework for the transfer process is found in the Hawaii Revised Statutes, Title 19 Chapter 334 Section 2.5: “The department may operate or contract for a secure psychiatric rehabilitation program for individuals who require intensive therapeutic treatment and rehabilitation in a secure setting.” The permissive language of the statute does not exclude transfer to an out-of-state facility.



Oversight of the transfer process, the criteria used to determine whether transfer is the best option for a patient, and the participants in the decision to transfer a patient are governed by the internal policy of the DOH Adult Mental Health Division.⁶⁷ Under this policy, the DOH and the office of the state Attorney General collaborate to conduct oversight of contract compliance. Patients authorized for transfer must meet one or more of a set of behavioral criteria such as “intractable aggression,” having “spent significant amounts of time in restraints and/or seclusion and is predicted to require continued use of those interventions in the future,” and unresponsiveness to attempts to reduce violent behavior.⁶⁸ The clinical staff and medical director at the Hawaii State Hospital, as well as the administrator and deputy attorney general within the Adult Mental Health Division, are involved in the decision to transfer patients that meet these criteria out of state.⁶⁹ The families of the patients are also consulted during this process.⁷⁰

DOH officials have previously rejected requests for transfer for failing to meet the established criteria.⁷¹ Due to the success of the program thus far, however, Dr. Fridovich expects that it will continue in the future.⁷² As provided for in HRS Title 19 Chapter 334 Section 2.5, the transfer process undergoes periodic review and revision to ensure patient wellbeing. Policies have been revised in the past to improve upon the case evaluation process and to elaborate on post-transfer communication procedure.⁷³ Patient responsibility following a transfer is shared between the State of Hawaii and the receiving facility. State officials continue to monitor patient progress, with reports sent regularly from the receiving facility to the Kaneohe clinical staff most familiar with the patients. Shared responsibility is crucial to patient health, as a change in medical status or other clinically significant events may warrant a change in level of care, requiring the Hawaii DOH to initiate another transfer.⁷⁴

The contract with GEO Care, Inc., which owns the South Carolina facility, cost \$653,000 for two years of care for the two transfer patients.⁷⁵ The daily cost is \$341 per patient for non-acute care, or \$441 for acute one-on-one care, to be paid to GEO by the State of Hawaii DOH. In this case, out-of-state care is less expensive than current daily rate for comparable care at the State Hospital in Kaneohe, which stands at \$800.29. It is important to note, however, that the administrative infrastructure built up around the out-of-state transfer system results in additional expenses that vary by case, such as patient evaluation, internal case consultations, and transportation, and may offset some of the financial benefit of out-of-state treatment.⁷⁶

9.2 Legislation Governing the Interstate Transfer of Psychiatric Patients

The Interstate Compact on Mental Health (ICMH) was created in 1955 through the cooperation of several states to provide the best available care to mentally ill patients by facilitating patient transfer between psychiatric facilities in different states with fewer administrative hurdles. The compact is designed to improve the quality and response time



of psychiatric care throughout the country by networking the resources of member states. Today, 45 states, including New Hampshire, and the District of Columbia are members.⁷⁷

The legislature of each member state passed the same core laws included in the compact, though the exact varies slightly from state to state.⁷⁸ The compact mandates that “any patient may be transferred to an institution in another State whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby.”⁷⁹ It also includes provisions so that factors relevant to the well-being of the patient, such as the location of family members, are considered. Before a transfer occurs, the receiving facility must agree to accept the patient. If legislation within the state of the receiving facility includes a priority system for the admission of patients, the patient in question must be given priority as a local resident. The burden of transportation costs falls on the sending state. To oversee the transfer, each party state must appoint a “compact administrator” who coordinates activities under the compact including the circulation of any reports or correspondence.⁸⁰

Some of the additional necessary legal framework for transfer already exists within the New Hampshire state code. Title X Chapter 135-C Section 26 gives the DHHS commissioner the power to approve and designate the “New Hampshire hospital and any other facility” as the “receiving facilities for the care, custody, and treatment of persons subject to involuntary admissions.”⁸¹ This permissive language, similar to that found in the Hawaii state code, does not preclude the use of out-of-state facilities. In addition, Title X Chapter 135-C Section 29 makes provision for the transportation of patients, authorizing “any law enforcement officer” to “take custody of the person to be admitted and immediately deliver him to the receiving facility” in the case of involuntary admission.

The hospitals presented in Sections 9.3 through 9.7 as options for receiving facilities are public institutions that provide inpatient psychiatric treatment in a secure setting. Under the ICMH, a state does not need to form a contract with another state to transfer patients, which reduces the administrative hurdles associated with contract procurement. Accordingly, only state-run psychiatric hospitals were considered to reduce cost and effort associated with these additional administrative procedures. States in close proximity to New Hampshire were examined in order to keep patients close to any family members residing within the state and to minimize any difficulties associated with patient transportation, considerations not available to the island state of Hawaii. Because Vermont has only one state hospital with a small number of beds, it was excluded from consideration. Pennsylvania was also excluded because its psychiatric hospitals do not accept transfer patients from out-of-state.⁸²



9.3 Potential Public Receiving Facilities in Massachusetts

The state psychiatric system of Massachusetts operates three continuing-care facilities: Worcester Recovery Center and Hospital, Tewksbury Hospital, and Lemuel Shattuck Hospital. The hospitals have 260, 161 and 115 beds, respectively, for a total of 536 beds.⁸³ All have secure beds equipped to handle patients that pose a danger to themselves and/or others.⁸⁴ In 2016, the average cost of care per day was \$1,035, and the average length of stay was 200 days. The Massachusetts Department of Mental Health maintains an active referral list of patients from private acute psychiatric care facilities who are waiting for placement into one of the three state facilities.⁸⁵

There are several measures in place to ensure the safety and wellbeing of hospital staff and patients. The Mandatory Forensic Review (MFR) program requires risk assessment for certain groups of patients thought to be at risk for violence.⁸⁶ Reviews are conducted by Designated Forensic Professionals within the Department of Mental Health (DMH) Forensic Services who receive specialized training and certification from the department.⁸⁷ In addition, staff are trained in restraint and seclusion practices with a focus on de-escalation and restraint reduction.⁸⁸ A small number of campus police officers are stationed at each facility. The individual units are staffed with officers according to the level of illness treated there.⁸⁹

The DMH also outlines safety procedure within its Community Risk Mitigation Policy, which includes provisions for several committees charged with conducting effective oversight of risk management and incident response. A Risk Review Summary (RRS), including the Community Risk Identification Tool (CRIT) and any other relevant patient history, is used to develop risk mitigation strategies and determine the most appropriate course of treatment for each patient.⁹⁰ Staff are trained through a program titled “Safety, Hope, and Healing,” which provides staff with an “in depth understanding of strategies to promote safe environments for staff and persons served.”⁹¹ Annual refreshers on the curriculum, as well as monthly refreshers on physical engagement and disengagement skills, ensure that safety is a continuing priority.⁹²

Clinical Reviews also function to ensure the appropriateness of patient treatment given any changes in behavior or adverse events.⁹³ In addition, Critical Incident Reports are used to compile data that will inform any future policy changes.⁹⁴ The Enhanced Clinical Review program provides an additional safeguard. It informs facility and community access determinations for patients who have been identified as at-risk of violent behavior in prior reviews.⁹⁵

In the past, the Massachusetts state psychiatric hospitals have accepted transfers under the ICMH. These instances are rare, but two to three individuals were transferred in from out-of-state over the past four years. In most cases, these patients were citizens of



Massachusetts living in a different state, or prior patients of the Massachusetts state psychiatric system. In the other cases, the patients were transferred into the Massachusetts psychiatric system in order to be treated closer to family members living in Massachusetts.⁹⁶

9.4 Potential Public Receiving Facilities in Maine

The Maine state psychiatric system consists of Riverview Psychiatric Center and Dorothea Dix Hospital. Riverview contains 92 secure beds in four units. Its Upper and Lower Kennebec Units house civilly committed patients, while forensic patients reside in the Upper and Lower Saco Units.⁹⁷ There are currently two patients on the waiting list for the Saco Units and five on the waitlist for the Kennebec Units.⁹⁸ All units are locked. From 2015-2016, treatment time for civilly committed patients ranged from 47-284 days.⁹⁹ The average treatment duration was approximately 114 days.¹⁰⁰ The approximate cost per day per patient is \$1,300.¹⁰¹

Dorothea Dix contains three secure inpatient treatment units, each with 15 beds housing a mix of acute and non-acute patients.¹⁰² One unit houses the majority of the forensic patients in the hospital.¹⁰³ The court that placed these patients into the care of the hospital determines the level of observation of forensic patients.¹⁰⁴ The waitlist averages six to seven patients and wait times have ranged from 4 to 27 days in the past year.¹⁰⁵ From 2015-2016, treatment time for civilly committed patients ranged from 44-359 days.¹⁰⁶ The average treatment duration was approximately 137 days.¹⁰⁷ The treatment and residential areas are locked.¹⁰⁸ The approximate cost per day per patient is \$1,500.¹⁰⁹

Several procedures are in place to ensure appropriate treatment of patients. The Level of Care Utilization System (LOCUS), developed by the American Association of Community Psychiatrists, is a systematic approach to determining the appropriate level of care for psychiatric patients. The LOCUS tool evaluates patients within six categories: risk of harm; functional status; medical, addictive and psychiatric co-morbidity; recovery environment—stressors and supports; treatment and recovery history and attitude and engagement. The Maine psychiatric hospitals then utilize a structured decision-making guide to determine the appropriate level of care and treatment.¹¹⁰ State psychiatric procedures are also guided by a range of other evidence-based practices.¹¹¹

Both Riverview and Dorothea Dix have accepted patients from other states and sent Maine patients to out of state facilities under the ICMH.¹¹² Thus far, the patients who were sent to Maine from other facilities in other states were transferred after it was determined that they would be best served in Maine because they had lived there previously, or had family members who resided within the state.¹¹³



9.5 Potential Public Receiving Facilities in Rhode Island

Due to its relatively small population, the Rhode Island state psychiatric network includes only the Eleanor Slater Hospital System. The hospital has two service areas, Medical Long-Term Care and Adult Psychiatric Services.¹¹⁴ The hospital has one campus in Burillville and one in Cranston, with 495 beds in total. It contains the only Long Term Acute Care Hospital (LTACH) in the state, with 284 beds. Patients in LTACH are required to have a primary physical medical diagnosis, though some may have an additional secondary psychiatric diagnosis.¹¹⁵ There are seven units in total. Five of the seven are medical units and are therefore not secured. The remaining two units, both of which provide psychiatric care, are secure.¹¹⁶

Due to the large number of patients admitted to the hospital through the court system, Eleanor Slater is not accepting civilly committed patients at this time.¹¹⁷ The hospital will resume civil admissions when doing so will not offset the ratio of psychiatric to medical patients required to obtain Medicaid reimbursement, which is greater than one-half medical patients. For the care of patients housed in secure units, Eleanor Slater is reimbursed through Medicaid at a rate of \$750 per day.¹¹⁸ To ensure a high quality of care, the hospital regularly conducts performance improvement reviews. Hospital administrators, physicians, nurses and staff collaborate to review hospital procedure and determine what, if any, modifications are necessary.¹¹⁹

Rhode Island has successfully transferred one patient out-of-state under the ICMH, but has not recently accepted any patients after closing to psychiatric admissions.¹²⁰ The patient transferred to a facility in another state was acutely ill and could be offered the necessary care at Eleanor Slater.¹²¹ Provided Eleanor Slater begins accepting civilly committed patients again, it is a viable receiving facility for civilly committed patients residing in the SPU.

9.6 Potential Public Receiving Facilities in Connecticut

The Connecticut Department of Mental Health and Addiction Services (DMHAS) consists of four facilities offering inpatient treatment. Only two of these facilities are discussed here, as the remaining facilities primarily care for uninsured or underinsured residents of surrounding Connecticut counties.

The Greater Bridgeport Community Mental Health Center (GBCMHC) contains three units: Psychiatric Intensive Care Unit I (PICU I), the admissions unit; PICU II, the extended care unit (PICU II); and the Co-Occurring Treatment Unit (CTU). PICU I and PICU II each contain 21 beds in locked units that provide secure, highly-structured care for severely mentally ill patients. PICU I focuses on assessment and stabilization, with the goal of returning the patient to his or her community. PICU II focuses on



rehabilitation and houses patients in need of extended care. The CTU is also a secure facility and contains an additional 20 beds for patients with co-occurring illness requiring mental health and substance abuse rehabilitation care. The Integrated Dual Disorders Treatment (IDDT) evidence-based practice serves as the model for care in the CTU.¹²²

The Connecticut Valley Hospital (CVH) contains three divisions: the General Psychiatry Division, the Whiting Forensic Division, and the Addictive Services Division. CVH has 596 beds spread over 28 inpatient units on two separate campuses, Middletown and Hartford.¹²³ The General Psychiatry Division contains 209 beds.¹²⁴ The Whiting Forensic Division contains 229 beds.¹²⁵ The division almost exclusively treats adjudicated patients, but civil patients may be admitted if enhanced security or specialized care are necessary.¹²⁶ Both the General Psychiatry and Whiting Forensic Divisions partner with the Office of the Commissioner to ensure continued appropriateness of patient treatment plans.¹²⁷ The cost of care at CVH is approximately \$1200 per day.¹²⁸

All services provided in the Connecticut psychiatric system are designed within the “Recovery to Wellness” framework. This approach focuses on helping patients develop life skills to assist with recovery and maintenance of “an optimal state of mental health.”¹²⁹ Individual treatment plans are developed with many sources of input, including community providers, families, and advocates outside of the hospital staff.¹³⁰ For security purposes, Connecticut Valley Hospital maintains a DMHAS police presence on its campus.¹³¹

The waitlists for each hospital are updated regularly. GBCMHC currently has one patient awaiting admission, while CVH has thirteen, two of which are awaiting admission from New York and Pennsylvania through the ICMH.¹³² In the past, the Connecticut Department of Mental Health and Addiction Services has admitted other patients to state hospitals from out-of-state under the ICMH. Those cases involved Connecticut residents being cared for outside that state that were returned to Connecticut.¹³³

9.7 Potential Public Receiving Facilities in New York

The Office of Mental Health in New York operates 25 psychiatric facilities.¹³⁴ Only three of these facilities are secure and equipped to handle potentially violent patients. Of those three, the Central New York Psychiatric Center exclusively serves persons incarcerated in the New York State and County Correctional Systems. The remaining two facilities, Kirby Forensic Psychiatric Center and Mid-Hudson Forensic Psychiatric Center, treat those involuntarily committed and deemed potentially dangerous. Kirby Forensic Psychiatric Center is a maximum-security hospital containing 200 beds, over 100 nurses, and over 50 physicians.¹³⁵ Admissions to the Mid-Hudson Forensic Psychiatric Center “are consequent to judicial findings of incompetent to stand trial or not



responsible by reason of mental disease or defect.”¹³⁶ The hospital currently has 169 beds and admitted 289 patients in the last year.¹³⁷

As part of the New York Mental Hygiene Law, the state of New York is a signatory of the ICMH. Though the New York Mental Hygiene Law itself does not contain specific parameters for facilitating the transfer of patients who require placement into secure facilities, the state is able to accept such patients under the ICMH.

9.8 Implementation of Out-of-State Transfer in New Hampshire

The first consideration for implementation is financial viability. The Hawaii model of out-of-state transfer is potentially applicable, as it can reduce the cost of patient care for the state. It is reasonable to expect that by identifying an out-of-state facility with available beds, New Hampshire could develop a transfer program with comparable costs. This may still come at additional cost to the state, however, which currently spends \$270 per patient per day at the SPU.¹³⁸ It is important to note, however, that \$1,350 is spent per patient per day at the New Hampshire State Hospital.¹³⁹ Therefore, although a transfer program may be costlier than the current system, it may be less expensive than moving patients back into the NHH, improving security at NHH, or constructing new secure facilities.

Practicality must also be considered. Due to the nation-wide shortage of hospital beds for mentally ill patients, it is likely that a transfer system would be able to support only small numbers of patients. The SPU currently has 40 beds. As of March 2016, up to 14 of these beds were occupied by patients who have not been charged with or convicted of a crime.¹⁴⁰ Although Hawaii has transferred fewer than 14 patients out-of-state, it is estimated that an additional ten patients are eligible for transfer, and will likely be moved to South Carolina.¹⁴¹ It appears, therefore, that accommodation of most or all non-criminal patients in the New Hampshire SPU in out-of-state facilities is likely achievable if the small number of necessary beds exist in the states examined in Sections 9.3 through 9.7.

As in Hawaii, the state and/or the Department of Health and Human Services (DHHS) must first ensure that the necessary legislative framework is in place, including the criteria used to determine whether transfer is appropriate and a moratorium on the placement of non-criminal patients in the SPU similar to the proposal found in New Hampshire House Bill 1541 from 2016. The state would then work to identify appropriate facilities in other states and form a cooperative agreement with those facilities. Like in the Hawaii model, following the transition period, jurisdiction and oversight responsibility would no longer fall to the New Hampshire DOC, but to the DHHS and the receiving health facility.



The implementation of out-of-state transfer in New Hampshire is a feasible policy alternative to housing violent patients in the SPU given its basis in an applicable legal framework already within the state code, potential cost-saving value, and availability of receiving facilities in nearby New England and Northeastern states that have already accepted out-of-state patients under the ICMH.

10. CONCLUSION

Maintaining the status quo policy and continuing the treatment of civilly committed patients in the SPU would not require any additional expenditures or legislative changes. The collaboration between DHHS and DOC allows patients to be transferred between the NHH and the SPU as needed and to receive psychiatric care in both. Some stakeholders may, however, prefer to see the status quo changed, due to external controversy, a lack of Medicaid funding, the possibility of moving patients into a more therapeutic setting, or other reasons.

Each of the four new policy options presented above—a) renovating existing psychiatric facilities, b) constructing a new secure psychiatric facility, c) developing an assistant outpatient treatment program, and d) transferring patients to an out-of-state facility—offers a viable alternative to treating non-adjudicated psychiatric patients in the Secure Psychiatric Unit of the New Hampshire State Prison for Men at Concord. Each of these four options has different potential benefits and costs associated with it.

Improving pre-existing facilities in New Hampshire would equip the state to handle potentially violent patients currently being placed in the SPU in a non-correctional setting without committing to a major and expensive new construction project. This alternative has the benefit of a lower cost than constructing a new secure psychiatric facility, but may still be costlier than stakeholders and policymakers would prefer.

Constructing a new psychiatric hospital would also enable New Hampshire to house the most potentially dangerous civilly committed patients outside of prison grounds. This approach would incur substantial financial costs associated with new construction, but these costs may be partially offset by the potential positive economic impact, as well as previously unavailable Medicaid reimbursement. Further, a new psychiatric facility may allow New Hampshire to relieve the pressure on its emergency rooms by housing other psychiatric patients in a less secure area of a new facility.

Implementing an AOT program would require little infrastructural investment, as it would rely on pre-existing frameworks and networks of community care. AOT, however, faces obstacles to achieving patient compliance. In addition, it has proven to be an effective treatment method for individuals with severe mental illness in some cases, but may not be a viable treatment option for all patients currently housed in the SPU.



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Transferring patients to psychiatric facilities in other states has the likely benefit of being the least costly option, however, it is a less direct solution. New Hampshire is also well-equipped to carry out this alternative as it is a member state of the ICMH and the necessary legal framework already exists within the state code. A drawback to this option is the cost associated with implementing the administrative and transportation structures required in order to transfer patients, though a related benefit is the existence of potential receiving facilities in nearby states.

It is hoped that this report elucidates the costs and benefits associated with each available policy option. Ultimately, it is left to New Hampshire policymakers and stakeholders to determine what option, or combination of options, will best serve the state.



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