Improving Transitions in Care:

Focus on the Revocation of Conditional Discharge Process in New Hampshire

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Date submitted: December 21, 2020
Abstract

Background: At this time there is no standardized education for providers of New Hampshire Hospital addressing the Revocation of Conditional Discharge Process. Psychiatric patients in New Hampshire most at risk for harm to self or others are managed through Involuntary Commitment Orders. These orders are intended to support those most at risk of destabilization and treatment non-compliance. The Revocation of Conditional Discharge Process is one of the procedures used to re-hospitalize a patient whose care is managed through an Involuntary Commitment Order when needed. The psychiatric providers at New Hampshire Hospital must complete this last step in the revocation process, the Absolute Revocation. Each portion of the revocation process submitted to the Legal Office must be valid and legally sound. Patterns have been noted in which the steps to revoke a Conditional Discharge fail to be completed appropriately, thus jeopardizing the process and patient care. In FY 2019, per data collected and analyzed by the Legal Office of New Hampshire Hospital, 89% of appealed Absolute Revocation cases were not upheld when those reversed on appeal and those that were withdrawn due to fatal error were included. In FY 2020, 73% were not upheld. A failed revocation results in the inability to continue hospitalization by this process, placing patients and providers at risk.

Purpose: The global aim of this initiative will be to improve compliance with the steps of the Revocation of Conditional Discharge process in order to decrease risk of reversal of appealed Absolute Revocations. The initial pilot of this quality improvement project will aim to improve provider knowledge and mastery of completing the Absolute Revocation process by implementing an e-learning module developed to educate the providers at New Hampshire Hospital about each of the steps necessary for compliance.
Methods: A project plan was developed after a review of the available knowledge using Roy’s Adaptation Model and the Institute of Medicine's Core Competencies as the foundation and framework to guide development, implementation and assessment of an educational module specifically designed to address knowledge deficits to improve compliance and mastery of the steps of the process at New Hampshire Hospital.

Interventions: An educational module was developed to provide comprehensive education regarding all steps in the Revocation of Conditional Discharge Process, with a focus on the steps and timelines of the Absolute Revocation portion of the process. Pre and post-tests were designed and utilized to assess the level of knowledge and mastery of the process steps.

Results: Seven participants completed the module, pre- and post-test in the set time frame, statistical significance for effectiveness of the learning module was found when pre and post-test scores were analyzed using paired t-tests.

Conclusion: Although not all targets outlined in the specific aim were met, the educational module and tests were found to be statistically significant even with the small sample size. This educational project can now serve as the foundation for future education regarding the process and related care needs and issues to key individuals across the care continuum.

Keywords: revocation of conditional discharge, involuntary psychiatric commitment in New Hampshire, psychiatric provider education, mental health system, patient-centered care
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Improving Transitions in Care:

A Focus on the Revocation of Conditional Discharge Process in New Hampshire

Introduction

Psychiatric patients in New Hampshire, diagnosed with Schizophrenia, Bipolar Illness, Schizoaffective Disorder and other DSM V diagnoses who are most at risk for harm to themselves or others are managed through Involuntary Commitment Orders. These orders are intended to support those most at risk of destabilization and treatment non-compliance. The Revocation of Conditional Discharge Process is one of the procedures used to re-hospitalize a patient whose care is managed across the care continuum through an Involuntary Commitment Order. The psychiatric providers at New Hampshire Hospital must complete this last step in the revocation process, the Absolute Revocation. Each portion of the revocation process submitted to the Legal Office must be valid and legally sound. Patterns have been noted in which the steps to revoke a Conditional Discharge failed to be completed appropriately thus jeopardizing the process and patient care. The Legal Office of New Hampshire Hospital has found over the past two fiscal years that up to 89% of appealed Absolute Revocation cases were not upheld when those reversed on appeal and those that were withdrawn due to fatal errors were included. When an Absolute Revocation is reversed, a patient can no longer be hospitalized legally under He-M 609.7. This can negatively impact the patient and treatment team. Patients may then be discharged without adequate preparation to stabilize or promote continued care, placing them at risk of significant negative consequences associated with inadequate discharges.

A failed revocation is a costly disruption in care. It can negatively impact the patient and treatment team. Patients may need to be discharged without adequate preparation to stabilize or promote continued care, placing them at risk of significant negative consequences associated
with inadequate discharges. The cost financially is also great, an estimated minimum cost being greater than $10,000 for revocations reversed. Designated providers of New Hampshire Hospital need to understand and fully comply with steps of the revocation process in order to submit an Absolute Revocation that will be upheld.

The global aim of this initiative will be to improve compliance with the steps of the Revocation of Conditional Discharge process in order to decrease risk of reversal of appealed Absolute Revocations. The initial pilot in this quality improvement project aimed to improve provider knowledge and confidence in completing the Absolute Revocation process by implementing an e-learning module developed to educate the providers at New Hampshire Hospital about each of the steps necessary for compliance. This educational project can serve as the foundation for future education regarding the process, related care needs and issues to key individuals across the care continuum.

Problem Description

There is no standardized educational program addressing the Revocation of Conditional Discharge Process at New Hampshire Hospital. However, knowledge and mastery of the steps of the process are essential in maintaining inpatient care under NH Administrative rules He-M 609, the rules of Conditional Discharge. The Revocation of the Conditional Discharge Process is an involuntary hospitalization process in New Hampshire. Care for psychiatric patients at New Hampshire Hospital who are most at risk for harm to self or others is often managed through Involuntary Commitment Orders that cover the transition from inpatient treatment to outpatient care via conditional discharges. In New Hampshire, involuntary treatment can be ordered by a Probate Court Judge in cases where the patient is diagnosed with a qualifying mental health diagnosis and is determined to be at risk of dangerousness for up to five years. During the
ordered involuntary care period, the patient is discharged with conditions to be monitored by a community mental health program (NH He-M 609, 2016). The conditions that a patient must agree to and adhere to include that he/she will: attend and participate in scheduled treatment/appointments; adhere to a medication regimen to promote symptom stability and improved ability to function; comply with laboratory studies if indicated; and refrain from misuse or abuse of substances to the extent that it impacts illness or ability to function or involve oneself in care. If the conditions listed above are not met, the patient’s right to care in the community can be revoked temporarily as they are taken to a local emergency department in by authorities for further evaluation for involuntary re-hospitalization per New Hampshire He-M 609 (2016).

The Revocation of Conditional Discharge Process is used to re-hospitalize a patient who is in need of treatment and on a commitment for involuntary psychiatric care. It is essential for psychiatric providers at New Hampshire Hospital to understand the revocation process for many reasons. These providers must complete the last step in the revocation process by submitting an Absolute Revocation form that is valid and legally sound to continue to have a patient hospitalized under NH Administrative Rule He-M 609. These providers must assess the patient and the previous steps and then complete the Absolute Revocation form in the specific time frame per the process it follows (NH He-M 609, 2016). Patterns containing significant omissions and missed steps in the Revocation of Conditional Discharge (RCD) process have been identified. Failed revocations place the patient and providers at risk. The Absolute Revocation when not able to be upheld eliminates the option of continued hospitalization under HEM 609. This need for abrupt change in status without adequate time to optimize discharge planning results in decreased time to stabilize a patient, and impaired coordination of care and can negatively impact the patient and those in the care system (Puschner et al., 2011; Vigod et
al., 2013). This risky transition can lead to deterioration of trust in treatment teams, diminished chance of treatment adherence, a surge in symptoms, risk of early readmission (Felix et al., 2015), and tragically, the loss of life due to suicide (Chung et al., 2017).

**Available Knowledge**

The mental health system in New Hampshire is in crisis. There is an excessive burden on services within the system, such as community mental health centers, local emergency rooms, housing supports, local law enforcement, and psychiatric units and hospitals. There are significant resource limitations. These factors create issues for patients and providers across the state. Headlines and reports highlighting recent lawsuits have targeted patient rights violations, focusing on patients held in emergency rooms for extensive amounts of time (Moon, 2020; Nordstrom et al., 2019; Ramer, 2020a, 2020b). Emergency Department (ED) boarding, or the process under which a psychiatric patient is held in an emergency room waiting for an inpatient bed, is a phenomenon that occurs across the United States (Abid et al., 2014; Nolan et al., 2015). In New Hampshire, some patients are held for weeks in an ED without due process or ability to argue for their release (Moon, 2020). However, the attention on emergency room boarding only focuses on one piece of a greater set of problems within a complex, multi-faceted system (Ramer, 2020b). There are multiple problems associated with the system contributing to ED boarding. The dwindling number of inpatient beds, inadequate number of mental health specialists, and lack of community resources all add to outpatient care limitations (Abid et al., 2014, Morris, 2017). Increased rates of social stressors such as homelessness, rising substance abuse issues, and glitches with insurance coverage and lacking support systems for those affected by psychiatric illness (Abid et al., 2014) negatively impact this problem.
Even with the known issues impacting the mental health system, especially the involuntary care processes, under certain circumstances, some individuals need hospitalization who are not willing or able to consent. State laws regarding involuntary hospitalization and treatment outline the path to care when the patient is not able to consent to care due to symptomatology and patterned human responses. Inpatient hospitalization has the advantage of providing a structured environment of increased security and support (APA, 2020) and can be necessary when outpatient treatment is not able to be provided in a safe and effective manner. Inpatient psychiatric care allows for close monitoring of the patient’s symptoms, the patient’s level of functioning, distress, and response to treatment (APA, 2020).

Prevailing state laws determine steps to be taken if an individual is not consenting to hospitalization or treatment but requires psychiatric treatment. In New Hampshire, the processes for involuntary hospitalization are delineated under NH RSA 135:C (2019) and NH State Rule He-M 609 (2016). The Revocation of Conditional Discharge process detailed in HeM 609 is the process by which adult patients who have been ordered by a Probate Court Judge to have an Involuntary Commitment to New Hampshire Hospital are discharged to the care of a community mental health center with conditions of discharge to be followed and the reasons that would prompt readmission to an involuntary unit (NH He-M 609, 2016). The process is complex and involves a variety of disciplines to be involved during execution.

The Revocation of the Conditional Discharge process is usually initiated when the CMHC representative receives evidence that a patient has not followed one or more of the conditions of discharge, and/or has engaged in dangerous behaviors, and/or is at risk of harm to self or others (NH RSA 135:C, 2019; NH He-M 609, 2016). Patients determined to be in need of evaluation for involuntary hospitalization may enter the system in two ways that end with the
Absolute Revocation of the Conditional Discharge Process. The first of these two processes is the Temporary Revocation process and the second is the Involuntary Emergency Admission (IEA) process. These pathways are outlined with time frames noted in Appendix B. Each path has well delineated steps that must be completed by clinicians and supportive resources in a specific manner within set time frames (NH RSA 135:C, 2019; NH He-M 609, 2016). There are limited facilities and potential beds that these patients can be admitted to and this can complicate acceptance and admission to a psychiatric bed. Emergency department (ED) boarding, the additional time patients are left in an emergency room waiting for transfer to an inpatient psychiatric bed, can complicate this process with delays in care, lack of direct communication with receiving clinician, sub-optimal environment for care of the psychiatric patient’s needs, lack of specialized training of emergency department personnel in care of mental health patients and delayed patient delivery to the designated receiving facility (DRF), that is licensed to admit and provide care to involuntary psychiatric patients. The delays that occur in the mental health system, especially in the emergency department, elicit changes in accountability as steps are completed. There are time intervals for staffing changes and each time there are delays in a patient being accepted to a specific designated receiving facility there is increased risk of omissions and missed steps in the community portion of the revocation process. The original personnel assigned are unable to complete the portions of the process they are working on to facilitate admission under the involuntary rules for a patient in need.

There are many dedicated professionals throughout the mental health system in New Hampshire who strive to provide care to this vulnerable population. They advocate for improved systems and resources and they readily engage in care processes to support psychiatric patients. However, this can be a challenging system for all involved. The system itself is
complicated, unyielding and legally structured by regulations that provide opportunity for continuity of care for the chronically and persistently mentally ill. Unfortunately, the system’s inflexibility can create barriers to care.

Managing symptoms experienced by patients who have chronic mental illness in inpatient and outpatient settings throughout this compromised state has challenges for patients, families, and providers. Rules and regulations promote the stabilization of symptoms in the least acute level of care possible within the system. Those patients most at risk for harm to self or others are generally managed through Involuntary Commitment orders. These orders are designed to support those most at risk of destabilization and treatment non-compliance. However, the system structure that guides involuntary care is complicated and inflexible. Many steps need to be followed in compliance within a specific timeline to meet the legal threshold (NH RSA 135:C, 2019; NH He-M 609, 2016).

The involuntary care system removes the patient's right to consent to hospitalization, and in some specific circumstances it also removes the right to consent to treatment. Patients are held against their will in emergency departments (Ramer, 2020b) where initial assessments are completed. The patients are then usually handcuffed and delivered to an involuntarily facility or unit by authorities. The patient may be in his or her home when police arrive, and they are then taken out into the community in custody and placed in the law enforcement vehicle for transport to the hospital. The mixed messages of infringement of civil rights, forced transport to evaluation and a process that is relayed as eliciting feelings of humiliation, vulnerability and targeted attack, for the benefit of care can be confusing for patients. The system not only involves the loss of freedoms, but also can lead to potential misinterpretation of intent and diminished therapeutic relationship. This process is depicted in Figure 1 on the next page.
As noted in the preceding paragraph, the system involves not only mental health clinicians but also, providers for medical clearance, attorneys, security officers, and community and county law enforcement. The local police may be tasked with locating a patient in the community, transporting, and at times guarding the patient in the community-based hospital. The emergency room and the mental health center are key stakeholders in the process's first steps and must complete their respective steps accurately. The county sheriff's office then provides delivery of the patient to a care facility capable of receiving the involuntary patient. The patients are generally handcuffed and transported in sheriff’s vehicle. Then, New Hampshire Hospital, or the designated receiving facility admitting the patient, is ultimately responsible for the assessment and Absolute Revocation as outlined in He-M 609 (NH RSA 135:C, 2019; NH Rules He-M 609, 2016).

It must be emphasized that the system is inflexible and complicated. Each step needs to be completed in compliance with New Hampshire statutes for an Absolute Revocation to be upheld. The Absolute Revocation allows continued hospitalization to those in need who meet
criteria. All parties involved in the process must have a solid understanding of each role and responsibility in the system.

During a revocation there is risk of disrupted therapeutic alliance, potential misinterpretation of intent, frustration, anger, embarrassment and a relayed sense of targeted victimization from a patient already suffering with symptoms impairing their mood and thoughts. Failure to maintain a revocation can result in a need to discharge the patient from the hospital without adequate preparation or hand-off. Inadequate discharge preparation may cause increased symptoms, rapid return to the emergency department of the local hospital, readmission, decompensated or disturbing behaviors, injury, or even death (Dixon et al., 2009; Felix et al. 2015).

Inpatient care is often a necessary step in stabilization and symptom management of patients with chronic and persistent mental illness. However, as stated previously, providing essential treatment to psychiatric patients is not an easy or welcomed task. It has been well documented that psychiatric patients may lack insight and have active symptoms impairing their ability to engage and consent even when care is needed (Testa & West, 2010). For this reason, involuntary hospitalization or civil commitment has been a main element in psychiatric care, with the addition of involuntary outpatient treatment years ago to avoid hospitalization when possible while continuing to ensure that individuals receive needed care (DeNesnera, 2015; Testa & West, 2010). As in most states, once a patient is admitted there is an emergency assessment period as part of the commitment process (Hedman et al., 2016). In New Hampshire, the initial time period for involuntary emergency admission is a designated period where a person can be held while the required determinations of need for petitioning for an involuntary commitment or revocation can be made, this is a ten-day period of time, excluding weekends for those admitted
on Involuntary Emergency Admission track (NH RSA 135:C, 2019). This process starts at admission to the inpatient unit, not at the start of the stay in the emergency department. Patient may be held for days or even weeks in an emergency room before the timeline begins. This extended period of patient holding without a right to a Hearing has elicited much debate and legal actions, including requests to the Supreme Court to consider if this process of holding the patient’s in the emergency room while these patients wait for transfer to an DRF violates the “law or the patient’s constitutional rights” (Morris, 2017, p.1).

The fragmented mental health system and the lack of connected community resources negatively impact patients and process. There is a significant lack of supported housing options for those with chronic and persistent mental illness, and robust Assertive Community Treatment services including evening community medication monitoring and administration. The limited number of inpatient beds, and delays in appointments with prescribing providers all complicate the path to stabilizing care at New Hampshire Hospital. These factors heighten the need to have patients in need of care maintained and treated in this high level of care. For those patients maintained in treatment through involuntary commitment orders who need a secure environment and stabilization, the revocation system is the key to care. However, patterns containing significant omissions and missed steps in the RCD process create increased risk within the system.

The Legal Office of New Hampshire Hospital reviews compliance with the revocation process and the legal rulings. Data from fiscal year (FY) 2019 and FY 2020 was collected and analyzed by the Legal Office and is depicted in Table 1. This data confirmed ongoing compliance concerns. The Legal Office of New Hampshire Hospital reported for FY 2019 noted that 165 patients were considered Revocation of Conditional Discharge (RCD) patients and 191
patients were considered as such in FY 2020. This total number of patients in the RCD process included patients admitted via Temporary RCD and those admitted via IEA who had their CD absolutely revoked. The FY 2019 report highlighted that 68% of appealed cases were reversed. However, an even more troubling statistic from this FY 2019 data was the finding that 89% of filed cases were not upheld when those withdrawn due to fatal errors in process and documentation were included. In FY 2020, the total number of those not upheld including those withdrawn was reported at 73%.

Table 1

*New Hampshire Hospital Legal Office Review of Absolute Revocation Appeals Data*

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total RCD Admissions to NHH</th>
<th>Number of RCD Appeal Cases Filed</th>
<th>Total Number of RCD Decisions</th>
<th>Number of Cases Upheld</th>
<th>Number of Cases Reversed</th>
<th>Total Number and Percentage Not Upheld Including Those Withdrawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2020</td>
<td>191</td>
<td>75</td>
<td>40 withdrawn</td>
<td>20</td>
<td>15</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>35 decisions</td>
<td>57%</td>
<td>43%</td>
<td>73%</td>
</tr>
<tr>
<td>FY 2019</td>
<td>165</td>
<td>56</td>
<td>37 withdrawn</td>
<td>6</td>
<td>13</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>19 decisions</td>
<td>32%</td>
<td>68%</td>
<td>89%</td>
</tr>
</tbody>
</table>

Risk is high for a revocation not to be upheld and the process itself can negatively impact the patient's trust in the system and diminish the treatment team's therapeutic relationship. The association of involuntary commitment orders with coercion and the patient’s involuntary confinement add to the complexity of the process and concerns about the potential negative impact if a revocation fails. A failed revocation also sends a mixed message to the patient
regarding the importance of care, compliance with appointments and medications. Failed revocations can certainly negatively impact the relationship between patients and providers. Relationships between providers and patients can influence therapeutic outcomes. Positive therapeutic relationships contribute to commitment to care, treatment adherence and to the experience of all involved in the process (Gerace, et al., 2018; Peplau, 1997).

Empathy is vital to the health of the patient - provider relationship. Literature has noted the role that nurses and other mental health providers have in managing conflict and stressors that arise with control of patient freedom. Risk needs to be managed in the context of illness severity. Fostering empathy, recovery-oriented principles and therapeutic partnerships can improve safety and outcomes (Gerace, et al., 2018; Peplau, 1997).

Patients who have a reversed revocation may need to be discharged without adequate stabilization or planning to promote continued stabilization as they return to the community and again an empathic approach yields improved knowledge of the patient’s needs and experience. Evidence suggests that patients who receive more substantial discharge planning are more likely to utilize outpatient psychiatric services (Steffen et al., 2009) and are less prone to adjustment issues and problems that require re-hospitalization. Inadequate discharge planning and lack of follow up post-discharge can be reasons for limited outpatient follow through and factors in unfavorable clinical outcomes (Puschner et al., 2011).

Failed discharges and lack of connection to outpatient services can hurt patients (Vigod et al., 2013), families, the community, resources for psychiatric care, and providers. Discharge issues can lead to potential readmissions resulting in excessive healthcare resource utilization and expenses (Dixon et al., 2009; Felix et al., 2015). Untimely discharges can lead to risks associated with incomplete assessments, injuries, medical errors, diminished trust, and strength
of relationships with healthcare providers, and overall decompensation of the patient (Felix et al., 2015). Unfortunately, inadequately prepared discharges have resulted in diminished function of patients and, tragically, in the loss of life due to suicide, a risk that is high during this transition in care. There is already an increased risk of suicide post-discharge from psychiatric hospitalization, with a rate of 78 per 100,000, approximately 15 times the national average in the United States (Chung et al., 2017). In New Hampshire, the suicide rate is high and has increased by 48.3% since 2000 (CDC, 2018). In cases where patients have been ordered by a Probate Court Judge to an Involuntary Commitment Order, the risk is compounded by additional variables and there is an elevated risk of adverse events. These patients have been deemed to be at a level of risk of harm to self or others that warrant court-ordered involuntary care (DeNesnera, 2015).

Effective management of these transitions in care, especially with discharges involving the patients most at risk of harm to self or others and treatment non-compliance, is essential to effective treatment across the continuum of care (Viggiano et al., 2012). Poor care coordination and follow-up care issues are considered two primary factors in failed discharges (Dixon et al., 2009; Felix et al., 2015). The lack of available services, issues with communication between care providers, lack of informational exchange, and fragmentation of service lines can all contribute to failed transitions (Puschner et al., 2011; Smith et al., 2017). When the steps of a revocation are not completed correctly, risk increases. System failures can impact symptomatology, a patient's level of distress, and quality of life, but there is also a significant financial toll. In 2013, psychiatric admissions in the United States for schizophrenia alone totaled $11.5 billion, with an estimated $646 million resulting in readmission within 30 days of discharge (Fuller et al., 2016). In New Hampshire, as noted in Table 1 of this paper, it is
estimated that each failed revocation costs at least $10,000 and is, unfortunately, without the benefit of cost-effective treatment.

As noted above, failed revocations place patients, providers, and the mental health system at risk. Many variables in the revocation process can compromise the validity of an Absolute Revocation. When the revocation is not valid, the case is reversed, and a patient can no longer be hospitalized under the RCD process (NH He-M 609, 2016). Each reversed revocation can jeopardize the safety, stability and care of the patient.

This initial phase of the quality improvement project focused on the steps the psychiatric provider at New Hampshire Hospital needs to complete so that an Absolute Revocation can be upheld if appealed (NH He-M 609, 2016). The provider needs to understand and fully comply with the steps in determining and then carrying out a legally sound revocation. Full understanding of this process is essential to successfully fulfilling the role of the psychiatric provider at New Hampshire Hospital, the state's main involuntary psychiatric facility.

There is evidence that established protocols and procedures yield more successful transitions in care within general medical research. Although, there is limited research, that protocols, guide cohesive and coordinated care in the field of psychiatry, guidelines aimed at appropriate preparation, care and transitions for psychiatric patients (Viggiano et al., 2012) need to be a starting point. It is evident from the high number of withdrawn or reversed revocations that state statutes, rules, and policies guiding this complicated process are not enough to provide guidance and facilitate adherence to the complex and time-sensitive revocation system. An intervention is needed to improve the process.

**Rationale**

Involuntary Commitment Orders are intended to support those most at risk of destabilization and
treatment non-compliance. Patients can be hospitalized under the statutes governing these orders to stabilize and recommit to treatment. However, the system is costly. Through this process, there is a cost to patient freedom, with involuntary assessments and hospitalization. The financial cost is also high, an estimated minimum cost being higher than $10,000 for each failed Absolute Revocation (Table 1). Designated providers of New Hampshire Hospital need to understand and fully comply with the steps of the revocation process in order to submit a valid Absolute Revocation. When a revocation is reversed, a patient can no longer be hospitalized legally under the Revocation of Conditional Discharge rules (NH He-M 609, 2016). This reversal can negatively impact the patient and treatment team. Patients may need to be discharged without adequate preparation to stabilize or promote continued care, placing them at risk of significant adverse consequences associated with inadequate discharges.

The psychiatrists and psychiatric APRNs need to understand all of the steps to defend the rationale and the Absolute Revocation process and the legal counsel of New Hampshire Hospital. These providers must justify the last action steps at an appeal hearing. They need to understand the impact that this process has on their role and has on the patient. There is no formal, standardized learning tool or class for providers at New Hampshire Hospital addressing the Revocation of Conditional Discharge Process. No research study can be identified that addresses provider knowledge of RCD steps. However, expertise is needed for all parties that contribute to the successful completion of each step of the process. It is assumed that a significant lack of understanding exists and contributes to the high rate of failed absolute revocations.

Specific Aim

This quality improvement initiative's global aim will be to improve compliance with the steps of the Revocation of Conditional Discharge process to decrease reversal of appealed
Absolute Revocations. The first phase in this quality improvement project targeted improved psychiatric provider knowledge through completion of the implementation an e-learning module developed to educate the providers at New Hampshire Hospital about each of the steps necessary for compliance with the Revocation of Conditional Discharge Process. The module reviewed the steps and specific time requirements of the revocation of conditional discharge process with focus on the areas identified as high risk for reversal of revocations.

The specific aim of this pilot was to evaluate the effectiveness of the RCD Process education tool in improving the knowledge level and mastery of subject matter accomplished by 100 % score on post-test by 100% of participants completing the module and corresponding assessments before November 14, 2020. Target sample size was set at 10 participants with potential sample size being 20. Based on the success of this pilot's implementation, there would be plan for the module will be modified to be offered to others at NHH and key sites throughout the process system such as community mental health centers.

This project is a foundation for a larger quality improvement initiative aimed at improving knowledge of and compliance with the Revocation of Conditional Discharge process to reduce reversed and failed revocations. Modifications to the educational program that reviews the steps needed for successful completion of the Revocation of Conditional Discharge Process could be used across key disciplines at New Hampshire Hospital and statewide. This could be offered to community mental health centers, additional designated receiving facilities, emergency room staff, and additional community members who support the revocation process at NHH and other inpatient units. A plan for pre- and post-intervention review for statistical differences in the Hearings Report for Revocation of Conditional Discharge (RCD) would allow an analysis of the impact of this educational program.
**Methods**

The profession of nursing “has a social mandate to contribute to the good of society through knowledge-based practice” (McCurry et al., 2010, p.42). This mandate requires nurse leaders to question the existing practices and procedures, identify areas where nurses can intervene, evaluate interventions and potential advances and engage in actions to promote improvements for the disciplinary goal to contribute to the health of individuals and overall society (McCurry et al., 2010). Roy’s Adaptation Theory provided a conceptual framework for this project and was chosen because of the congruence with the goal promoting health and adaptation through all levels including individual, system and the community. The utilization of nursing theory allows for meaningful actions and articulation of the rationale behind these actions to be guided. This Adaptation Model calls nurse leaders to holistically assess the patients and systems of the environment in context. The model allows for areas to be identified where a nursing leader can target intervention to reduce stress on the system and patient to facilitate positive change in the patient, system and community (Hanna, 2006) and provide holistic high-quality care (McCurry et al., 2010). The nursing metaparadigm defines the four concepts that serve as the underpinnings for nursing theories: 1. human beings, 2. environment, 3. health, 4. nursing, and Roy's Adaptation Theory focuses on the individual as a bio-psycho-social being interconnected with the environment around him (Roy et al., 2014). Roy’s theory utilizes the nursing metaparadigm as the encompassing medium in which strategies through the nursing process can be targeted to facilitate positive adaptive responses to yield positive outcomes (McCurry et al., 2010).

Roy's Adaptation Model was specifically chosen to provide the theoretical foundation for assessing the problem, developing the intervention, and implementing the quality improvement
project's steps because of the outline Sr. Callista Roy used to explain the interplay of the concepts. Nurses promote the balance between their client’s interrelated human systems and the world around them in a role to prevent, mitigate, or stop stress that produces negative stimuli and to enhance coping and adaptation. A comprehensive assessment of the person, stimuli, and environment is essential to mitigating stress through this process outlined by Sr. Callista Roy. Through the development of this project and learning tool, it was important to assess and address several identified stimuli; the focal or the active stressors, the contextual, or the environment and its impact on the patient and providers and the residual background factors related to the focal stimulus, in this case, their experience with the mental health system (Roy et al., 2014). This project’s development needed to focus on the legal steps and compliance with the process. This also needed to begin to address strategies to mitigate stress experienced by the patient, key individuals in the system, and the psychiatrist or psychiatric nurse practitioner absolutely revoking the patient.

Holistic assessment, modification of stressors and human adaptation are at the core of nursing leadership and inter-disciplinary collaboration. The focus on the concepts from Roy’s Adaptation Theory can serve as a model for others. Through this mission, nurse leaders facilitate new healthcare directions, promoting positive change in systems to support stability for the bio-psycho-social being that the care is centered on. Through leadership, education, advocacy and promotion of high-quality care, nurse leaders are in pivotal roles that can facilitate improved methods of care and sustainable evidence-based outcomes, and in this case greater application begins with this pilot (Buckner, 2019).

The Institute of Medicine's Core Competencies defined in 2003 provided additional structure to planning, and the implementation of this project. The first of the competencies
defined by the Institute is to provide patient-centered care, to have concern for patient differences, limitations, values, and needs. These competencies prompt the provision of information through education and advocacy to prevent worsening symptoms and disease states, promoting wellness (Institute of Medicine, 2003). The second competency preserves and encourages the utilization of interdisciplinary teams. To be a successful care provider, especially in the complex system of involuntary psychiatric care, one must collaborate and communicate effectively with multidisciplinary team members to ensure care extends reliably across the healthcare continuum (Institute of Medicine, 2003). The next proficiency is incorporating evidence-based practice, integrating research and clinical expertise to individualized patient plans to promote safe and optimal care. Healthcare providers are called upon to engage in learning and research-based activities, as is reasonable within their roles and positions (Institute of Medicine, 2003). The fourth competency is the application of quality improvement. The Institute of Medicine guides providers to identify deficiencies and target potential hazards in the care system, implement systems, advocate for changes to understand and measure the quality of care in processes, and outcomes related to patient and community needs. This competency calls for the provider to design and test interventions that change processes and strive for quality improvement. The last of these competencies include using informatics to communicate information, manage data, mitigate errors, and support decision making through the use of information technology (Institute of Medicine, 2003).

Using the PDSA Model (Plan Do Study Act Model) for quality improvement depicted in Figure 2 (Institute for Healthcare Improvement, 2020, Taylor et al., 2014), an educational intervention was designed, and implemented as the first phase and will be modified as results are studied in the next steps of this project. The online learning module was created in PowerPoint,
shaped by and uploaded to the online educational system available to the Department of Health and Human Services in the State of New Hampshire, Moodle, and supported by the Education Department of New Hampshire Hospital. This learning module (Appendix C) was designed to increase the knowledge of the Revocation of Conditional Discharge Process for the psychiatric providers at NHH, with the initial phase of implementation addressing the potential knowledge deficit and learning needs of the psychiatric providers evaluating and treating patients at New Hampshire Hospital.

Figure 2

**PDSA Model**

- **Act**
  - Identify an opportunity for improvement. Plan the project with evaluation criteria and method(s) of data collection.

- **Plan**
  - Implement the initial phase or pilot project with an intervention to facilitate change, on a small scale.

- **Study**
  - Analyze and compare the results to your predictions. Reflect and note what has been learned.

- **Do**
  - Modify the program and implement again with changes or implement on a larger scale, or end the current project.

(Institute for Healthcare Improvement, 2020).

The quality improvement initiative was deployed at New Hampshire Hospital. The selected subject group consisted of the psychiatric providers at this involuntary psychiatric
hospital. Participation was offered for all in the potential subject group, it was not ordered by
this project leader. The education was not mandatory, although there were mandatory education
modules assigned by Administration that the potential participants did need to complete during
the same time period that this additional module was offered.

Ethical principles that guide responsible conduct for research and quality improvement,
respect, beneficence and following standards to support justice will guide methods used in the
project and study of related issues (Harris et al., 2016). Deployment of an educational module
through Moodle that includes a pre- and post- knowledge assessment will be utilized to measure
effectiveness of the tool and change in level of knowledge.

Cost-Benefit Analysis

Quantifying the cost of a poorly initiated revocation or missed steps in this process is
challenging to compute. Involuntary Commitment Orders are intended to support those most at
risk of destabilization and treatment non-compliance. Patients can be hospitalized under the
statutes governing these orders to stabilize and recommit to treatment. However, costs to the
system and potentially the patient can be high. Through this process, there is a cost to patient
freedom, to involuntary assessments, and hospitalization. There is an estimated minimum cost of
more than $10,000 for each reversed revocation.

The psychiatric providers of New Hampshire Hospital need to understand and fully
comply with the steps of the revocation process in order to submit an Absolute Revocation that
can be upheld; however, it is also imperative that all clinicians completing the steps in the
Proposed and Temporary Revocations understand and fully comply to the rules. The stakes are
high, and each section needs to be completed correctly for a revocation to be upheld. When an
Absolute Revocation is reversed, a patient can no longer be hospitalized legally under NH He-M
This can negatively impact the patient and his or her treatment team. Patients may need to be discharged without adequate preparation to stabilize or promote continued care, placing them at risk of significant adverse consequences associated with inadequate discharges. Transition throughout the care continuum with support and available resources, such as access to prescription medication, access to outpatient team at time of discharge and timely relay of appropriate information can all support success. Transitions that are poorly managed or lacking in connectivity for patients can result in unnecessary stress, anxiety, non-compliance with treatment complications and even death (Al-Yateem & Dohety, 2015).

It is not possible to capture the potential costs of all individual scenarios. Minimal costs associated with a revocation failed on appeal are outlined in Table 2. The quantification represented in Table 2 is a low estimate. The costs to additional direct and indirect resources associated with the revocation process are not factored into the cost listed in this paper due to difficulties in quantifying even the estimated amounts. The cost listed is based on the minimal time a patient who is appealing revocation of his or her conditional discharge would be hospitalized at New Hampshire Hospital and does not include potential lost work time of the patient, cost of the search for a patient to begin the process and bring a patient in for a compulsory exam. It does not include the cost of law enforcement monitoring and transfer time. It does not account for the extended period of days or weeks that a patient may be held in the emergency room or treated at the community hospital before delivery to the designated receiving facility. The next data set, depicted in Table 2, outlines the costs associated with this project.
Table 2:

*Estimated system costs related to an Absolute Revocation reversed on appeal.*

<table>
<thead>
<tr>
<th>Area cost derived from:</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health charges:</td>
<td>$1,000</td>
</tr>
<tr>
<td>Estimated cost for ER boarding: “$2,264” (Nordstrom et al., 2019, p.690).</td>
<td>$2,264</td>
</tr>
<tr>
<td>New Hampshire Hospital charge: Daily charge of $1,506 x 5 days to allow for minimum time for Absolute Revocation evaluation, notice, filing, scheduling of Appeals Hearing and decision from Hearing Officer</td>
<td>$7,530</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$10,530</strong></td>
</tr>
</tbody>
</table>

Table 3:

*Estimated costs related implementation of project.*

<table>
<thead>
<tr>
<th>Area cost derived from:</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of this project implemented through Moodle:</td>
<td>$ 0</td>
</tr>
<tr>
<td>Cost of time from Project Leader:</td>
<td>$ 0</td>
</tr>
<tr>
<td>Cost of time from staff / personnel assisting:</td>
<td>$ 0</td>
</tr>
<tr>
<td>Cost of education for providers:</td>
<td>$ 0</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$ 0</strong></td>
</tr>
</tbody>
</table>
Interventions

The specific intervention was an educational, computer-based, e-learning module was developed to provide comprehensive education regarding all steps in the Revocation of Conditional Discharge Process. This module covers the steps of the Absolute Revocation process and this includes the timelines that one must adhere to in compliance with the process. Key content experts reviewed the information contained in this learning module and the pre- and post-test questions that assess knowledge deficits and application of the information. The intervention's effect was measured using tools to compare pre and post-test levels of provider knowledge about the timelines, steps, and forms of the revocation process.

The learning tool was developed with support from legal and clinical experts. The subject matter was researched thoroughly and areas to target for learning were identified. The two algorithms were developed and reviewed by a medico-legal expert and the legal expert for content and clarity. Forms were reviewed and specific scenarios that have been cause for recent reversals. There was guidance with nuanced language and areas to emphasize, identified as high risk within the revocation system. The Education Department at New Hampshire Hospital offered to incorporate the data into the online learning system that is used by the hospital, Moodle, and this was accomplished. Moodle is a Learning Management System (Ghosh et al., 2019). The Moodle e-learning platform enables modules to be created and implemented via a computer-based medium. This system can allow geographically dispersed system users to learn and complete assessments in their own time and at their own pace (Ghosh et al., 2019); however, the way in which the system is set at New Hampshire Hospital the users must be at work or connected to the Department of Health and Human Services login system to complete the online learning activities.
The core project team included a faculty mentor, an on-site mentor, and the DNP candidate as the project champion. The project leader developed all interventions with consultation from core team members and key experts and will implement the quality improvement intervention. The education module captured in Appendix B was developed to provide comprehensive overview of the Revocation process with focus on data known to increase risk and data provided as the reasons for reversal by Administrative Appeals Unit of the Department of Health and Human Services in FY 2020, addressed in Appendix A. All data collection and data analysis will be performed by the DNP candidate with appropriate oversight from mentors. See Appendices to view the interventions, the learning module (Appendix B) and the pre-test and post-test questions (Appendix C). The same test was given as pre- and post-test for direct comparison of successful learning.

Setting

This initial phase of the quality improvement project was deployed at New Hampshire Hospital (NHH), the state's psychiatric hospital, and the predominant designated receiving facility for involuntary patients in New Hampshire. NHH is the site where the vast majority of Absolute Revocations are determined and where the written notice is presented to the patient. New Hampshire Hospital is a 168-bed acute psychiatric hospital serving adults, located in Concord, New Hampshire. Most patients are admitted involuntarily to the hospital. This can be under New Hampshire's Involuntary Emergency Admission law and must be "in such mental condition as a result of mental illness to pose a likelihood of danger to himself or others" (NH RSA 135-C: 27, 2019, pg. 1). Admission can also be under the statutes that guide Involuntary Commitment Orders, where in New Hampshire, a patient may have up to a five-year commitment to care. A patient may be admitted directly through these laws if the patient has
violated the discharge conditions. This revocation process starts in the community, with the community mental health program providing ongoing care writing a proposed revocation and a temporary revocation (NH He-M 609, 2016). If the patient is admitted via this care algorithm, then the psychiatric provider has 72 hours to determine and provide written notice to the patient (NH He-M 609, 2016). The portion of the revocation process again removes the patient's right to freedom of choice and imposes involuntary care. The absolute revocation is completed in a highly acute designated receiving facility and is overseen by stringent legal rules that must be followed for a revocation to be successfully upheld if appealed.

**Study of the Interventions**

The effectiveness of the intervention used in this pilot was studied by analyzing the data to determine differences in pre- and post-intervention assessments. The intervention was a comprehensive learning module to improve participants' understanding of the Revocation of Conditional Discharge process with pre- and post-assessments completed in real-time before and after the intervention. Because there were no external factors other than the intervention effecting the participants' knowledge levels, the assumption was that the intervention would be responsible for any changes in knowledge levels and provider levels of confidence. It is hypothesized that there would be a statistically significant difference between pre- and post-assessments in participant knowledge.

**Measures**

An educational module and assessment system were created and used to collect data from participants and evaluate the effectiveness of the tools. Pre-intervention data was compared to post-intervention data for participants to determine the intervention's effectiveness in improving
participant knowledge about the timelines, steps, and forms of the revocation process. Graphs and tables are displayed in next sections representing data.

**Analysis**

Quantitative analysis of pre- and post-learning activity provider knowledge was performed. Data was reviewed for accuracy and completeness. Comparisons between pre- and post-knowledge assessments were performed to measure levels of participant knowledge. A comprehensive evaluation of the learning module's impact on the participants was performed using evaluation tools that was provided to each participant to gather information. A number was assigned for each participant to allow for a paired t-test to be performed using pre and post-test data. The paired t-tests assessed if there was a statistically significant difference in learning from the module. The results were noted and are summarized in the Findings section of this paper.

**Ethical Considerations**

The need for Institutional Review Board (IRB) approval from the University of New Hampshire and New Hampshire Hospital was explored prior to implementing the quality improvement initiative. No potential ethical conflicts were anticipated or found when reviewed or when implementing this quality improvement project. Ethically, there was no reason to deter this project. However, given the risks involved with missed steps and assumed deficits in knowledge related to the subject, concerning areas were identified where an intervention would be beneficial. Once issues were identified, it was clinically and ethically dutiful to develop and implement a learning module accessible by providers in order to begin the first phase of the project.
Results

Findings

The most notable finding of this quality improvement initiative was the positive change in knowledge of and mastery of the information after participants completed the learning module. This pilot's specific aim was to evaluate the effectiveness of the RCD Process education tool in improving the knowledge level and mastery of subject matter accomplished by 100% score on post-test by 100% of participants completing the module and corresponding assessments. Although not all targets identified in the specific aim were met by November 14, 2020, there were successes in this quality improvement project.

There were significant improvements in pre- and post-education scores. The pre-test mean score was a score of 57% correct compared to post-test score after completion of the educational module of 96%. Each of the participants achieved a higher score on the test after the education module was completed. Five out of the seven participants scored 100% on the post-test after completing the learning module. These test scores are shown in Table 3 with the graph depicting the pre- and post-education scores for the 7 participants. Table 4 lists the pre-test and post-test scores in columns.

The use of the educational module to facilitate gained knowledge and mastery of subject matter was found to be statistically significant. A paired t-test was used to evaluate for statistical significance between pre- and post-test scores to evaluate the effectiveness of the learning module. An overall significance was found when pre- and post-test scores of all questions were compared. The participant size was small with only seven of the providers completing all three parts, the learning module and corresponding pre- and post-test, $n=7$; however, even with this
small number, the results were positive. This result was statistically significant with $p = 0.0022$, significantly lower than $p = 0.05$.

Table 3

*Pre- and Post-Education Participant Test Scores*

![Pre and Post-Education Participant Test Scores](image)

Table 4:

*Participant Scores*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pre-test Score</th>
<th>Post-test Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>70</td>
<td>100</td>
</tr>
<tr>
<td>3</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>50</td>
<td>80</td>
</tr>
<tr>
<td>5</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>6</td>
<td>70</td>
<td>90</td>
</tr>
<tr>
<td>7</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 5:

*Percentage correct per Question on Pre and Post-tests*

<table>
<thead>
<tr>
<th>Question #</th>
<th>Pre-test % Correct</th>
<th>Post-test % Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>42.9</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>3</td>
<td>14.2</td>
<td>71.4</td>
</tr>
<tr>
<td>4</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>5</td>
<td>42.9</td>
<td>100</td>
</tr>
<tr>
<td>6</td>
<td>71.4</td>
<td>100</td>
</tr>
<tr>
<td>7</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>8</td>
<td>14.2</td>
<td>85.7</td>
</tr>
<tr>
<td>9</td>
<td>42.9</td>
<td>100</td>
</tr>
<tr>
<td>10</td>
<td>57.1</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5 lists the percentage correct on pre-test and post-test for all questions. There were two questions without 100% mastery of subject matter by participants on the post-test. These two questions were Question 3 and Question 8. Although not with a perfect result of 100 on the post-test, each had a statistically significant score change, 0.0300 and 0.0082, respectively. Of note, both of these questions had the lowest result of correct answers on the pre-test; each had only one participant choosing the correct answer on the pre-test. The first of these questions, Question 3 is noted below in Table 6. This question targets the timeline for the assessment and written notice for the Absolute Revocation. This was the question with the lowest post-test score and in review of the question and scores, one reason may be the wording of the test question. Question 3 read: “If the patient is admitted via IEA (involuntary emergency admission) then the assessment and written notice must be completed within.” It does not complete the full sentence
noting for the Absolute Revocation. The addition of these words may have changed how the participant interpreted the question and it may have changed their answer. A couple of participants provided comment that the repeated focus on timelines was helpful, but it was not enough to yield mastery on one of the questions measuring understanding and application of timeline knowledge.

Table 6

*Question 3*

<table>
<thead>
<tr>
<th>Question 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the patient is admitted via IEA (involuntary emergency admission) then</td>
</tr>
<tr>
<td>the assessment and written notice must be completed within:</td>
</tr>
<tr>
<td>A. Ten days not including Saturdays and Sundays</td>
</tr>
<tr>
<td>B. Three days not including Saturdays and Sundays</td>
</tr>
<tr>
<td>C. Ten days not including Sundays and Holidays</td>
</tr>
<tr>
<td>D. Three days not including Sundays and Holidays</td>
</tr>
</tbody>
</table>

The correct answer to Question 3 is A. Providers must follow the Revocation of Conditional Discharge rules that state when a patient is admitted via IEA, then the Revocation must be completed within ten days, not including Saturdays and Sundays. This timeline is different from the timeline for patients admitted via RCD. The rule for those admitted via RCD mandates that the Absolute Revocation within 72 hours of admission, not including Sundays and holidays.

The second question without a score of 100% on the post-test question was Question 8. This question targeted provider knowledge of the Conditions of Discharge that a patient must
follow. Only one participant answered this question correctly on the pre-test, while one participant still answered this question incorrectly on the post-test after reading the learning module. There was a 71.5 percent increase in mastery of subject matter as determined by the comparison scores for Question 8, this can be viewed in Table 7.

Table 7

**Question 8**

<table>
<thead>
<tr>
<th>Question 8</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All listed below (#s 1 - 4) are the general Conditions of Discharge:</td>
<td></td>
</tr>
<tr>
<td>1. Attend and participate in scheduled treatment and appointments</td>
<td></td>
</tr>
<tr>
<td>2. Adhere to medication regimen to promote symptom stability and improved ability function</td>
<td></td>
</tr>
<tr>
<td>3. Comply with ordered laboratory studies if indicated</td>
<td></td>
</tr>
<tr>
<td>4. To not use any recreational substances such as alcohol or marijuana</td>
<td></td>
</tr>
<tr>
<td>A. True</td>
<td>B. False</td>
</tr>
</tbody>
</table>

The correct answer to Question 8 is False. Although providers and treatment team members may advise patients to refrain from using any substances of abuse, the general conditions are not as stringent as not to use ANY recreational substances. The keyword in potential answers is the word "any" in the last condition listed.

Pre and post-test individual question comparison was interesting and gave rise to an additional need for focus on two area timing and the actual conditions a patient must follow. These are the two main components that a provider must be comfortable with when evaluating if there should be an absolute revocation of the conditional discharge. Some participants relayed
that they liked the repetitiveness of the emphasis on timelines, but even with repeated theme of timelines being emphasized throughout the presentation, it was not enough to yield a perfect score on post-test question measuring mastery of this. Below in Table 8 is the graph of comparison of pre and post-test answers.

Table 8

Pre and Post-test Individual Question Comparison

![Pre and Post-Test Individual Question Comparison](image)

Discussion

This quality improvement initiative provides a foundation for improving knowledge of and compliance with the Revocation of Conditional Discharge Process steps. This initial phase focused on the psychiatric providers at NHH. This is an essential yet small sample of potential participants who need to be well-versed in the process' steps and need to perform as experts across the revocation process continuum; less than 50% of the psychiatric providers participated. That said, this initiative, with its limitations, did yield positive results and key findings that will
be used to develop and direct logical next steps in improving understanding of the RCD process to yield greater compliance with the steps. This portion of the project can be used as the foundation to build on the cycle of change.

Recommendations can be made from the improved understanding of the complexities of the process and the pilot study's findings. The first point is that the revocation process is a unique and inflexible process complicated by two timelines. The two pathways governed by different time mandates must be emphasized in any training for this process. Even though this educational module was found to be statistically significant, it would benefit from adding additional data that emphasizes the timelines. In a review of the post-test data, this was still an area that was not mastered by all. The revocation process applies explicitly to only those who are on a Conditional Discharge and meeting the revocation criteria, and therefore although it is often encountered by the providers at New Hampshire Hospital, not all patients are admitted via this process. The timelines are not consistent across pathways to Absolute Revocation. There are many key parties who need to understand, apply knowledge, and master the ability to comply with the steps for the processes in order for the revocation to be executed successfully. A standardized educational program needs to facilitate understanding and mastery. This educational program could serve as a strong base with modifications derived from the project results. This standardized program would need to be available to other departments and the other facilities and organizations that employ critical players in the process, as this process flows across the continuum. The process is dependent on each step being followed correctly, not only the steps of the Absolute Revocation. Therefore, the person responsible for implementing and ordering each step must understand the process, their respective role and be able to complete the necessary steps correctly. The educational materials should be available through electronic
medium and it would be beneficial to have broader accessibility of access so that employees do not need access to links and systems that only work when logged into a work-based system or via VPN. Access to the module being limited to when a staff member is at work or logged in to VPN access was found to be a barrier to completion for some. Although many organizations have increased employee access to electronic work systems, during the COVID 19 pandemic, some organizations have restricted secured institutional logins to building login only. During this project, it was determined that this could be a barrier to participants' ability to complete the learning and testing. Healthcare and community organizations are in flux at this time. There are additional demands for education departments, for employees, and administrators. There are staffing deficits, new mandates, modified workflows, and additional occupational and life stressors due to the COVID crisis and increasing access options to the learning module and evaluations would provide opportunity to improve participation. Also, key stake-holding organizations would benefit from making education mandatory. This is a complicated, inflexible process that is not used every day for most clinicians who must execute their actions without error or omission when called to do so. There are other educational programs within healthcare and community organizations that staff are mandated to participate in yearly through Annual Required Education or mandated yearly certifications and mandated education may be of benefit. Even with mandated or yearly education, as noted previously, the revocation process is not used by clinicians every day, and it can be challenging to recall the rules and how to apply each step when needed. Reference materials being available for real-time use to guide the proper completion of each step would be helpful. Two algorithms (Appendix D and Appendix E) will be provided as reference materials to the NHH Psychiatric Providers. The algorithms,
Temporary Revocation of Conditional Discharge Process, and Steps for Successful Absolute Revocation of Condition of Conditional Discharge are in Appendix D and E respectively.

Decision trees, algorithms and checklists can be of benefit in healthcare. There is inherent unpredictability in healthcare, delays and interruptions throughout the day are frequent in healthcare. Prospective memory is important in completing the steps of the revocation process. This type of memory is the ability to recall to carry out actions that are planned for a future point in time. During stressful situations memory has greater likelihood of being more prone to error. Aids to memory and cognition such as algorithms and checklists have increased performance in healthcare settings and can assist professionals in completing complex and time sensitive tasks (Thomassen, et al., 2011).

The other areas for improvement include education for those individuals at New Hampshire Hospital and in the community who have vital roles in supporting these processes. These individuals include law enforcement, ER staff, community hospital and mental health center personnel, first responders, staff members of NHH, and the other designated receiving facilities from varied disciplines and departments essential to the processes' success. The need to target improved community mental health center clinicians’ knowledge and mastery is necessary in the next steps of this quality initiative due to the significant role these clinicians play in completing the first steps of the processes. However, there are other groups essential to the revocation process, such as law enforcement. These community servants would benefit from additional education. Patients are brought to the ER under a Complaint and Prayer for Compulsory Treatment (NH RSA 135-C:28 ) or under a Proposed Revocation of Conditional Discharge (NH He-M 609, 2016) by local police. The public health and psychiatric support in daily police activities are historically under-valued or without acknowledgement (Wood &
There are arguments already noted in criminal justice literature regarding the need for improved efforts to provide education, specialized training, and more cooperative working agreements with healthcare organizations to improve collaboration, understanding, and perception of the vulnerabilities and the needs of the mental health sector (Wood & Watson, 2017).

Assessment of barriers that impact adherence to care is also of high importance in preventing the need for the revocation process. Non-adherence to care and conditions of discharge are the main reasons why a person is readmitted via the RCD process. It is noted in the American Psychiatric Association Practice Guidelines for the Treatment of Patients with Schizophrenia (APA, 2020), that adherence with appointments and medication can be influenced by financial barriers, challenges scheduling appointments around work, school or family schedules, and transportation. Remaining mindful of the difficulties that a patient with chronic and persistent mental illness faces in simply performing activities of daily life, and the need to combat ongoing daily symptoms in order to function are necessary in remaining patient-centered and developing realistic plans. Addressing barriers as part of an appropriate and reasonable plan for effective care requires a collaborative working relationship with the patient, often with input from family or other support persons in the patient’s life (Mueser, et al, 2015; APA, 2020). When assessing for non-adherence to conditions or other aspects of care, it is important to remain patient centered and non-judging (Haddad et al, 2014; APA 2020).

The process of having a patient involuntarily committed can negatively impact the patient's trust in the system and diminish the treatment team's therapeutic relationship. However, when an Absolute Revocation is reversed on appeal it can devalue the patient’s view of the mental health clinicians involved, even when the reversal is due to a technical or clerical error.
The association of involuntary commitment orders with coercion and the patient perspective of involuntary care as unjustified imprisonment adds to concern for the potential negative impact if a revocation fails. The process carries with it an inherent risk to deteriorate the therapeutic relationship between the patient and treatment teams, and it is important for the provider to remain mindful of the power of positive therapeutic relationships. The American Psychiatric Association cites that a supportive, therapeutic alliance permits the provider to more completely assess and acquire pertinent information about the patient, strength and barriers to health (APA, 2020). This relationship which the nurse theorist Hildegard Peplau also refers to in her Theory of Interpersonal Relations, allows for trust and can promote openness to cooperation and involvement in treatment. In the referenced nursing theory, Peplau emphasized the patient’s experience and the impact that the patient-caregiver relationship has on patient’s perception of their experience (Adams, 2017; Hagerty, et al., 2017; Peplau, 1997). The engagement of family and support persons with the permission of the patient is also identified for strengthening the patient provider alliance and facilitating improved understanding of involuntary processes, treatment goals and available modalities to promote improved function and decreased symptomatic distress (APA, 2020). Additional support and education for patients and families can strengthen the relationships and promote high quality care.

It has been established that healthcare professionals with higher levels of empathy interact and work more efficiently in fulfilling their role in invoking positive change. Empathic responses demonstrate that the provider understands the experience of the patient and others in the system. Although empathy and perspective taking are important, a high percentage of professionals within the healthcare system have found it difficult to incorporate responses framed with an understanding of the other’s view or perspective, or they have not adopted this as a
framework for their practice (Moudatsou et al., 2020). Improving education related to the power of empathic communication would also be helpful in promoting effective care and positive patient-provider relations.

As noted throughout this project there are many factors outside of the Attending providers control during the Revocation Process. Even if the provider completes each step within his or her control correctly there may be other variables or previous missed steps that lead to the reversal. The relationship, and the approach to interactions with the patient are even more critical in salvaging a relationship at further risk when a revocation is not upheld on appeal. These patients who have a reversed revocation may need significant revisions to their plan of care to promote stabilization as they return to the community. Evidence suggests that patients who receive patient centered planning that includes addressing barriers to successful treatment (APA, 2020) and substantial discharge planning are more likely to utilize outpatient psychiatric services (Steffen et al., 2009) and are less prone to issues that require re-hospitalization, and again empathic and positive therapeutic interactions help yield the data needed to formulate successful reintegration plan and guide the information provided in.

**Conclusion**

Elyn Saks wrote in her book Refusing Care: Forced Treatment and the Rights of the Mentally Ill (2002) that "it has been said that how a society treats its least well-off members says a lot about its humanity" (Saks, 2002, p.1 of Introduction). The treatment of those with mental illness and vulnerable populations in the United States yields evidence that work needs to continue to better support the quality of life, comfort and care of those in our society who are most vulnerable (Saks, 2002). De-institutionalization and the decreasing number of inpatient psychiatric beds have not been accompanied by the necessary infrastructure of expanded
community-based resources. Treatment centers, supported intensive community treatment, and appropriate housing options are lacking. Our advanced society has not provided the resources necessary to provide care in less restrictive community settings for the number of patients who need, want, and will require appropriate treatment and support (Saks, 2002).

In New Hampshire, many advocates, from frontline volunteers to prominent government officials, promote and facilitate changes to better the lives of those suffering from chronic and persistent mental illness, and this must continue. Dedicated and clinically astute providers provide treatment in inpatient and outpatient systems. However, even basic steps that would improve care in the community and reduce the risk of patient decompensation and treatment non-adherence go without implementation across the state. Compliance with medication is a challenge with at-risk populations. Although missed medication remains a principal reason that Conditional Discharges are revoked, the community mental health systems in many areas of the state fail to deliver care that mitigates this risk. Outreach and time appropriate medication monitoring and administration are lacking. Patient resistance to comply with community appointments for medication monitoring triggers revocations and symptoms. However, with sedation as a common side effect of medications used to treat psychiatric disorders, and lack of evening hours for medication monitoring, this will continue. There is a call for patient-centered treatment planning that reduces barriers to effective care (APA, 2020). Inpatient and outpatient providers must continue to work collaboratively to address impediments to successful patient transitions, mitigating the risk of treatment non-compliance, and decompensation. These care systems need to have the financial and human resources necessary to adequately staff and successfully support the implementation of essential care for those in need.
As one can now understand, the Revocation of Conditional Discharge process is a complicated and inflexible process. It is a process that impacts many people across the mental health care continuum. It impacts outpatient teams, inpatient providers, but most importantly, the patient. The patient is not a voluntary participant in these processes. The patient did not choose to be ill and it must be noted, with illness there is already suffering, burdened tasks of everyday living and many risks of increased symptomatology and setbacks. Future recommendations must include the continued study of the factors contributing to the high number of failed revocations, goal-directed strategies to improve the process and support patient stability in treatment in lesser acute settings. There must be continued education to key individuals across the continuum of care, who must master and comply with the steps of the process. Lastly, we must encourage holistic, patient-centered care and judicious utilization of involuntary processes.
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## Appendix A

Reasons for Reversal of Revocation of Conditional Discharge (RCD) Appeals

FY 2020 Review Completed by the Legal Office of New Hampshire Hospital

<table>
<thead>
<tr>
<th>Reason for Reversal by Administrative Appeals Unit (AAU)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not read or explain notice to patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not give a copy of paperwork to patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No clear and convincing evidence that conditions were violated or that there was level of dangerousness warranting revocation process.</td>
<td>8</td>
<td>53%</td>
</tr>
<tr>
<td>Failed to prove reasonable effort to locate and contact the patient</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>Failure to consult with psychiatrist before the temporary or proposed revocations.</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>Lack of legal authority to revoke Conditional Discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failed to execute ARCD within the 72 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility (ER /DRF) not listed on Complaint or Temporary Revocation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist/ APRN /Witness unavailable to testify at Hearing.</td>
<td>2</td>
<td>13%</td>
</tr>
<tr>
<td>Failed at most everything, multiple steps not followed.</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>Guardian not notified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probate order expired. Patient does not have active CD.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error in CD Documentation.</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>Error in IEA</td>
<td>1</td>
<td>7%</td>
</tr>
</tbody>
</table>

Total: 15 Reversed Cases
Appendix B

Revocation of Conditional Discharge Learning Module

1. Revocation of Conditional Discharge Process

2. What is a Conditional Discharge?
   A Conditional Discharge means the release of an involuntarily admitted person from a designated receiving facility (DRF) on the condition that the person accept treatment in the community or be subject to readmission.

3. Who has a Conditional Discharge?
   Patients who are 22 years and older who have been ordered by a Probate Court Judge to have an Involuntary Commitment to New Hampshire Hospital, are discharged to the care of the Community Mental Health Center with conditions of discharge to be followed.

4. What is a DRF?
   Designated Receiving Facility (DRF): treatment facility which is designated by the commissioner to accept care, custody and provide treatment of involuntary psychiatric patients admitted.

5. Each time a Conditional Discharge (CD) is revoked, a new Conditional Discharge is drafted for agreement and signatures. The patient is discharged on this new CD.

6. When a patient is discharged from NHH on a Conditional Discharge, the CD is signed in agreement by:
   1. New Hampshire Hospital CEO or designee,
   2. NHH Psychiatrist or Psychiatric APRN,
   3. Community Mental Health Program representative, and the
   4. Patient.
There are four general conditions that a patient needs to follow, although the treatment team may add specific conditions as needed for a patient. Agreement to the conditions is represented by the signatures of the parties on the Conditional Discharge (CD).

1. Attend and participate in scheduled treatment/appointments.
2. Adhere to medication regimen to promote symptom stability and improved ability to function.
3. Comply with ordered laboratory studies if indicated.
4. Do not misuse or abuse substances to the extent that it impacts a patient’s illness, ability to function or involve self in care.

The Revocation Process

The Revocation of the Conditional Discharge Process is an involuntary hospitalization process in the state of New Hampshire. It is usually initiated when a community mental health program representative receives evidence that a patient has not followed one or more of the conditions of discharge, and or has engaged in dangerous behaviors, and or is at risk of harm to self or others.

The patient is determined to be in need of evaluation for Involuntary Hospitalization. There are two ways that the patient can enter the Revocation Process that ends with the Absolute Revocation. The first is via Temporarily Revocation and the second is via Involuntary Emergency Admission (IEA).

The steps will be outlined for both processes in the following slides. Each of these two branches on the revocation tree have specific timelines of when an Absolute Revocation must be completed.

- Respect the process, respect the patient.
  - Psychiatric symptoms and disorders that elicit the need for a Conditional Discharge vary. However, these symptoms impair a person suffering with chronic and persistent mental illness, impairing the patient’s thoughts, mood, function and actions.
  - Be aware, stay safe.

- Respect the process, respect the patient.
  - Those patients without insight and awareness are at increased risk of treatment noncompliance.
  - The patient may not recognize they are mentally ill. He or she may not be able to understand the need for medication, care, or appointments.
  - Those who lack insight may view steps taken to revoke the CD as unjust actions against them or as unfair steps to false imprisonment.
  - Be patient.
The Proposed Revocation

If it is believed that a patient has violated one or more conditions of discharge, then a Psychiatrist or APRN at a Community Mental Health Program providing continuing treatment on an outpatient basis authorizes a proposed revocation to facilitate evaluation for temporarily revoking the discharge.

The Temporary Revocation is dependent on the community mental health program/center that holds the CD completing the steps correctly.

Completion of these steps can be further complicated by extended time in the ER of the community hospital.

When the patient is accepted by a DRF, the name of the DRF that the patient is to be taken to by law enforcement must be written on the form. If it is not written on the form, the revocation will fail if appealed.

Revocations are lost due to steps not taken and paperwork not being complete.
Temporary Revocation

Step 3 completed by the Mental Health Center.

The Temporary Revocation Form

The DRF that the patient is to be delivered to must be written on the Temporary Revocation Form for the Revocation to be valid.

The Absolute Revocation

An Absolute Revocation will fail, if all forms are not filled out completely and accurately.

Filling out the forms is not as simple as filling in the dots.

The Absolute Revocation

- If a patient has an Involuntary Commitment Order, then the Absolute Revocation must be completed to continue inpatient care under the He-M-Bog at the Designated Receiving Facility.
- This is a time sensitive process.

Absolute Revocation

It is important to be mindful of timelines. Appropriate timing is a key factor in meeting legal requirements of an Absolute Revocation.

Timeline

- If a patient is admitted on a Temporary Revocation the assessment and written notice must be completed within 72 hours, not including Sundays and holidays.
- If a patient is admitted via Involuntary Emergency Admission, then assessment and written notice must be completed within 10 days, not including Saturdays or Sundays.

Always write in day AND time of completion of the examination.
IMPROVING TRANSITIONS IN CARE

Patient admitted via Temporary Revocation of Conditional Discharge.

A law enforcement officer shall take custody of the person whose conditional discharge has been temporarily revoked and shall deliver him or her, together with a copy of the notice, to the receiving facility identified by the psychiatrist or APN at the Community Mental Health Program.

The psychiatrist or APN at the DRE, as the Administrator’s designee, shall:

1. Personally examine each person;
2. Review the reasons for temporary revocation of the conditional discharge; and
3. Absolutely revoke the conditional discharge if he or she finds that the patient has:
   A. Violated a condition of the discharge; or
   B. Is in such a mental condition as a result of mental illness as to create a potentially serious likelihood of danger to self or to others.

The examination, review and determination shall be made within 72 hours of arrival of the patient to the DRE excluding Sundays and the state’s legal holidays. The DATE and TIME of completion must be written on the form.

Step 1

- Has the time frame lapsed?
- The assessment and written notice must be completed within 72 hrs. if the patient was admitted on a Temporary Revocation.
- Assessment and written notice must be completed within 30 days if the patient was admitted via IEA.
- Have the conditions been violated? How do you know? Have you checked the facts?
- Check the facts, as the designee you are expected to determine if the revocation is warranted and valid.

Absolute Revocation

The Absolute Revocation Process is completed at the Designated Receiving Facility where the person was admitted.

This portion of the Revocation Process is under direction of the Administrator of the hospital and is carried out by a Psychiatrist or APN. This provider is generally the Attending Provider for the patient’s team or designated covering provider. Data is collected, an examination is completed and then written notice is given to the patient and Guardian. All paperwork must then be directly filed with the Legal Office.

If the patient or Legal Guardian wishes to appeal, then the Hearing will be scheduled within 5 days.

Timing is essential to successful completion.

• If a patient is admitted on a Temporary Revocation the assessment and written notice must be completed within 72 hours, not including Sundays and holidays.

• If a patient is admitted via Involuntary Emergency Admission the assessment and written notice must be completed within 10 days, not including Saturdays and Sundays.

Absolute Revocation Decision Tree

Assess and determine that criteria has been met to complete the Absolute Revocation.

Review the Temporary Revocation

Completed by the Mental Health Center
Improving Transitions in Care

If the patient was admitted via Revocation process:
- Were the Proposed and Temporary Revocation forms completed appropriately?
- Are appropriate signatures in place?
- Is the facility that law enforcement was ordered to deliver patient noted at the bottom of the Temporary Revocation?

If the patient was admitted via Revocation process:
- The DRE that the patient was delivered to must be written on the Temporary Revocation Form for the form to be valid. If this is not written on the form, the revocation will fail if appealed.

Absolute Revocation via admission on Temporary Revocation

If the Psychiatrist or the Psychiatric APRN determines that an absolute revocation is warranted, then he or she shall:
1. immediately prepare, offer and explain to the patient the information in a written notice of the revocation
2. provide the reasons for the revocation, and
3. give the notice of the person’s right to appeal and right to legal counsel as set forth in Hs-M 609.

This assessment and written notice must be completed within 72 hours, not including Sundays and holidays.

Absolute Revocation Decision Tree

Absolute Revocation when admitted via Involuntary Emergency Admission

The facility Psychiatrist or Psychiatric APRN shall absolutely revoke a person’s conditional discharge when the person has been admitted to a facility be an EBA when he or she has personally examined the individual and found that the patient either:
1. Has violated a condition of the discharge, or
2. Is in such a mental condition as a result of mental illness as to create a potentially serious likelihood of danger to self or others.

This assessment and written notice must be completed within 10 days, not including Saturdays or Sundays.

Absolute Revocation Decision Tree
Complete each section of this form correctly.

Start with Form 609-8

Form 609.10

There is a step to follow if there is significant possibility of bodily harm to the evaluator or others.

If it is not safe to explain and/or offer a copy of the forms to the patient because of a significant possibility of bodily harm to you and/or to the others, then use the section at bottom to explain.

Absolute Revocation Decision Tree
1. Organize and review the Temporary Revocation or IEA paperwork.

2. Be familiar with dates and findings.
   - Date CD was ordered, when it expires.
   - Date of IEA Hearing if applicable and result.
   - Date AND time of Admission

If appealed, the revocation will fail if requirements in timing are not met.

---

1. Review the Absolute Revocation paperwork and process.

2. Take note of your examination and the delivery of written notice and the patient response. This exchange may need to be formally presented at the Hearing.

3. If you designated a staff member to deliver written notice, verify where and when it was given to the patient.

---

Review any unusual situations with NHH Legal Counsel prior to the Hearing.

Prepare and present your case with confidence.
Appendix C

Pre- and Post-Test for Learning Module

1. A patient who is on a Conditional Discharge under Lakes Region Mental Health Center has overdosed on Lithium and has been admitted to Concord Hospital. The patient does not want treatment when medically stabilized; however, when evaluated, the patient still needs inpatient psychiatric care. Riverbend Community Mental Health Center will complete:
   A. Temporary Revocation of Conditional Discharge.
   B. An IEA (Involuntary Emergency Admission).
   C. An Absolute Revocation of Conditional Discharge.
   D. None of the above.

2. The steps of the Proposed Revocation and the Temporary Revocation are dependent on the patient’s community mental health center’s completion of each of the steps correctly.
   A. True
   B. False

3. If the patient is admitted via IEA (involuntary emergency admission) then the assessment and written notice must be completed within:
   A. Ten days not including Saturdays and Sundays
   B. Three days not including Saturdays and Sundays
   C. Ten days not including Sundays and Holidays
   D. Three days not including Sundays and Holidays

4. If a patient has been admitted via Temporary Revocation of Conditional Discharge to NHH, the psychiatrist or psychiatric nurse practitioner:
   A. Reviews documentation and verifies if the patient meets criteria for the Absolute Revocation
   B. Verifies that the terms of the active, valid CD have been violated,
   C. Assesses the patient, and signs the form provides for written notice to the patient
5. A patient has been admitted via Temporary Revocation of Conditional Discharge to NHH, and the psychiatrist or psychiatric nurse practitioner determines that an Absolute Revocation is warranted then:
   A  He or she shall immediately prepare offer in explain to the patient the information in a written notice of the Absolute Revocation
   B  Provide the reasons for the revocation and give the notice of the person's right to appeal and right to legal counsel as set forth in the HeM 609.
   C  Alert the Guardian to the revocation and the patient’s decision to appeal or accept the Absolute Revocation
   D  All of the above
   E  A and B

6. The assessment and written notice of a patient admitted on a Temporary Revocation must be completed:
   A  Three days not including Sundays and Holidays
   B  Within seventy-two hours not including Sundays and Holidays
   C  Three days not including Saturdays and Sundays
   D  Seventy-two hours not including Saturdays and Sundays

7. The Designated Receiving Facility (for Involuntary Admissions), also referred to as the DRF, that law enforcement is to deliver the patient to must be written on the Temporary Revocation form for the form to be valid.
   A  True
   B  False

8. All listed below (#s 1 - 4) are the general Conditions of Discharge:
   1. Attend and participate in scheduled treatment and appointments
   2. Adhere to medication regimen to promote symptom stability and improved ability function
3. Comply with ordered laboratory studies if indicated
4. To not use any recreational substances such as alcohol or marijuana
   A True
   B False

9. If the clinician from the community mental health center is unable to explain the reasons for the Temporary Revocation, offer a copy of the form and inform the patient of the right to a hearing, then:
   A The temporary revocation is invalid.
   B The clinician must contact the Legal Office of New Hampshire Hospital to request permission from the Hearing’s Officer for the continued transfer.
   C The clinician must provide detailed description of circumstances that could potentially cause bodily harm on the temporary revocation form.
   D The clinician should start the IEA (Involuntary Emergency Admission process).

10. If a patient is admitted on a Temporary Revocation of Conditional Discharge on a Friday in the month of August at 1:15PM, the psychiatrist or psychiatric nurse practitioner, as the designee, has until what day and time to finish completing the Absolute Revocation.
    A Monday at 1:14 PM
    B Tuesday end of day
    C Tuesday at 1:14 PM
    D Wednesday at 1:14 PM
Appendix D

Proposed and Temporary Revocation of Conditional Discharge Process

1. Attend and participate in scheduled treatment/appointments.
2. Adhere to medication regimen to promote symptom stability and improved ability to function.
3. Comply with ordered laboratory studies if indicated.
4. Do not misuse or abuse substances in manner that impacts illness, ability to function or ability to involve self with treatment.

Client violated conditions of an active, valid Conditional Discharge

Discuss with Psychiatrist or APRN

Psychiatrist or APRN authorizes an evaluation for possible RCD

No

The Revocation Process is not continued.

Yes

CMHC Staff drafts Proposed Revocation of Conditional Discharge

Client agrees to be evaluated

No

Staff drafts Complaint for Compulsory Evaluation and delivers to police

Yes

Police bring the patient in for evaluation. Patient is in custody and delivered against his or her will for evaluation.

Evaluation yields approval for Temporary Revocation to be completed

Yes

Complete all sections of the Temporary Revocation

Provide evidence of the violations of the conditions. Be specific, note dates and details. Note where the patient will be delivered to on the form, this is the order for law enforcement to bring the patient to the Designated Receiving Facility

Review all of the data with the patient. Provide a copy of the Proposed and Temporary Revocations to the patient. If the patient does not accept, note this at bottom of form and note who was witnessing the attempt to provide.

Patient delivered to the Designated Receiving Facility and will be evaluated for an Absolute Revocation by Psychiatrist or Psychiatric APRN.

Be available to confirm data with the Psychiatrist or APRN assessing situation and completing the Absolute Revocation of Conditional Discharge. Be prepared to testify if the patient appeals the Absolute Revocation.
Appendix E

Steps for Successful Absolute Revocation of Conditional Discharge

Steps for Successful Absolute Revocation of Conditional Discharge

1. Discharge
2. Sign-in Voluntarily
3. Re-IEA (with new events)
4. Sign-in Voluntary by Guardian
   - Consult Legal if Needed

Questions to ask for determining validity of Revocation:
1. Did patient violate conditions?
2. Did patient know about appointments?
3. Were steps followed correctly in Proposed and Temporary Revocations?

Filing Tips:
Ensure all steps are followed in execution of Revocation.
1. Was this completed within 72 hrs.?
2. Was there a witness?
3. Was sheet 609.8 reviewed completely?
4. Was the “Hearing” section read to the patient?
5. Did I provide the patient with a copy?
6. If direct provision of paperwork was delegated to a staff member, then has it been confirmed that the patient was given the paperwork directly by designee?
7. If patient has a Guardian, was the Guardian alerted?

Have patient note decision to appeal and sign. If patient does not note on the form and who this was witnessed by. Note what happens on bottom of 609.8.

Read “Hearing” section to patient.
The entire section at bottom of page 609.8 must be read to patient.

Does the patient have a guardian?
YES

Update Guardian regarding Absolute Revocation and note if Guardian wants a Hearing
Send copy to Guardian Office

**File Absolute Revocation:
1. Give patient copy of entire Revocation (609.8, 9, 10)
2. Give original to legal. Legal files and Attys meets with patient.
3. If appealing, the hearing will be scheduled within 5 work days.
   It will take up to 3 business days to get the results.
   Be prepared to testify.

Collect data. Review all data confirming violations
Verify data with CMHC

Does data yield support of valid Absolute Revocation?
YES

Complete the Absolute Revocation 609.8.

Review the Absolute Revocation (609.8) with the patient and a witness.

Admitted via Temporary Revocation
Is time frame within 72 hrs. of admission?
YES

Is "yes" the answer to each of these questions?
1. Does patient have a valid CD?
2. Is time frame open to revoke?
3. Does patient need inpatient care?

NO

Admitted via IEA IEA upheld
Is time frame within 10 days of admission?
YES

NO
Acknowledgements

It is with sincere appreciation that I thank the following:

- Dr. Jessica Hatch for her guidance through preparations and analyses.
- Dr. Donna Pelletier for her support and constructive feedback.
- Debra Fournier for her mentorship, and leadership, allowing our discipline to be actively involved in delivery of high quality, patient-centered care and system improvements.
- Dr. Alexander DeNesnera for his expertise, and his encouragement throughout this project and my career in treating involuntary patients in New Hampshire.
- The Legal Office of New Hampshire Hospital. Steven Bunker, Esq., Legal Counsel, for providing direction and guidance and Robert Lindgren and Catherine Cadorette for providing data, and ongoing evidence that this project is necessary and meaningful.
- The Education Department, especially Chad Boutin for connecting the module to the net-learning platform and Kelly Cummings for facilitating this connection.
- Lakes Region Mental Health, for sharing the community perspective and background information, especially Jennifer Jackes and Maggie Pritchard for this collaboration.
- The many colleagues who participated and others who provided information and motivation and Leadership at New Hampshire Hospital who made this project possible.
- My family and closest friends for giving me the time and support needed to complete this project and program
- Lastly, it is with much appreciation that I acknowledge the late Lynne Mitchell, Esq., whose passion for her work as New Hampshire Hospital’s Legal Counsel and vast knowledge of the rules and weaknesses of involuntary processes inspired me to embark on a journey to improve the Revocation Process.