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## Psychiatric Boarding in New Hampshire: Violation of a Statutory Right to Treatment

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# Psychiatric Boarding in New Hampshire: Violation of a Statutory Right to Treatment

JAMES A. MCCLURE IV\*

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INTRODUCTION

Police escort Jane to the emergency room and report that she shows signs of mania and suicidal ideation. The hospital admits her for emergency care at 7:40 p.m. Four hours later, at around 11:30 p.m., a doctor determines that Jane is a danger to herself. The doctor recommends immediate, involuntary commitment at the state psychiatric hospital.

Jane prepares for her transfer, but a nurse tells her she cannot leave yet. The psychiatric hospital reports that no beds are available, and no other psychiatric facilities in the state have openings.

Jane waits through the night, barely sleeping because of the bright lights and noises all around her. She receives minimal care from the well-meaning nurses and doctors, who do their best to stabilize her condition but must also tend to numerous other patients with pressing needs. Jane's condition worsens, and she becomes increasingly agitated.

Five days pass. Jane becomes frustrated and lashes out, overwhelmed with anxiety. Security staff and paramedics are called fourteen times to restrain her. The hospital spends \$26,000 on personnel for Jane's 130 hours of care.

Finally, a bed opens up at the state psychiatric hospital, and Jane is transported there for specialized treatment. Her involuntary commitment has begun.<sup>1</sup>

New Hampshire law provides for the involuntary commitment of a patient such as Jane when she is a danger to herself or others as a result of mental illness.<sup>2</sup> The patient has a right to treatment under N.H. Rev. Stat. Ann. §§ 135-C:1, *et seq.*<sup>3</sup> Specifically, the patient should receive "adequate and humane treatment" pursuant to an "individual service plan" and "in the least restrictive environment necessary."<sup>4</sup> However, appropriate facilities often are not available for patients waiting in emergency rooms,<sup>5</sup> and patients

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<sup>1</sup> Based on a true story of a patient in New Hampshire. See Shawn V. LaFrance & Daniel J. Walsh, *HELP: People Seeking Mental Health Care in New Hampshire* 8, FOUND. FOR HEALTHY COMMUNITIES (Feb. 2013), <http://www.healthynh.com/images/PDFfiles/publications/a%20HELP%20Rpt%20FINAL%2002%2022%20%2013.pdf>.

<sup>2</sup> N.H. REV. STAT. ANN. § 135-C:27, 34 (2014).

<sup>3</sup> See *id.* §§ 135-C:1, *et seq.*

<sup>4</sup> *Id.* §§ 135-C:13, 135-C:57.

<sup>5</sup> See, e.g., Casey McDermott, *Panelists Discuss Mental Health In New Hampshire*, CONCORD MONITOR (Sep. 24, 2014), <http://www.concordmonitor.com/news/13687361-95/panelists-discuss-mental-health-in-new-hampshire> (reporting on remarks by an emergency room doctor that patients are "left waiting days at the hospital before they can get to treatment elsewhere"); Sarah Palermo, *Mentally Ill Patients Face Spartan Conditions, Long Delays In New Hampshire*, CONCORD MONITOR (Mar. 10, 2013), <http://www.concordmonitor.com/home/4741184-95/hospital-state-mental-pod>; Sarah Palermo,

can become trapped for hours or even days.<sup>6</sup> This phenomenon is called “psychiatric boarding.”<sup>7</sup>

New Hampshire is not alone in providing a statutory right to treatment, and the problem of psychiatric boarding is common in other states.<sup>8</sup> While enforcement of statutory rights to treatment often is elusive,<sup>9</sup> the Washington Supreme Court delivered a landmark ruling on psychiatric boarding in August 2014, finding that it violated the state laws protecting involuntarily committed patients.<sup>10</sup>

Could the Washington court’s rationale lead to similar conclusions in other states? Looking to New Hampshire as an example, the state statutes for commitment and treatment rights are analogous to Washington’s,<sup>11</sup> and this suggests that the Washington ruling could prove a valuable precedent for barring psychiatric boarding in other states.

This Note will compare Washington’s involuntary commitment law to New Hampshire’s, argue that psychiatric boarding is illegal under New Hampshire law, and propose solutions for complying with the statute, including the continued implementation of community-based services. If

*Record Number Of People Waited Last Week In NH Emergency Departments For Mental Health Services*, CONCORD MONITOR (Aug. 25, 2013), <http://www.concordmonitor.com/news/8188121-95/record-number-of-people-waited-last-week-in-nh-emergency-departments-for-mental-health> (reporting that forty-seven people suffering from mental health crises waited for beds at the State Hospital on one night).

<sup>6</sup> McDermott, *supra* note 5.

<sup>7</sup> David Bender et al., *A Literature Review: Psychiatric Boarding*, U.S. DEP’T OF HEALTH & HUM. SERVS. (Oct. 29, 2008), <http://aspe.hhs.gov/daltcp/reports/2008/psybdlr.htm> (defining “boarding” as “the practice in which admitted patients are held in hallways or other emergency department (ED) areas until inpatient beds become available”).

<sup>8</sup> See Bender, *supra* note 7 (noting that in 2008, eighty percent of emergency department medical directors reported that boarding occurred in their facilities); JOHN PARRY, CIVIL MENTAL DISABILITY LAW, EVIDENCE, AND TESTIMONY 509 (2010) (writing that “[m]ost states have provisions in their laws guaranteeing an array of rights to those committed to facilities,” and these commonly include “a right to treatment or habilitation”).

<sup>9</sup> See 2 MICHAEL L. PERLIN, MENTAL DISABILITY LAW § 3A-3.1 (LEXIS Law Publ’g, 2d ed. 1998) (discussing the right to treatment and asking if “such a broad order [can] ever, realistically, be implemented?”).

<sup>10</sup> *Det. of D.W. v. Dep’t of Soc. and Health Servs.*, 332 P.3d 423, 428 (Wash. 2014).

<sup>11</sup> Compare N.H. REV. STAT. ANN. § 135-C:57 (“Persons receiving mental health services shall have the right to . . . [a]n individual service plan [and] . . . [t]reatment in the least restrictive environment necessary to achieve the purposes of the treatment.”) with WASH. REV. CODE § 71.05.360(2) (“Each person involuntarily detained or committed pursuant to this chapter shall have the right to adequate care and individualized treatment.”).

New Hampshire implemented its statutory scheme as written, it would satisfy patients' rights to treatment.

## I. INVOLUNTARY EMERGENCY ADMISSIONS IN NEW HAMPSHIRE

Forty-seven states, including New Hampshire, have statutory provisions for emergency involuntary commitment of individuals exhibiting dangerousness as a result of mental illness.<sup>12</sup> In New Hampshire, a petitioner for involuntary commitment must prove by clear and convincing evidence that the individual poses a potentially serious likelihood of danger to self or others.<sup>13</sup> The petitioner must point to specific acts, such as a drug overdose,<sup>14</sup> physical attacks on family members,<sup>15</sup> or a credible threat to kill one's spouse.<sup>16</sup>

Involuntary commitment denies a person the individual liberty and autonomy at the core of the American political tradition, and it therefore requires significant procedural safeguards.<sup>17</sup> The Supreme Court stated in *Addington v. Texas* that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."<sup>18</sup> New Hampshire law reflects this constitutional concern and sets forth a detailed procedure for involuntary commitment.<sup>19</sup>

### A. The Legal Basis for Involuntary Commitment

#### 1. New Hampshire Statutes Providing for Involuntary Commitment

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<sup>12</sup> PARRY, *supra* note 8 at 471; 1 MICHAEL L. PERLIN, MENTAL DISABILITY LAW § 2A-1 (LEXIS Law Publ'g, 2d ed. 1998).

<sup>13</sup> *In re B.T.*, 891 A.2d 1193, 1198 (N.H. 2006).

<sup>14</sup> *Id.* at 262 (stating that respondent's overdose "was undoubtedly a specific act that had the potential to cause her serious bodily injury").

<sup>15</sup> *State v. Lavoie*, 924 A.2d 370, 373 (N.H. 2007) (finding dangerousness where the defendant spat in his mother's face, tried to strangle her, and physically fought his father).

<sup>16</sup> *See In re O'Neil*, 992 A.2d 672, 675 (N.H. 2010) (describing dangerous behavior where the respondent suggested to his insurance agent that he would violate a protective order keeping him from his wife and that "someone [might end] up hurt or dead").

<sup>17</sup> *Addington v. Texas*, 441 U.S. 418, 425 (1979); *see* BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 201-02; BRUCE J. WINICK, CIVIL COMMITMENT 17 (2005).

<sup>18</sup> *Addington*, 441 U.S. at 425.

<sup>19</sup> N.H. REV. STAT. ANN. § 135-C:27-33; *see In re Richard A.*, 771 A.2d 572, 576 (N.H. 2001) (analyzing the "significant statutory safeguards" that "exist to minimize the risk of erroneous deprivation of liberty due to civil commitment"); Opinion of the Justices, 122 N.H. 199, 204 (1982) (interpreting the New Hampshire Constitution as requiring stricter due process standards than the federal minimum for purposes of involuntary commitment).

New Hampshire law provides that a person is “eligible for involuntary emergency admission if he is in such mental condition as a result of mental illness to pose a likelihood of danger to himself or others.”<sup>20</sup> This basic standard—danger to self or others as a result of mental illness—parallels most other state statutes providing for civil commitment.<sup>21</sup> It derives from the state’s *parens patriae* power and police power.<sup>22</sup>

The statute applies to those experiencing “mental illness,”<sup>23</sup> though states often define this term vaguely.<sup>24</sup> New Hampshire, for instance, defines “mental illness” as “a substantial impairment of emotional processes, or of the ability to exercise conscious control of one’s actions, or of the ability to perceive reality or to reason, when the impairment is manifested by instances of extremely abnormal behavior or extremely faulty perceptions.”<sup>25</sup>

Mental illness alone, without an additional finding of dangerousness, “is insufficient to involuntarily admit any person into the mental health services system.”<sup>26</sup> Under New Hampshire statutory law, a person is a “danger to himself” when, within the previous forty days, he has attempted, inflicted, or threatened to inflict “serious bodily injury on himself,” and “there is a likelihood the act or attempted act will recur if admission is not ordered.”<sup>27</sup>

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<sup>20</sup> N.H. REV. STAT. ANN. § 135-C:27.

<sup>21</sup> Robert M. Levy & Leonard S. Rubenstein, *THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES* 29 (1996); PARRY, *supra* note 8, at 471; PERLIN, *supra* note 12 § 2A-1.

<sup>22</sup> BRUCE J. WINICK, *CIVIL COMMITMENT* 42 (2005) (“The avoidance of danger to self constitutes an expression of the state’s *parens patriae* power to protect the individual’s well being. The avoidance of danger to others constitutes an expression of the state’s police power interest in protecting the community from harm.”); see *O’Connor v. Donaldson*, 422 U.S. 563, 573–74 (1975) (noting that most state laws for involuntary commitment are generally advanced “to prevent injury to the public, to ensure [the committed person’s] own survival or safety, or to alleviate or cure his illness”); Levy & Rubenstein, *supra* note 21, at 15 (“[I]nvoluntary institutionalization creates a conflict between the individual’s right to liberty and government’s twin powers to shield vulnerable citizens from harm and to protect society from danger.”).

<sup>23</sup> N.H. REV. STAT. ANN. § 135-C:27.

<sup>24</sup> WINICK, *supra* note 22, at 48.

<sup>25</sup> N.H. REV. STAT. ANN. § 135-C:2.

<sup>26</sup> *Id.* § 135-C:1; *In re B.T.*, 891 A.2d 1193, 1199 (N.H. 2006) (interpreting the stated policy of New Hampshire’s statutory scheme for involuntary commitment to mean that that state cannot “order an involuntary admission based solely on the existence of a mental illness”).

<sup>27</sup> N.H. REV. STAT. ANN. § 135-C:27(I)(a)–(b); *In re B.T.*, 891 A.2d. at 1198. The statute provides other possible criteria for finding a danger to self. *Id.* N.H. REV. STAT. ANN. § 135-C:27(I)(c) (“The person’s behavior demonstrates that he so lacks the capacity to care for his own welfare that there is a likelihood of death, serious bodily injury, or serious debilitation if admission is not ordered.”); *id.* at § 135-C:27(I)(d) (providing an alternative test for finding

A person is a “danger to others” when, within the previous forty days, he has “inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another.”<sup>28</sup>

## 2. Case Law Governing Involuntary Commitment

The involuntary commitment statute comports with the state’s legitimate interests in “providing care to its citizens who are unable because of emotional disorders to care for themselves” and “protect[ing] the community from the dangerous tendencies of some who are mentally ill.”<sup>29</sup> However, the state’s power to achieve these interests is tempered by the individual’s liberty interests.<sup>30</sup> In particular, “[f]reedom from bodily restraint” is “at the core of the liberty protected by the due process clause from arbitrary governmental action.”<sup>31</sup> The risk of harm to an involuntarily committed individual is “significantly greater than any possible harm to the state.”<sup>32</sup>

Accordingly, the New Hampshire Supreme Court has interpreted the involuntary commitment statute to contain safeguards for individual rights.<sup>33</sup> “The liberty of the patient is to be curtailed only to the extent necessary to protect her and the public,” and a standard of clear and convincing evidence applies at civil commitment proceedings to protect the personal interests at stake.<sup>34</sup>

Dangerousness is a legal concept rather than a medical one; “it is the judge who makes the decision and not the psychiatrist.”<sup>35</sup> A petition for civil commitment must “allege specific acts or action demonstrating dangerousness,” and while a psychiatrist’s report is “a crucial piece of

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that a person is a “danger to himself,” requiring, among conditions, that he is severely mentally disabled, has been involuntarily committed in the past, has no guardian, refuses treatment, and an approved psychiatrist for a mental health program determines, based on the patient’s history, that “there is a substantial probability that the person’s refusal to accept necessary treatment will lead to death, serious bodily injury, or serious debilitation if admission is not ordered”).

<sup>28</sup> N.H. REV. STAT. ANN. § 135-C:27(II).

<sup>29</sup> *Addington v. Texas*, 441 U.S. 418, 426 (1979).

<sup>30</sup> See *Levy & Rubenstein*, *supra* note 21, at 15 (contending that the “massive curtailment of liberty” that occurs during involuntary commitment can infringe upon “the right to liberty, to freedom of association, to travel, to freedom from unreasonable searches and seizures, and to bodily autonomy”).

<sup>31</sup> *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992).

<sup>32</sup> *Addington*, 441 U.S. at 427.

<sup>33</sup> *In re Richard A.*, 771 A.2d 572, 577–76 (N.H. 2001).

<sup>34</sup> *In re B.T.*, 891 A.2d 1193, 1198 (N.H. 2006); *Dolcino v. Clifford*, 321 A.2d 577, 578 (N.H. 1974).

<sup>35</sup> *State v. Hudson*, 409 A.2d 1349, 1351 (N.H. 1979).

evidence,” it is not dispositive at a commitment hearing.<sup>36</sup> On their own, signs of “agitation, delusion, disorganized thinking, and paranoia” do not satisfy the specific acts requirement for proving a danger to self or others.<sup>37</sup>

The purpose of commitment is treatment, not punishment.<sup>38</sup> Once a patient is rehabilitated, the state no longer may confine him.<sup>39</sup> The United States Supreme Court held in *O'Connor v. Donaldson* that under the due process clause, a patient must be released if he no longer is both mentally ill and a danger to himself or others.<sup>40</sup>

Although most states provide by statute the right to treatment for those involuntarily committed, there is “virtually no case law on the question of a state constitutional right to treatment.”<sup>41</sup>

## B. Procedure for Involuntary Commitment

The procedure for involuntary commitment in New Hampshire often begins at an emergency room when a “petitioner,” such as a police officer or relative, brings a person to the hospital after witnessing him exhibit signs of mental illness and dangerousness.<sup>42</sup> A police officer may place the person under protective custody for up to six hours while awaiting examination.<sup>43</sup>

The petitioner completes a written petition for examination and commitment.<sup>44</sup> Once the petitioner completes his form, the patient begins what could be a long wait.<sup>45</sup> A qualifying physician or advanced practice registered nurse (“APRN”) must examine the patient within three days and, if warranted, complete a certificate recommending commitment.<sup>46</sup>

If a qualifying physician or APRN completes a certificate recommending commitment, a law enforcement official must “take custody of the person”

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<sup>36</sup> *In re Fasi*, 567 A.2d 178, 181 (N.H. 1989).

<sup>37</sup> *In re B.T.*, 891 A.2d at 1199.

<sup>38</sup> *In re Richard A.*, 771 A.2d at 578.

<sup>39</sup> N.H. REV. STAT. ANN. § 135-C:33(I).

<sup>40</sup> 422 U.S. 563 at 575–76 (1975).

<sup>41</sup> PERLIN, *supra* note 9, at § 3A-13.

<sup>42</sup> N.H. REV. STAT. ANN. § 135-C:28(I) (defining “petitioner” as “any individual, including a physician or APRN completing a certificate, who has requested that a physician or APRN conduct or who has conducted an examination for purposes of involuntary emergency admission”).

<sup>43</sup> *Id.* § 135-C:28(III).

<sup>44</sup> *Id.* § 135-C:28(I).

<sup>45</sup> See McDermott, *supra* note 5.

<sup>46</sup> N.H. REV. STAT. ANN. § 135-C:28(I).



and “immediately deliver him” to a “designated receiving facility.”<sup>47</sup> The “designated receiving facility” is a “treatment facility” approved by the state “to accept for care, custody, and treatment persons involuntarily admitted to the state mental health services system.”<sup>48</sup> About half of New Hampshire’s inpatient beds for committed patients are located in the state capital, Concord.<sup>49</sup> Many patients must travel there from rural areas, and if they resist, police may transport them in handcuffs.<sup>50</sup>

Upon arrival, the facility must notify the patient of a right to legal counsel, including a right to appointed counsel if the patient is indigent.<sup>51</sup> Within three days of an “involuntary emergency admission” at the receiving facility, the patient is entitled to a hearing in district court to determine if probable cause existed for admission.<sup>52</sup>

If the court finds that probable cause exists for the emergency admission, the admission must not exceed ten days unless a subsequent petition is filed.<sup>53</sup> The statute does not, however, make provisions for the protection of patients who first waited several days in the emergency room because no receiving facilities were available.<sup>54</sup> The plain language of the statute omits any mention of boarding in emergency rooms because this scenario is outside what the legislature intended to occur.

Under the statutory scheme, increased deprivation of liberty corresponds to an increase in procedure.<sup>55</sup> After a patient spends ten days at a receiving facility under emergency admission, a petitioner can file in probate court for longer involuntary admission.<sup>56</sup> The order for admission could last up to five years.<sup>57</sup> However, this admission may occur only after an additional psychiatric examination and a hearing at which the person has a right to counsel and a right to cross-examine the psychiatrist who filed the relevant report.<sup>58</sup>

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<sup>47</sup> *Id.* § 135-C:29

<sup>48</sup> *Id.* § 135-C:2

<sup>49</sup> Rick Jurgens, *Valley Regional Proposes New Mental Health Facility*, VALLEY NEWS (Feb. 1, 2015), <http://www.vnews.com/news/15434146-95/valley-regional-proposes-new-mental-health-facility>.

<sup>50</sup> *Id.*

<sup>51</sup> N.H. REV. STAT. ANN. § 135-C:30(I), (II).

<sup>52</sup> The three-day period does not include Sundays and holidays. *Id.* §§ 135-C:30(V), 135-C:31(I).

<sup>53</sup> *Id.* § 135-C:32.

<sup>54</sup> *See id.* (contemplating a maximum of ten days of involuntary emergency admission without any reference to the possibility of additional detainment in an emergency room); McDermott, *supra* note 5.

<sup>55</sup> *See* N.H. REV. STAT. ANN. §§ 135-C:32, 35, 36, 40.

<sup>56</sup> *Id.* § 135-C:32.

<sup>57</sup> *Id.* § 135-C:46.

<sup>58</sup> *Id.* §§ 135-C:40, 43

## II. THE RIGHT TO TREATMENT

### A. Legal Basis for the Right to Treatment

The state has a duty to provide services and care to those who are institutionalized.<sup>59</sup> Some patient rights are easily defined; for instance, the rights to safe conditions, confidentiality of medical records, and freedom from unreasonable seclusion.<sup>60</sup> However, the meaning and scope of an enforceable “right to treatment” varies by jurisdiction, as the state “necessarily has considerable discretion in determining the nature and scope of its responsibilities.”<sup>61</sup>

Under the federal Constitution, substantive due process implies some level of treatment, since, at a minimum, the state must show that “the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.”<sup>62</sup> When a person is a danger to himself, the purpose of commitment is to ameliorate the danger he poses to himself.<sup>63</sup> Likewise, the purpose of commitment when a person is a danger to others is not merely confinement; the purpose is to reduce the risk of danger through medical treatment so that he may leave.<sup>64</sup> Involuntary commitment that fails its purpose by confining a patient but not providing adequate treatment would arguably violate due process requirements by arbitrarily depriving a person of liberty.<sup>65</sup>

In *Youngberg v. Romeo*, the Court recognized a limited right to treatment and training for those involuntarily committed to a state institution, though

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<sup>59</sup> *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982) (finding it uncontroverted that “[w]hen a person is institutionalized [and] wholly dependent on the State . . . a duty to provide certain services and care does exist”).

<sup>60</sup> *E.g. id.* at 315–16, 318 (asserting a “right to security” and “freedom from restraint” inherent in substantive due process for those involuntarily committed); WINICK, *supra* note 22, at 197.

<sup>61</sup> *Youngberg*, 457 U.S. at 317; Levy & Rubenstein, *supra* note 21, at 215; WINICK, *supra* note 22, at 197.

<sup>62</sup> *Jackson v. Indiana*, 406 U.S. 715, 738 (1972); WINICK, *supra* note 22, at 199.

<sup>63</sup> See WINICK, *supra* note 22, at 199 (stating that “[t]he purpose of civil commitment based on the government’s *parens patriae* power is to promote the best interests of individuals who, by reason of their mental illness,” are not well-situated “to make decisions on their own behalf.”).

<sup>64</sup> *Id.* at 200.

<sup>65</sup> *Id.* at 200–01; see THE EVOLUTION OF MENTAL HEALTH LAW 45 (Richard J. Bonnie and Lynda Frost eds., 2001) (describing a right to services that arguably arises “whenever the state deprives a person of liberty or otherwise takes custodial control”).

only as necessary “to ensure safety and freedom from undue restraint.”<sup>66</sup> Beyond this constitutional right to treatment, many state legislatures have enacted broader and better-defined rights to treatment.<sup>67</sup> The consensus, however, is that the right to treatment generally entails a humane environment, adequate staffing, and individualized treatment plans.<sup>68</sup>

New Hampshire law provides such a right.<sup>69</sup> After defining criteria for involuntary commitment, the relevant statute lists the rights of those receiving mental health services.<sup>70</sup> These include the right to an individual service plan and “[t]reatment in the least restrictive environment necessary to achieve the purposes of the treatment.”<sup>71</sup> The patient “has a right to adequate and humane treatment provided in accordance with generally accepted clinical and professional standards.”<sup>72</sup> The New Hampshire Supreme Court has held that the statutory right to treatment conveys more than a general goal by the legislature; it protects the “civil rights of the mentally disabled who are confined in State institutions.”<sup>73</sup>

In addition to protecting a patient’s liberty interests, the involuntary commitment statute also implies a concern for the patient’s ability to function at his probable cause hearing.<sup>74</sup> In the forty-eight hours before the hearing, the hospital cannot administer medication that would adversely affect the patient’s judgment or “limit his ability to prepare for the hearing.”<sup>75</sup>

New Hampshire courts may enforce the state’s statutory right to treatment.<sup>76</sup> Since violation of the right requires a remedy, the state impliedly has waived sovereign immunity in claims alleging violation of the right to treatment.<sup>77</sup>

## B. The Related Right to Community-Based Services

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<sup>66</sup> 457 U.S. at 319; PARRY, *supra* note 8, at 452; *see* PERLIN, *supra* note 9, § 3A-9.8 (discussing the limited reach of the right to treatment articulated thus far by the Supreme Court).

<sup>67</sup> PARRY, *supra* note 8, at 452; WINICK, *supra* note 22, at 201; *see* PERLIN, *supra* note 9, § 3A-14.2 (writing that states responded to the lack of a clearer Supreme Court mandate for treatment by implementing their own statutory rights to treatment).

<sup>68</sup> PARRY, *supra* note 8, at 471.

<sup>69</sup> N.H. REV. STAT. ANN. § 135-C:57.

<sup>70</sup> *Id.* § 135-C:55-60.

<sup>71</sup> *Id.* § 135-C:57.

<sup>72</sup> *Id.* § 135-C:13.

<sup>73</sup> *Chasse v. Banas*, 399 A.2d 608, 610 (N.H. 1979).

<sup>74</sup> *See* N.H. REV. STAT. ANN. § 135-C:31(IV).

<sup>75</sup> *Id.*

<sup>76</sup> *Chasse*, 399 A.2d at 610.

<sup>77</sup> *Id.*

When the state commits a person involuntarily, it must provide treatment in the least restrictive setting possible. In *Olmstead v. L.C. ex rel. Zimring*,<sup>78</sup> the Supreme Court held that Title II of the Americans with Disabilities Act (“ADA”) prohibits the unjustified segregation of individuals with disabilities, and it set forth certain requirements for states to provide community-based services rather than relying exclusively on more restrictive forms of treatment like institutionalization.<sup>79</sup>

New Hampshire faced a complaint under this interpretation of the ADA in *Amanda D. v. Hassan* (2012).<sup>80</sup> The state was sued by a class of plaintiffs who had serious mental illnesses and who were unnecessarily institutionalized, or at serious risk of unnecessary institutionalization, in state-run facilities.<sup>81</sup> In 2014, New Hampshire entered a class action settlement agreement in which it agreed to provide a more effective mental health system with significantly enhanced and expanded community-based services.<sup>82</sup> The promised services included mobile crisis teams, Assertive Community Treatment teams,<sup>83</sup> supported housing, employment services, and family and peer support.<sup>84</sup> Thus, under both federal ADA mandates and New Hampshire’s involuntary commitment statute, New Hampshire patients are entitled to these less restrictive forms of treatment—such as community-based services—whenever possible.<sup>85</sup>

### III. PSYCHIATRIC BOARDING IN NEW HAMPSHIRE

#### A. Definition of “Psychiatric Boarding”

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<sup>78</sup> 527 U.S. 581 (1999).

<sup>79</sup> *Id.* at 607; PARRY, *supra* note 8, at 453–54; *see also* 90 A.L.R. Fed. 2d 1 (2014).

<sup>80</sup> *Amanda D. v. Hassan*, Civ. No. 1:12-cv-53-SM (D.N.H. 2012).

<sup>81</sup> *Id.*

<sup>82</sup> Class Action Settlement Agreement, *Amanda D. v. Hassan*, Civ. No. 1:12-cv-53-SM (D.N.H. 2012), <http://www.drnh.org/mentalhealthcrisis.html> [hereinafter Settlement].

<sup>83</sup> Assertive Community Treatment teams are designed to provide “comprehensive, intensive, and flexible treatment, services, and supports to individuals with mental illness, when and where they need them.” U.S. Dep’t of Justice, *Investigation of the New Hampshire Mental Health System Pursuant to the Americans with Disabilities Act* 21–22 (Apr. 7, 2011), [http://www.ada.gov/olmstead/documents/new\\_hampshire\\_findings.pdf](http://www.ada.gov/olmstead/documents/new_hampshire_findings.pdf). They “combine treatment, rehabilitation, and support services from professionals in a variety of disciplines, including but not limited to, psychiatry, nursing, substance abuse, and vocational rehabilitation.” *Id.* at 22.

<sup>84</sup> *Id.*

<sup>85</sup> N.H. REV. STAT. ANN. § 135-C:57.

“Psychiatric boarding” occurs when a patient is held in an emergency room because no inpatient beds are available for treatment.<sup>86</sup> Boarding persists until inpatient beds become available or, if permitted, the patient leaves without treatment, and this wait can last twenty-four hours or even days.<sup>87</sup>

Although at common law doctors did not have a duty to treat potential patients, federal law requires hospitals to provide treatment in emergency rooms, regardless of ability to pay, pursuant to the Emergency Medical Treatment and Labor Act, among other measures.<sup>88</sup> Thus, an emergency room must attempt to treat and stabilize a person brought to the facility for evaluation and commitment.<sup>89</sup> But the emergency room can only accomplish so much, and once a doctor or APRN determine that the patient should go to a facility specializing in psychiatric care, such facilities often are unavailable.<sup>90</sup> The patient is then “boarded” in the emergency room.<sup>91</sup>

#### B. Prevalence of Psychiatric Boarding

A 2008 national study found that seventy-nine percent of emergency departments reported the occurrence of psychiatric boarding at their facilities, and ninety percent of those facilities boarded patients every week.<sup>92</sup> According to another study, psychiatric patients are almost five times more likely to be boarded than non-psychiatric patients.<sup>93</sup>

Nationally, a patient subjected to psychiatric boarding will wait an average of 2.8 hours longer for appropriate care than a non-psychiatric patient; however, the figure is much higher in the Northeast.<sup>94</sup> In New Hampshire, a 2013 report found that over half of all patients recommended

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<sup>86</sup> Bender et al., *supra* note 7; Lois A. Weithorn, *Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1369 (2005) (defining “boarding” as “the phenomenon of persons with mental disorders remaining in hospital emergency rooms while waiting for mental health services to become available”); *ACEP Psychiatric And Substance Abuse Survey 2008*, AM. COLL. OF EMERGENCY PHYSICIANS (2008), <http://newsroom.acep.org/download/ACEP+Psychiatric+and+Substance+Abuse+Survey+-+April+2008.pdf>.

<sup>87</sup> Bender et al., *supra* note 7.

<sup>88</sup> David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMEDICAL L. 215, 223 (2014).

<sup>89</sup> Mary A. Blegen et al., *Psychiatric Boarding Incidence, Duration, and Associated Factors in United States Emergency Departments*, 41 J. EMERGENCY NURSING 57, 62 (Jan. 2015).

<sup>90</sup> *See id.* at 62–63.

<sup>91</sup> *Id.* at 63; Chorney, *supra* note 88, at 216–18.

<sup>92</sup> *ACEP Psychiatric and Substance Abuse Survey 2008*, *supra* note 86.

<sup>93</sup> Blegen et al., *supra* note 89, at 62.

<sup>94</sup> *Id.* at 63.

for involuntary emergency admission for mental health treatment waited for twenty-four hours or longer.<sup>95</sup> For those who waited over twenty-four hours, the average wait was two-and-a-half days, and the longest wait was seven days.<sup>96</sup> A subsequent New Hampshire study found that an average of twenty-one adults and five children were waiting for involuntary emergency admission each day during a four-month period.<sup>97</sup>

### C. Detrimental Effects of Psychiatric Boarding

Patients waiting in the emergency room do not receive needed therapies to improve their mental conditions.<sup>98</sup> Instead, they are subjected to the typical commotion of an emergency room: “flashing lights, buzzing alarms and staff rushing from room to room.”<sup>99</sup> What little care they do receive is substandard compared to the specialized treatment they would receive at a designated receiving facility, and the delays can exacerbate dangerous conditions.<sup>100</sup> Psychiatric boarding is associated with emergency room overcrowding, which correlates with increased mortality, morbidity, longer inpatient stays, and decreased patient satisfaction.<sup>101</sup>

Boarding also is expensive for all parties involved.<sup>102</sup> In 2012, a South Carolina emergency room boarded a psychiatric patient for 38 days, at an added cost of \$56,392 for the hospital.<sup>103</sup> Massachusetts implemented a

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<sup>95</sup> Shawn V. LaFrance & Daniel J. Walsh, *supra* note 1.

<sup>96</sup> *Id.*

<sup>97</sup> Shawn LaFrance, *Waiting for Help: Barriers to Timely Access for People with Mental Health Needs* 3, FOUND. FOR HEALTHY COMMUNITIES (Apr. 29, 2014), <http://www.healthynh.com/images/PDFfiles/BehavioralHealth/JOHN%20Final%20Summary%20Report%2004%2030%2014%20FINAL%20Waiting%20for%20Help.pdf>.

<sup>98</sup> Blegen et al., *supra* note 89, at 57.

<sup>99</sup> *ACEP Psychiatric And Substance Abuse Survey 2008*, *supra* note 86; Sarah Palermo, *Mental Health Care Providers Seek More Support From the State As Wait List for Help Grows*, CONCORD MONITOR (Jan. 7, 2013), <http://www.concordmonitor.com/community/town-by-town/concord/3721861-95/mental-health-state-hospital>.

<sup>100</sup> Blegen et al., *supra* note 89, at 57.; see Stephanie Armour, *South Carolina Psychiatric Patient Stuck 38 Days in ER*, BLOOMBERG (Jul. 18, 2013), <http://www.bloomberg.com/news/articles/2013-07-18/south-carolina-psychiatric-patient-stuck-38-days-in-er> (recounting the story of a psychiatric patient who was locked in a room to protect her from another patient while boarding at the emergency department).

<sup>101</sup> Blegen et al., *supra* note 89, at 57.

<sup>102</sup> Alissa Katz, *Billions Fail to Make Dent in ED Boarding of Psych Patients*, 36 EMERGENCY MED. NEWS 24, 25 (Nov. 2014).

<sup>103</sup> Armour, *supra* note 100.

Behavioral Health Task Force in 2012, and it found that psychiatric boarding drove increased health care costs for the commonwealth government.<sup>104</sup> Moreover, while the hospital boards psychiatric patients, emergency room staff and resources are diverted from non-psychiatric patients who require emergency medical services.<sup>105</sup>

#### D. Psychiatric Boarding and Substantive Due Process

The amount of time that involuntarily committed patients may be held before a probable cause hearing is a highly litigated issue.<sup>106</sup> Psychiatric boarding is a closely related issue because it lengthens the overall time of involuntary confinement.

New Hampshire's statutory scheme does not explicitly mention the added time a patient might wait in an emergency room before a probable cause hearing.<sup>107</sup> When a petitioner brings a person to the emergency room for involuntary commitment, and the person is then subjected to several days of psychiatric boarding, his detention is arguably a violation of his due process rights.<sup>108</sup>

To bring such a claim under § 1983, however, a plaintiff would need to identify a state actor.<sup>109</sup> The hurdle is high.<sup>110</sup> In 2005, the First Circuit reviewed a case in which an involuntarily committed patient sued private healthcare providers under § 1983.<sup>111</sup> The court applied three tests—the state compulsion test, the nexus/joint action test, and the public function test—and under each analysis, the court held that the private healthcare providers were

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<sup>104</sup> Chorney, *supra* note 88, at 231.

<sup>105</sup> Katz, *supra* note 102, at 25.

<sup>106</sup> PARRY, *supra* note 8, at 472.

<sup>107</sup> The statute requires a probable cause hearing after three days of confinement, but the three-day countdown does not begin until the patient arrives at a receiving facility. N.H. REV. STAT. ANN. § 135-C:31.

<sup>108</sup> See, e.g., Brief of Respondents at 8–9, *In re the Detention of D.W.*, 120 Wash.App. 1043 (2014) (No. 45111-5-II), 2014 WL 4657352, at \*7 (arguing that psychiatric boarding violates substantive due process because patients have no real opportunity for improvement).

<sup>109</sup> 42 U.S.C. § 1983; *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 922, 937 (1982) (requiring that “the conduct allegedly causing the deprivation of a federal right be fairly attributable to the State”); *Estades-Negroni v. CPC Hosp. San Juan Capestrano*, 412 F.3d 1, 4 (1st Cir. 2005) (“a plaintiff claiming a § 1983 violation must allege that a person or persons acting under color of state law deprived him of a federal constitutional or statutory right”).

<sup>110</sup> See, e.g., *Harvey v. Harvey*, 949 F.2d 1127, 1130 (11th Cir. 1992) (“Only in rare circumstances can a private party be viewed as a ‘state actor’ for section 1983 purposes.”).

<sup>111</sup> *Estades-Negroni*, 412 F.3d at 1–2.

not state actors.<sup>112</sup> It therefore affirmed dismissal of the patient's § 1983 claim.<sup>113</sup>

The New Hampshire District Court likewise raised the state-actor hurdle in *Trimble v. Androscoggin Valley Hospital, Inc.*,<sup>114</sup> where the court rejected a due process claim brought on behalf of an involuntarily committed patient who killed himself in the hospital.<sup>115</sup> The court declined to follow<sup>116</sup> its prior decision in *Kay v. Benson*,<sup>117</sup> where the plaintiff brought a due process claim against a physician who signed a certificate for his involuntary commitment.<sup>118</sup> The court in *Kay* denied the physician's summary judgment motion because the plaintiff alleged sufficient facts to show that the physician "was clothed with state authority so substantial in nature as to render his actions virtually identical to actions traditionally taken by a state."<sup>119</sup> However, the court in *Trimble* found that in the intervening fifteen years, other courts "reached emphatically different conclusions" than in *Kay*.<sup>120</sup> The clear trend was that "[a] private physician or private hospital should not become a state actor for" § 1983 liability when acting under the state's involuntary commitment law.<sup>121</sup> In light of this trend, the district court declined to follow *Kay*.<sup>122</sup>

Though claimants subjected to psychiatric boarding might still find ways to surmount the state-actor hurdle,<sup>123</sup> this Note will instead focus on the statutory right to treatment as precluding psychiatric boarding.

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<sup>112</sup> *Id.* at 5–8.

<sup>113</sup> *Id.* at 9.

<sup>114</sup> 847 F. Supp. 226 (D.N.H. 1994).

<sup>115</sup> *Id.* at 228.

<sup>116</sup> *Id.*

<sup>117</sup> 472 F. Supp. 850 (D.N.H. 1979).

<sup>118</sup> *Id.* at 851.

<sup>119</sup> *Id.*

<sup>120</sup> *Trimble*, 847 F. Supp. at 229.

<sup>121</sup> *Id.* at 229.

<sup>122</sup> *Id.* at 229–30.

<sup>123</sup> In *Kay*, the court rejected due process claims against the medical center and its rehabilitation counselor. 472 F. Supp. at 851. However, other actors remain untested. For instance, if a provider at a community mental health center—under contract with the state—brings a patient to the emergency room, petitions for commitment, and the patient is then boarded for several days, could the patient bring a due process claim against the community mental health center as a state actor? See COMMUNITY MENTAL HEALTH CENTERS, N.H. DEP'T OF HEALTH AND HUMAN SERVS., <http://www.dhhs.state.nh.us/dcbcs/bbh/centers.htm> (last visited Nov. 22, 2015) (describing the state's Community Mental Health Centers as "private")



#### IV. PSYCHIATRIC BOARDING AS A STATUTORY VIOLATION OF THE RIGHT TO TREATMENT

While a § 1983 claim would face the hurdles described above, a state statutory claim—grounded in a patient’s right to treatment—could provide stronger footing for a challenge to psychiatric boarding.<sup>124</sup>

Could a statutory right to treatment bar psychiatric boarding? In 2014, the Washington Supreme Court found such a prohibition.<sup>125</sup> In a groundbreaking opinion, the court held that psychiatric boarding violated a patient’s statutory right to treatment when used merely to avoid overcrowding at certified facilities.<sup>126</sup>

The following analysis shows similarities between New Hampshire’s statutory framework for the commitment and treatment of mentally ill persons and the Washington statutes that invalidated psychiatric boarding. An analogous interpretation of New Hampshire’s statutory right to treatment militates against the continued use of psychiatric boarding.

##### A. Washington State’s Mental Health Statute Is Similar to New Hampshire’s

Washington State’s statutory scheme for involuntary commitment closely resembles the statutory scheme in New Hampshire.

Both states declare treatment as a purpose of the laws.<sup>127</sup> In Washington, commitment serves to “provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders,” as well as “continuity of care” for such persons.<sup>128</sup> In New Hampshire, the state’s purposes include providing “adequate and humane care” to those with severe mental disability; coordinating “a comprehensive, effective, and efficient system of services for persons with mental illness”; and reducing “the

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and “not-for-profit agencies that have contracted with the [state health department] to provide publicly funded mental health services to individuals and families”).

<sup>124</sup> N.H. REV. STAT. ANN. § 135-C:57 (2015); see *Det. of D.W. v. Dep’t of Soc. and Health Servs.*, 332 P.3d 423, 428 (Wash. 2014) (holding that the state’s right-to-treatment law did not permit psychiatric boarding as a means to avoid overcrowding).

<sup>125</sup> See Anne Scheck, *Psychiatric Boarding Banned in Washington State: Now What?* EMERGENCY MED, NEWS 20, 21 (Nov. 2014) (discussing the groundbreaking ruling in Washington State and its implications for healthcare providers and state health departments).

<sup>126</sup> *Det. of D.W.*, 332 P.3d at 428.

<sup>127</sup> Compare N.H. REV. STAT. ANN. § 135-C:1 (1995) with WASH. REV. CODE ANN. § 71.05.010 (West 1998).

<sup>128</sup> WASH. REV. CODE ANN. § 71.05.010(2), (4) (West 1995).

occurrence, severity and duration of mental, emotional, and behavioral disabilities.”<sup>129</sup>

Rehabilitation is a chief concern. Washington endeavors to prevent indefinite commitment, while New Hampshire calls for care to be “[d]irected toward eliminating the need for services and promoting the person’s independence.”<sup>130</sup>

Another goal of the Washington framework is to “encourage, whenever appropriate, that services be provided within the community.”<sup>131</sup> Similarly, New Hampshire strives to provide care “[w]ithin each person’s own community” and in a manner that is “[l]east restrictive of the person’s freedom of movement and ability to function normally in society.”<sup>132</sup>

The two states’ criteria for involuntary commitment closely mirror each other. A person with mental illness is eligible for involuntary emergency admission if he is a danger to himself or others.<sup>133</sup> The state cannot confine the person just anywhere; Washington requires treatment in an “evaluation and treatment facility,” while New Hampshire requires treatment in an analogous “receiving facility.”<sup>134</sup>

Both states require a qualified medical professional to examine the patient upon his arrival at a psychiatric facility, and the professional must complete a “certificate” or “petition” showing that the patient met the statutory criteria for involuntary commitment.<sup>135</sup> The patient is then entitled to a probable cause hearing within three days.<sup>136</sup>

After the hearing, a patient in Washington may be detained for up to fourteen additional days of involuntary, intensive treatment, and in order to

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<sup>129</sup> N.H. REV. STAT. ANN. § 135-C:1(I), (II) (1995).

<sup>130</sup> *Id.* § 135-C:1(II); WASH. REV. CODE ANN. § 71.05.010(1) (West 1998).

<sup>131</sup> WASH. REV. CODE ANN. § 71.05.010(1) (West 1998).

<sup>132</sup> N.H. REV. STAT. ANN. § 135-C:1(II) (1995).

<sup>133</sup> *Id.* § 135-C:27 (1987); *see* WASH. REV. CODE ANN. § 71.05.153(1) (West 1998) (allowing a mental health professional to take a person into custody for evaluation and treatment if, “as the result of a mental disorder,” he “presents an imminent likelihood of serious harm”).

<sup>134</sup> *Compare* N.H. REV. STAT. ANN. § 135-C:2(XIV) (1995) (requiring treatment facilities to be designated for treatment by the health department) *with* WASH. REV. CODE ANN. § 71.05.020(16) (West 1998) (requiring facilities providing mental health services to be certified by the health department).

<sup>135</sup> N.H. REV. STAT. ANN. § 135-C:28(I) (2001); WASH. REV. CODE ANN. § 71.05.160(1) (West 1998).

<sup>136</sup> N.H. REV. STAT. ANN. § 135-C:31(I) (1995) (setting a deadline of three days for the probable cause hearing); WASH. REV. CODE ANN. § 71.05.180 (West 1998) (setting a deadline of seventy-two hours for the probable cause hearing).

detain a person after fourteen days, further judicial process is required.<sup>137</sup> A patient in New Hampshire may be detained for ten days before further commitment proceedings are required.<sup>138</sup>

The states impose an additional limit on the time of detainment. In Washington, the facility may release a patient if he “no longer presents a likelihood of serious harm.”<sup>139</sup> In New Hampshire, the facility “shall discharge the person” if he no longer satisfies the statutory criteria.<sup>140</sup>

Finally, the states give substance to their stated policy goals by enumerating rights to treatment. Washington law provides: “Each person involuntarily detained or committed pursuant to this chapter shall have the right to adequate care and individualized treatment.”<sup>141</sup> New Hampshire law provides: “Each client has a right to adequate and humane treatment provided in accordance with generally accepted clinical and professional standards.”<sup>142</sup> New Hampshire patients also have a right to an “individual service plan” and “[t]reatment in the least restrictive environment necessary to achieve the purposes of the treatment.”<sup>143</sup>

#### B. Violation of the Statutory Right to Treatment in Washington State

The Washington Supreme Court interpreted the state’s commitment and treatment statutes to bar psychiatric boarding in *Detention of D.W.*<sup>144</sup> The case arose from a common problem: a county lacked space in its certified facilities for involuntarily detained patients, so instead, the county held them in emergency rooms.<sup>145</sup> The county argued that a regulation sanctioned psychiatric boarding.<sup>146</sup> It construed this regulation to allow “single bed certification” at uncertified facilities (emergency rooms) when no certified facilities were available.<sup>147</sup>

Ten patients challenged the legality of this practice.<sup>148</sup> The county had held the patients in emergency rooms or acute care clinics using single-bed certification.<sup>149</sup> The patients waited for three to ten days,<sup>150</sup> yet when no

<sup>137</sup> WASH. REV. CODE ANN. §§ 71.05.230, 71.05.310 (West 1998).

<sup>138</sup> N.H. REV. STAT. ANN. § 135-C:32 (2010).

<sup>139</sup> WASH. REV. CODE ANN. §§ 71.05.230, 71.05.330 (West 1998).

<sup>140</sup> N.H. REV. STAT. ANN. § 135-C:33(I) (2002).

<sup>141</sup> WASH. REV. CODE ANN. §§ 71.05.230, 71.05.360(2) (West 1997).

<sup>142</sup> N.H. REV. STAT. ANN. § 135-C:13 (1995).

<sup>143</sup> *Id.* § 135-C:57(I), (IV) (1995).

<sup>144</sup> *Det. of D.W. v. Dep’t of Soc. and Health Servs.*, 332 P.3d 423, 428 (Wash. 2014).

<sup>145</sup> *Id.* at 424.

<sup>146</sup> *Id.*; WASH. ADMIN. CODE 388-865-0526 (2004).

<sup>147</sup> WASH. ADMIN. CODE 388-865-0526 (2004).

<sup>148</sup> *Det. of D.W.*, 332 P.3d at 424.

<sup>149</sup> *Id.* at 424–25.

rooms opened up, the county petitioned to hold the patients longer.<sup>151</sup> The patients moved to dismiss the petitions because they were not held in certified facilities, and thus did not receive adequate treatment while confined.<sup>152</sup>

One of the county's mental health supervisors testified at an evidentiary hearing that the county obtained single-bed certification simply by faxing a form to the state hospital, which, according to the supervisor, almost always approved the certifications without asking questions.<sup>153</sup> He also testified that patients held under such circumstances received "less care than they would if they were in an evaluation and treatment center," and the emergency room was "actually a more restrictive environment."<sup>154</sup>

The commissioner dismissed the county's petitions, and after the county appealed, the patients' claims eventually reached the Washington Supreme Court.<sup>155</sup> Two hospital systems intervened on the county's side, along with the state Department of Social and Health Services.<sup>156</sup> Appellants argued that the state's involuntary commitment law and its implementing regulation permitted single-bed certification as a solution to overcrowding at certified facilities.<sup>157</sup>

The court strictly construed the statute because it impacted liberty interests.<sup>158</sup> In reaching its decision, the court relied on Washington's statutory provision for "the right to adequate care and individualized treatment," as well as the mandate that patients "be held in certified evaluation and treatment facilities."<sup>159</sup> Individuals have a right to treatment under Ninth Circuit precedent, and lack of funds cannot justify the state's failure to treat the patient.<sup>160</sup>

The court noted that Washington's statutory definition of "certified evaluation and treatment facilities" did not include emergency rooms or acute care centers, and such facilities could be used only if they were

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<sup>150</sup> Brief of Respondents at 1, *In re Detention of D.W.* (2014) (No. 45111-5-II), 2014 WL 4657352, at \*vii.

<sup>151</sup> *Det. of D.W.*, 332 P.3d at 424.

<sup>152</sup> *Id.* at 424–25.

<sup>153</sup> *Id.* at 425.

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.* at 425–26.

<sup>157</sup> *Det. of D.W.*, 332 P.3d at 427.

<sup>158</sup> *Id.* at 426.

<sup>159</sup> *Id.*

<sup>160</sup> *Id.* at 426 (citing *Ohlinger v. Watson*, 652 F.2d 775, 778–79 (9th Cir. 1981)).

specifically designated as “evaluation and treatment centers” by the Department of Social and Health Services.<sup>161</sup> The parties in *Detention of D.W.* did not contend that emergency rooms were so designated.<sup>162</sup>

The court ruled that the patients were entitled to adequate treatment at certified facilities, and the only permissible reason for not using a certified facility would be to further the overarching goal of the statute: providing adequate treatment.<sup>163</sup> If, for instance, a doctor cited a medical reason for keeping a patient in the emergency room—“such as dialysis or chemical dependency treatment”—then single-bed certification might be appropriate.<sup>164</sup> The regulation permitting single-bed certification only went this far.<sup>165</sup>

Washington did not use psychiatric boarding to further treatment; it used psychiatric boarding to cope with lack of resources.<sup>166</sup> Therefore, the court held that the state violated the patients’ rights when it relied on psychiatric boarding to avoid overcrowding at certified facilities.<sup>167</sup>

### C. Could a Similar Case Arise in New Hampshire?

Although plaintiffs have generally had mixed results in bringing claims under state right-to-treatment laws,<sup>168</sup> *Detention of D.W.* could encourage similar claims in other states. Under the Washington ruling, a patient’s rights do not change simply because a certified facility is unavailable. A New Hampshire court could likely reach the same result using a similar rationale.

#### 1. The Basis for a Similar Case in New Hampshire

As described above, New Hampshire and Washington have similar statutory frameworks for involuntary commitment.<sup>169</sup> Both states declare

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<sup>161</sup> *Id.* at 427.

<sup>162</sup> *Id.* In contrast to emergency rooms, certified receiving facilities are approved by the state for specialized, psychiatric care. WASH. REV. CODE ANN. § 71.05.020(16) (West 1998).

<sup>163</sup> *See Det. of D.W.*, 332 P.3d at 427 (grounding the court’s decision in the statutory right to adequate treatment and permitting deviation from the use of certified treatment facilities only “when, in the exercise of professional judgment, a properly qualified agent of the mental health division determines that there is either a medical justification for involuntarily detaining a patient outside a certified facility or that the single bed certification would facilitate continuity of care”).

<sup>164</sup> *Id.*

<sup>165</sup> *Id.*

<sup>166</sup> *Id.* at 427–28.

<sup>167</sup> *Id.* at 428. Response to the ruling is discussed *infra* in Section V.

<sup>168</sup> PARRY, *supra* note 8, at 452.

<sup>169</sup> *See supra* Section IV.

treatment as their purpose;<sup>170</sup> both enumerate a right to treatment;<sup>171</sup> both contemplate time limits for confinement and mandate judicial process to safeguard individual rights;<sup>172</sup> and both require treatment in certified facilities.<sup>173</sup>

Just like the respondents in *Detention of D.W.*, involuntarily committed patients in New Hampshire are entitled to treatment at a certified facility and in the least restrictive environment necessary.<sup>174</sup> The court in *Detention of D.W.* strictly construed the statutory requirement that patients receive treatment in certified “evaluation and treatment facilities,” and New Hampshire likewise requires treatment in a designated “receiving facility.”<sup>175</sup> Just as the Washington court held that emergency rooms did not meet the statutory criteria, similarly, New Hampshire could reach the same result by finding that emergency rooms are not designated receiving facilities, and are not used to provide better medical treatment, but rather to avoid overcrowding.

The court discussed regulations at length in *Detention of D.W.*, since the regulations had expressly permitted single-bed certification.<sup>176</sup> New Hampshire regulations address psychiatric boarding only indirectly.<sup>177</sup> They mandate that a receiving facility accept a patient sent to that facility pursuant to the involuntary commitment law, “unless there are no beds available at the time of admission.”<sup>178</sup> What should happen if no beds are available at any of the receiving facilities? The regulations do not say.

Appellants in *Detention of D.W.* argued that the Washington regulations provided an answer: lacking beds at certified facilities, the state could board patients in emergency rooms using “single bed certification.”<sup>179</sup> Yet the

<sup>170</sup> N.H. REV. STAT. ANN. § 135-C:1 (1998); WASH. REV. CODE ANN. § 71.05.010 (West 1995).

<sup>171</sup> N.H. REV. STAT. ANN. § 135-C:13 (1998); WASH. REV. CODE ANN. §§ 71.05.230, 71.05.360(2) (West 1995).

<sup>172</sup> N.H. REV. STAT. ANN. § 135-C:32(I) (1995); WASH. REV. CODE ANN. §§ 71.05.230, 71.05.330 (West 1998).

<sup>173</sup> N.H. REV. STAT. ANN. §§ 135-C:2(XIV), 135-C:26 (1995) (requiring treatment facilities to be designated for treatment by the health department); WASH. REV. CODE ANN. § 71.05.020(16) (West 1998) (requiring facilities providing mental health services to be certified by the health department).

<sup>174</sup> N.H. REV. STAT. ANN. § 135-C:57 (2002).

<sup>175</sup> N.H. REV. STAT. ANN. §§ 135-C:2(XIV), 135-C:26 (1995).

<sup>176</sup> *Det. of D.W. v. Dep’t of Soc. and Health Servs.*, 332 P.3d 423 (Wash. 2014).

<sup>177</sup> See N.H. CODE ADMIN. R. He-M 405.06 (1983) (mentioning the possibility of a receiving facility lacking beds but not stating what should happen in such scenarios).

<sup>178</sup> *Id.*

<sup>179</sup> *Det. of D.W.*, 332 P.3d at 427.

court rejected appellants' interpretation of the regulation, holding that overcrowding was no excuse for psychiatric boarding.<sup>180</sup> New Hampshire does not have an equivalent "single bed certification" regulation, and even if it did, a court would likely interpret it as inconsistent with the statutory requirement that a patient immediately be transferred to a certified receiving facility.<sup>181</sup>

New Hampshire regulations also implicate psychiatric boarding when discussing the purposes of receiving facilities. One purpose of a receiving facility is to admit involuntarily committed patients "beginning with initial custody and continuing through the day following the probable cause hearing."<sup>182</sup> This language mandates that patients should go to designated receiving facilities as soon as possible from the time of "initial custody." For involuntarily committed patients waiting in emergency rooms, the time of initial custody has already begun.

Finally, the New Hampshire statute for involuntary commitment states that "[u]pon completion" of a certificate for emergency admission, "any law enforcement officer shall . . . take custody of the person to be admitted and *immediately deliver him* to the receiving facility identified in the certificate."<sup>183</sup> The command to "immediately deliver" the patient to the facility gives no leeway for psychiatric boarding.

## 2. Possible Ambiguities in New Hampshire's Statutory Right to Treatment

While the Washington right to treatment is analogous to New Hampshire's, claimants in a first impression case will encounter some differences and ambiguities in the laws. These variations in language should not lead to a different holding.

When interpreting statutes, New Hampshire courts "examine the language found in the statute, and where possible, [they] ascribe the plain and ordinary meanings to words used."<sup>184</sup> The court will "interpret legislative intent from the statute as written and will neither consider what the legislature might have said nor add language it did not see fit to include."<sup>185</sup> "When the language used in the statute is clear and

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<sup>180</sup> *Id.* at 428.

<sup>181</sup> N.H. REV. STAT. ANN. § 135-C:29(I) (1998) ("Upon completion of an involuntary emergency admission certificate under RSA 135-C:28, any law enforcement officer shall . . . take custody of the person to be admitted and immediately deliver him to the receiving facility identified in the certificate.")

<sup>182</sup> N.H. CODE ADMIN. R. He-M 612.03 (1986).

<sup>183</sup> N.H. REV. STAT. ANN. § 135-C:29 (1995) (emphasis added).

<sup>184</sup> *In re Sandra H.*, 846 A.2d 513, 520 (N.H. 2004).

<sup>185</sup> *State v. Paul*, 104 A.3d 1058, 1060 (N.H. 2014).

unambiguous,” the court will not modify its meaning by judicial construction.<sup>186</sup>

The legislature’s policy objectives are relevant to interpretation of ambiguous provisions. The court will “interpret a statute in the context of the overall statutory scheme and not in isolation.”<sup>187</sup> Its goal is to apply statutes “in light of the legislature’s intent in enacting them” and “in light of the policy sought to be advanced by the entire statutory scheme.”<sup>188</sup>

The language in New Hampshire’s statutory right to treatment contains ambiguities, discussed *infra* in this section, and a reviewing court will thus look beyond the language to the legislature’s policy goals in determining legislative intent. Here, the legislature’s stated purpose in its mental health system laws is to:

- (a) Establish, maintain, and coordinate a comprehensive, effective, and efficient system of services for persons with mental illness.
- (b) Reduce the occurrence, severity and duration of mental, emotional, and behavioral disabilities.
- (c) Prevent mentally ill persons from harming themselves or others.<sup>189</sup>

The legislature’s stated policy is to provide “adequate and humane care” that is:

- (a) Within each person’s own community.
- (b) Least restrictive of the person’s freedom of movement and ability to function normally in society while being appropriate to the person’s individual capacity.
- (c) Directed toward eliminating the need for services and promoting the person’s independence.<sup>190</sup>

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<sup>186</sup> *In re Sandra H.*, 846 A.2d. at 520.

<sup>187</sup> *In re Muchmore & Jaycox*, 986 A.2d 456, 458 (N.H. 2009).

<sup>188</sup> *Appeal of Mascoma Valley Reg’l Sch. Dist.*, 677 A.2d 679, 681 (N.H. 1996).

<sup>189</sup> N.H. REV. STAT. ANN. § 135-C:1 (1995).

<sup>190</sup> *Id.*



Thus, the stated purpose and policy weigh toward broad application of treatment rights when interpreting the statutes for involuntary emergency admission.

Under § 135-C:57, individuals have a right to “[t]reatment in the least restrictive environment necessary to achieve the purposes of the treatment.”<sup>191</sup> § 135-C:55 restricts the application of this right, along with other patients’ rights, “to those persons who have been found eligible for services under RSA 135-C:13 and to those persons who have been admitted to receiving facilities.”<sup>192</sup> The right to treatment, as enunciated in § 135-C:57, would thus apply only to: (1) those eligible for services under § 135-C:13, and (2) those admitted to receiving facilities. These two groups raise questions of interpretation.

First, when has a person “been found eligible for services under RSA 135-C:13,” such that the statutory right to treatment in § 135-C:57 applies? § 135-C:13 prohibits discrimination in provision of services, stating: “Every severely mentally disabled person shall be eligible for admission to the state mental health services system, and no such person shall be denied services because of race, color or religion, sex, or inability to pay.”<sup>193</sup> This section appears to address those seeking services voluntarily more than it does those forced to receive services involuntarily.

Nonetheless, § 135-C:13 could arguably encompass those held for involuntary, emergency commitment. It states that individuals found to be “severely mentally disabled” are eligible for state mental health services. A separate provision defines “severely mentally disabled” to mean “having a mental illness which is either so acute or of such duration as to cause a substantial impairment of a person’s ability to care for himself or to function normally in society.”<sup>194</sup> This definition would likely cover those who, as a result of mental illness, are a danger to themselves or others. Considered alongside the broader definition, legislative intent to provide treatment, as well as the constitutional requirement to provide treatment when liberty is deprived for that purpose, § 135-C:13 is properly read to include patients who are in custody and boarded in emergency rooms.

The second group of patients within the scope of § 135-C:55 are those “admitted to receiving facilities.”<sup>195</sup> Under § 135-C:26, receiving facilities are for “the care, custody, and treatment of persons subject to involuntary

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<sup>191</sup> N.H. REV. STAT. ANN. § 135-C:57 (2002).

<sup>192</sup> *Id.* § 135-C:55 (1987).

<sup>193</sup> *Id.* § 135-C:13 (1986).

<sup>194</sup> *Id.* § 135-C:2(XV) (1995).

<sup>195</sup> N.H. REV. STAT. ANN. § 135-C:55 (1987).

admissions.”<sup>196</sup> Thus, the second question of interpretation: When has a patient been “admitted” to receiving facilities?

If “admitted” means arrival at the receiving facility or assignment to a bed, then a patient waiting in the emergency room has not yet been admitted. On the other hand, if “admitted” means that a patient is in custody and waiting for transport to a particular receiving facility, then a patient subjected to psychiatric boarding is “admitted”—just to an overcrowded facility. This reading is more consistent with the statutory scheme, which contemplates that a person may be held up to six hours while a petition is filed, and once the petition and medical certificate are complete, the person must “immediately” be transferred to a designated receiving facility.<sup>197</sup>

§ 135-C:28 may provide guidance for interpreting the term “admitted.” It states that “involuntary emergency admission . . . may be ordered upon the certificate of a physician or APRN.”<sup>198</sup> The physician “shall identify in the certificate the facility in the state mental health services system to which the person shall be admitted.”<sup>199</sup> In choosing a facility, he must identify the option “which least restrict[s] the client’s freedom of movement, ability to make decisions, and participation in his community while achieving the purposes of habilitation and treatment.”<sup>200</sup> This section suggests that the patient is “admitted” to a receiving facility upon completion of the certificate by an emergency room doctor, with the overarching “purposes of habilitation and treatment” guiding the process throughout the patient’s detention.

Extension of the right to treatment to boarded patients is further supported by § 135-C:31, which states that a receiving facility may transfer a patient to another receiving facility only if the second “receiving facility can better provide the degree of security and treatment required for the person.”<sup>201</sup> Again, this provision indicates that the patient’s treatment is the foremost concern while he is in custody.

In sum, the overall statutory scheme supports a finding that patients subjected to psychiatric boarding are entitled to treatment in the least restrictive environment necessary. In light of the legislative intent to provide treatment to those with serious mental illness, and the clear mandate to provide treatment to those whose liberty is curtailed involuntarily, courts

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<sup>196</sup> *Id.* § 135-C:26 (1986).

<sup>197</sup> *Id.* §§ 135-C:28(III), 29 (2009).

<sup>198</sup> *Id.* § 135-C:28 (1993).

<sup>199</sup> *Id.*

<sup>200</sup> *Id.* §§ 135-C:15, C:28 (1986).

<sup>201</sup> N.H. REV. STAT. ANN. § 135-C:31(V).

should resolve the statutory ambiguities in a way that supports treatment of individuals subjected to psychiatric boarding.

V. EFFECTIVE RESPONSE: IMPLEMENT THE STATUTE AS WRITTEN AND EXPAND COMMUNITY-BASED SERVICES

The ruling in *Detention of D.W.* forced Washington officials to consider treatment options for boarded patients.<sup>202</sup> Such patients previously had been in legal limbo, but the court clarified their rights. The chair of the state house appropriations committee responded to the ruling by commenting, “It’s always been inhumane not to provide treatment; now it’s clearly illegal.”<sup>203</sup>

Health officials struggled with how to respond. An official at the department of social and health services worried that as a result of the ruling, more mentally ill patients could end up on the streets without receiving the care they needed.<sup>204</sup> However, hospitals cannot simply throw patients out because of overcrowding; they must comply with federal requirements for safe discharges.<sup>205</sup> Dr. Alex Rosenau, President of American College of Emergency Physicians (“ACEP”), said there was “no doubt” the ruling would “help with crowding,” but he wondered: “what is step two?”<sup>206</sup>

One way or another, the court required Washington to implement the statute as written. Officials were compelled to make difficult budgetary decisions and ensure sufficient resources at certified facilities.<sup>207</sup>

New Hampshire too should make the difficult budgetary decisions now and implement its statutes as written. The state’s detailed statutory procedures for commitment derive from the serious liberty interests at stake and mandate that New Hampshire must provide “[t]reatment in the least restrictive environment” consistent with both legislative intent and critical constitutional considerations.<sup>208</sup>

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<sup>202</sup> See Andy Mannix & Lynn Thompson, *Ruling that bans ‘psychiatric boarding’ has health officials scrambling*, SEATTLE TIMES (Aug. 8, 2014), [http://seattletimes.com/html/localnews/2024266358\\_psychiatricboarding1.xml.html](http://seattletimes.com/html/localnews/2024266358_psychiatricboarding1.xml.html) (reporting that health officials were “scrambling” after the ruling, and one official began planning for increased community-based services and inpatient beds).

<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

<sup>206</sup> Anne Scheck, *Psychiatric Boarding Banned in Washington State: Now What?* EMERGENCY MED. NEWS 20, 20–21 (Nov. 2014).

<sup>207</sup> See *id.* (noting that Washington State committed \$30 million to “improv[ing] access to mental health services”).

<sup>208</sup> N.H. REV. STAT. ANN. § 135-C:57 (1986).

### A. Community-Based Services Are the Best Starting Point

New Hampshire should continue expanding community-based services for those with mental illness. This will relieve pressure on the state's inpatient facilities and reduce the number of patients requiring emergency care. Community mental health services are more cost- and outcome-effective than attempting to add beds at long-term facilities.<sup>209</sup>

The state already has a good start toward the implementation of a full, robust system of community-based services. In New Hampshire's class-action settlement in *Amanda D.*, the state agreed to significantly expand and enhance its community-based services, including mobile crisis teams, supported housing, Assertive Community Treatment teams,<sup>210</sup> and employment services.<sup>211</sup>

Telehealth programs also could reduce boarding. The mobile crisis services implemented through *Amanda D.* focus on more populous areas of New Hampshire.<sup>212</sup> For underserved and rural areas, telehealth could provide a partial solution.<sup>213</sup> The terms "telehealth" or "telemedicine" broadly describe "the use of medical information exchanged from one site to another via electronic communications to improve the patient's health status."<sup>214</sup>

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<sup>209</sup> Sharaya L. Cabansag, *Defending Access to Community-Based Services for Individuals with Developmental Disabilities in the Wake of the "Great Recession"*, 55 HOW. L.J. 1025, 1033–34 (2012).

<sup>210</sup> See U.S. DEP'T OF JUSTICE, *supra* note 83.

<sup>211</sup> Settlement, *supra* note 82.

<sup>212</sup> See *id.*

<sup>213</sup> Chorney, *supra* note 88, at 233.

<sup>214</sup> Tracy A. Lustig, Rapporteur, *The Role of Telehealth in an Evolving Health Care Environment*, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES PRESS, 134 (2012), [http://www.nap.edu/openbook.php?record\\_id=13466](http://www.nap.edu/openbook.php?record_id=13466).

## B. Long-Term Institutionalization Would Not Remedy the Problem

At first glance, increasing the number of beds at long-term facilities may seem like a quick fix for psychiatric boarding, and some state officials have called for this solution.<sup>215</sup> However, this response would not serve patients well, since long-term institutionalization is not as effective as community-based services,<sup>216</sup> and if the state over-relies on long-term facilities to provide care, it will expose itself to the same liability that led to its settlement in *Amanda D.*<sup>217</sup> Instead, the state should focus on enhancing community-based services.

### 1. Long-Term Institutionalization Is Less Effective and Exposes the State to Liability

The trend over the past several decades has been to rely less on long-term institutionalization because it is not as effective as community-based services.<sup>218</sup> Institutionalization is an extreme measure that entails social costs and substantial risks to those committed.<sup>219</sup> Furthermore, spending scarce resources on facility-based treatment may leave people without necessary services in the community, resulting in individuals cycling in and out of hospitals without creating long-term stability within the community.

If for no other reason, New Hampshire should avoid increased reliance on long-term institutionalization because the same reliance exposed the state to liability under *Amanda D.*<sup>220</sup> The state agreed to provide a greater balance of community-based services in its settlement agreement.<sup>221</sup> Over-reliance

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<sup>215</sup> Rick Jurgens, *Valley Regional Proposes New Mental Health Facility*, VALLEY NEWS (Feb. 1, 2015), <http://www.vnews.com/news/15434146-95/valley-regional-proposes-new-mental-health-facility> (reporting that in 2013, “a joint policy statement from state mental health officials and the New Hampshire Community Behavioral Health Association, an organization of the state’s 10 community mental health clinics, called for the state to add at least 48, and as many as 64, involuntary beds”).

<sup>216</sup> See, e.g., *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 601 (1999); Sharaya L. Cabansag, *supra* note 209, at 1034.

<sup>217</sup> See Settlement, *supra* note 82.

<sup>218</sup> See, e.g., *Olmstead*, 527 U.S. at 601; Cabansag, *supra* note 209, at 1034.

<sup>219</sup> Institutionalization presents a moral hazard to society by segregating a class of people for disparate and potentially inhumane treatment. See Susan Stefan, *UNEQUAL RIGHTS* 109–10, 112 (2001) (discussing the risks of mass institutionalization of those with mental illness, including both harm to the individual and stigmatization of disability). It also may diminish the everyday life of those with mental illness by impacting their “family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” *Olmstead*, 527 U.S. at 601.

<sup>220</sup> See Settlement, *supra* note 82.

<sup>221</sup> *Id.*

on institutionalization violates the ADA and violates the doctrine of the least restrictive alternative.<sup>222</sup>

## 2. Long-Term Institutionalization Is Uneconomical

From a state budgetary perspective, adding beds at long-term facilities is too costly compared to more economical solutions like increased community-based services.<sup>223</sup> Like many states, New Hampshire faced a budget shortfall for fiscal year 2015 with no apparent resources to fund additional mental health services.<sup>224</sup> Community-based services can cost a fraction of institutionalization and may qualify for Medicaid reimbursement.<sup>225</sup> In 2010, the average cost of treating a person at New Hampshire's primary long-term facility was \$287,000 per year, compared to \$44,000 per year to treat a person in the community.<sup>226</sup>

### C. Treatment Must Precede the Probable Cause Hearing

The trigger for the three-day countdown to a probable cause hearing currently begins with the patient's arrival at a designated receiving facility.<sup>227</sup> The state could arguably cure procedural due process concerns by starting the

<sup>222</sup> See Levy & Rubenstein, *supra* note 21, at 32 (discussing the doctrine of the least restrictive alternative for treatment).

<sup>223</sup> Cabansag, *supra* note 218, at 1041; Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 457–58 (1991).

<sup>224</sup> See, e.g., Garry Rayno, *Health and Human Services department facing \$58 million budget shortfall*, UNION LEADER (Jan. 21, 2015), <http://www.unionleader.com/apps/pbcs.dll/article?AID=/20150122/NEWS0621/150129736> (reporting on the state health agency's budget shortfall and describing a "balancing plan" that included delaying a "community mental health system project"); Reid Wilson, *Even Amid Recovery, State Budgets Bleed Red Ink*, WASH. POST (Dec. 12, 2014), <http://www.washingtonpost.com/blogs/govbeat/wp/2014/12/12/even-amid-recovery-state-budgets-bleed-red-ink/> ("At least 16 states are projected to run budget shortfalls in the next year or two").

<sup>225</sup> See Mannix & Thompson, *supra* note 202 (quoting Rep. Ross Hunter, Chair of the Washington House Appropriations Committee, as estimating the cost of a bed at a long-term institution as \$600 per day, while community-based services cost half that amount and are eligible for Medicaid reimbursement); LaFrance, *supra* note 97 (comparing the cost of a day of inpatient care, \$2,912, with the cost of a day of supportive housing, \$297).

<sup>226</sup> U.S. DEP'T OF JUSTICE, *Investigation of the New Hampshire Mental Health System Pursuant to the Americans with Disabilities Act* 5 (Apr. 7, 2011), [http://www.ada.gov/olmstead/documents/new\\_hampshire\\_findings.pdf](http://www.ada.gov/olmstead/documents/new_hampshire_findings.pdf).

<sup>227</sup> N.H. REV. STAT. ANN. § 135-C:31(I) (2009).

countdown earlier with the filing of the involuntary emergency admission petition, such that patients boarded in the emergency room would receive a hearing sooner. However, this response does not necessarily help such individuals because patients do not receive adequate treatment while in the emergency room, and as a result, they are less likely to perform well at a hearing.<sup>228</sup> Moreover, this option does not cure the state's potential liability for violation of the right to treatment, since patients could leave without having received their promised "adequate and humane treatment."<sup>229</sup>

## VI. CONCLUSION

Psychiatric boarding violates patients' right to treatment by confining them in highly restrictive environments that do not provide adequate care and that do not meet the statutory criteria for receiving facilities. Washington's statutory framework for involuntary commitment and its corresponding ruling in *Detention of D.W.* suggest that involuntarily committed patients could succeed in a similar claim in New Hampshire. The state should implement the statute as written and continue to expand community-based services, thus ensuring that no patients fall between the cracks.

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<sup>228</sup> Sarah Palermo, *supra* note 99 (describing the negative stimuli typically encountered while waiting in a hospital emergency room).

<sup>229</sup> N.H. REV. STAT. ANN. § 135-C:13 (2011).