Beds are scarce at state’s psychiatric hospital
Lack of treatment: “Mentally ill people are being taken care of on the street by police officers and in the jails by corrections officers,” says expert on police policies, procedures.

By SHAWNE K. WICKHAM

Even when police officers are trained to defuse a tense situation, finding a bed for someone having a mental health crisis remains a huge challenge in New Hampshire. On Memorial Day, there were 61 people in hospital emergency departments in the Granite State awaiting a bed at the state psychiatric hospital, including 25 children, according to Ken Norton, executive director of the New Hampshire chapter of the National Alliance on Mental Illness. “We broke our all-time record again,” he said. “It’s tragic.”

In New Hampshire, someone in crisis can be sent to a designated “receiving facility” for up to 72 hours. After that, there has to be a probable cause hearing to determine whether the person has a mental illness and poses a danger to himself or others; if so, he can be held another seven days, according to Norton. The problem is that there’s often no place that can take these individuals. “On any given day, we have 20 or 30 adults who are waiting in emergency rooms around the state” to get into New Hampshire Hospital, said Bill Rider, president and CEO of the Mental Health Center of Greater Manchester.

There are other facilities that can take voluntary or involuntary commitments, Rider said. Elliot Hospital’s Pathways unit has 12 beds; his center’s Cypress Center has 16. But Rider said those beds are usually full. And he said three of the four acute psychiatric residential treatment facilities that Manchester used to have are now closed. Norton got an email from a hospital social worker Friday morning. “They have a man there who has been there for 11 days,” he said. “It’s wrong medically, it’s wrong legally, it’s wrong ethically, it’s wrong morally and it’s wrong economically,” Norton said.

State law dictates that a person who has been involuntarily committed “shall” be transported to the state hospital once that petition is filled out, he said. “Not ‘when there’s a bed.’” It puts the medical professionals in a difficult situation because they’re not able to provide the needed treatment, Norton said. And hospitals have no legal ability to hold people. “So the state, by forcing them to board people, is putting them in a really unethical situation because it is forcing them to hold liability,” he said.

The burden of care often shifts back to those on the front lines, according to Charles Reynolds, a Dover expert in police policies and procedures. “Mentally ill people are being taken care of on the street by police officers and in the jails by corrections officers,” he said. “What we’re doing is we’re tracking these people in need of medical and psychiatric treatment into the criminal justice system and they become repeat offenders,” he said. “It’s just a revolving door, and the police are dealing with this every day.”
The real solution, Reynolds said, goes beyond what a patrol officer can do. And the drug epidemic has only exacerbated the situation, he said. The state hospital plans to open an additional 10 beds this summer, but Rider said that won’t eliminate the current backlog. “The longterm solution is more robust community mental health treatment that is easily accessible for people and that can go out and catch people where they’re at,” he said.

That’s why the mental health center is working with Manchester police to create a mobile crisis response team that could respond to emergencies. And they’re partnering with the new Hope for New Hampshire Recovery center in Manchester, where they plan to create four “respite” beds for those in crisis. A similar crisis response team started in Concord last year and another is planned for Nashua. “I think we’re all realizing that the synergy that can be generated for a healthier community comes with us getting out of our shells and working with each other,” Rider said.

NH Union Leader – June 19, 2016
No crime, but still in prison
Two populations: In N.H., mental health patients can be housed with inmates who have committed murder.
By DAVE SOLOMON
CONCORD — Beatrice Coulter is a registered nurse who’s worked in the mental health arena for more than 40 years, but she never saw anything like what she witnessed at the Secure Psychiatric Unit inside the state prison. Patients who have committed no crime are incarcerated there because New Hampshire, unlike 47 other states, has no other place to put them. The SPU was designed to hold individuals involved in the criminal justice system due to mental health issues, such as those deemed guilty by reason of insanity or those awaiting certification as competent to stand trial. But it also houses patients who have done no wrong.

Coulter thought she could do some good when she took a job in the unit last year, but lasted only four days. She now works for a community-based mental health organization and identifies herself as an “advocate for ethical mental health treatment.” A national patient advocacy group recently reached out to Coulter and others on the front lines in New Hampshire in preparation for legal action to stop a practice that’s been going on since the 1980s.

“We work in all 50 states and the things we hear and deal with regarding people who have mental illness run the gamut,” said Frankie Berger, director of advocacy at the Treatment Advocacy Center in Arlington, Va. “But we have never seen anything this egregious.” “The more that I have dug into this, and the more we are interacting with people in New Hampshire who are dealing with this, the worse it gets,” Berger said. “People are at wit’s end. The families who are dealing with this, who have family members in the unit, are besides themselves. Since it is under the Department of Corrections, they feel they can’t address this grievance without backlash.”
Considered a danger
Individuals whose mental illness is so severe that they are considered a danger to themselves or others can be committed through a legal process to the New Hampshire State Hospital. If the staff at the hospital determines the patient can’t be safely handled there, the patient is transferred to the state prison because the state does not have what are known as “civilly committed forensic beds,” meaning secure units in a hospital setting for dangerous but non-criminal patients.

There is a legal procedure for deciding if a patient should be transferred from the state hospital to the SPU. Anne Edwards, associate attorney general, said the SPU is a medical unit. “It’s not a prison unit,” she said. “It holds both civil committees and it has inmates who have mental health issues from state prison and the county prisons and the local jails.” Edwards acknowledged it’s true that patients who have committed no crimes could be housed with inmates who have committed murder. “And the staff is aware of that, and people are managed according to their degree of mental illness and their degree of dangerousness,” she said. The current situation is not ideal but it’s legal, Edwards said. “The ideal situation would be to have two secured psychiatric units, but that’s not what we have,” she said. “But we do believe the system that we have is legal.”

It’s up to the Legislature to decide whether to change the state’s policy, Edwards said. “They’d need to change the law to make sure that we can move civil committees to another place other than the Secure Psychiatric Unit and then that other place needs to be created,” she said. In the end, “It’s really more of a capital budget type of issue.” There’s also the issue of staffing, Edwards said; there’s already a shortage of mental health workers in the state. “So that would be part of the challenge in creating a new secured psychiatric unit of some type,” she said.

Earlier this year, state Rep. Renny Cushing of Hampton, ranking Democrat on the House Criminal Justice and Public Safety Committee, sponsored a bill to prohibit the transfer of individuals from the state hospital to the SPU and to authorize the state to transfer patients to a “therapeutic forensic hospital” in another state instead. The bill was sent to interim study.

Kenneth Norton, executive director of the National Alliance on Mental Illness in New Hampshire, said philosophically he understands the concern about housing mentally ill individuals in a prison setting. But he has more concern about the wording of the bill that was introduced. “We were very opposed to having people moved out of state, because then they’re away from their family and their friends, their support system,” Norton said.

A fiscal note on the bill states the cost for services in a New York therapeutic forensic hospital in 2013 was $859 per day — or $313,535 annually. Norton said only a very small number of individuals with mental illness pose a danger to themselves or others, and only a handful land in the SPU each year. His more immediate concern is the large number of patients who end up staying in hospital emergency
departments for days, even weeks, while awaiting beds in the state hospital. (See related story, Page A8.)

Unwelcomed distinction
Berger said New Hampshire, Kentucky and South Dakota are the only states that treat mentally ill people in state prison. “This narrative to try to make it out to be some freestanding facility that’s not part of the prison is just myth,” said Coulter. “There is no distinction that is made. They are commingled with individuals who are guilty by reason of insanity. For someone who has been in mental health as long as I have, it was the first time I have ever seen this, and was extremely troubled by it.”

The Treatment Advocacy Center is preparing paperwork for a formal grievance with the Civil Rights Division in the federal Department of Justice, which could lead to a lawsuit. “It will probably take a big lawsuit to get the funding necessary to do the right thing,” said Berger, “because it is all about the money. That’s not to dismiss the fact that it’s a tight budget situation and there are many things that need funding in New Hampshire, but this is so illegal that we have to stop it immediately.” The state is already under court order to spend an additional $30 million to improve its mental health system over the next four years because of a successful class-action lawsuit brought by the Disability Rights Center. But the issue of the Secure Psychiatric Unit was not addressed in that case.

Vulnerable population
Cushing said the population at issue is so small, so vulnerable and so in the shadows that the situation has persisted since the 1980s, despite efforts to address it in 2005, 2010 and again in the last session of the Legislature. The Legislature’s solution to the problem in the 1990s was to write into state law that the prison unit was an acceptable “receiving facility” for civilly committed patients. “It was done as a stopgap measure in the 1980s, as a result of some sort of violent incident that happened at the state hospital by a psychiatric patient who was civilly committed, and they didn’t have the capacity to deal with someone in that situation. So the response was to put them in the prison,” said Berger.

“The state Legislature realized in the 1990s that this was illegal, so they waved a magic wand by passing a bill saying it is legal,” she said, “but we have a federal Constitution. Just because state lawmakers say it is legal doesn’t magically make it legal.”

Efforts over the years
The matter came to the attention of the national group in May, when a web tracker it uses to monitor legislation related to the mentally ill turned up Cushing’s bill, HB 1541. It marked the most recent of many efforts over the years to address the problem. “In 2005, a study committee included a letter signed by then-Attorney General Kelly Ayotte, HHS (Health and Human Services) Commissioner John Stephen, and DOC Commissioner Bill Wrenn, which said we have to do something about this or we are going to get sued,” said Cushing. “It’s been going on for 30 years. The state has been dumping people in there and everyone thinks it’s perfectly fine.”
“When we had the hearing earlier this year, they had the audacity to call it a hospital,” he said. “There is no one who accredited that unit as a secure psychiatric hospital. No one with any medical credentials calls it a hospital. If it was a hospital, the state would be getting reimbursed by the federal government through Medicaid for the people who are being held there.” However, Norton said he speaks with colleagues in other states that have forensic hospitals. And he said, “If you went to one, it would not look a lot different than what our prison looks like,” he said.

Norton said the leadership at the SPU is made up of “really very highly qualified, caring people.” At the hearing on Cushing’s bill, no one complained about the quality of care, he said. “The issue was the philosophical issue of people who had not committed a crime being treated in a correctional facility,” Norton said. “Yes, I think philosophically that that’s wrong, but in terms of the priorities of things that need to be fixed in New Hampshire, that’s not high on the list.”

NH Union Leader – June 19, 2016
Crisis intervention: Training helps officers determine whether someone has a mental health condition.
By SHAWNE K. WICKHAM
A growing number of police officers in New Hampshire are getting special training to deal compassionately with individuals they encounter who are experiencing a mental health crisis. And William Rider, president and CEO of the Mental Health Center of Greater Manchester, believes that training made a critical difference after two Manchester patrol officers were shot and wounded last month. The Manchester department had held a “crisis intervention team” (CIT) training in February.

“I will tell you without a doubt that Ian MacPherson is alive today because the Manchester Police Department has been armed with the power of compassion through this CIT training,” Rider said. MacPherson, a 32-year-old man with a history of mental illness, was arrested unharmed and charged with two counts of attempted capital murder. Rider praised how the arresting officers conducted themselves that morning. “People are sophisticated enough now to recognize that somebody was operating under a psychotic way of thinking,” Rider said. “And they did their darn level best to make sure he didn’t get injured, despite the fact their adrenaline must have been pumping like crazy because two of their officers were down.”

Rider said CIT training teaches officers to use verbal de-escalation techniques; they learn to empathize with the troubled individual. The idea, he said, is that “you’re joining with him or her against the troubles that they see on the horizon...” So instead of police seeing the individual as the problem, “it’s the thought inside the person’s head that’s the problem,” he said. “That’s what forms the alliance.”

Kenneth Norton, executive director of the New Hampshire chapter of the National Alliance on Mental Illness (NAMI), said law enforcement has come a long way in how it handles people with mental illness.
“When I reflect back on a long career in mental health and I look at progress, that’s one of the biggest areas of progress that I think we’ve made,” he said.

NAMI-NH has worked with the New Hampshire police academy to train all new recruits, as well as inservice officers, in dealing with those in crisis. Norton said the training includes role-playing and bringing in individuals with mental illness to tell their own stories. Capt. Michael Begley, who supervises patrol officers for the Manchester Police Department, said 26 officers, along with eight counselors from MHCGM, took the crisis intervention training in February. The goal is to have as many officers trained as possible, he said. Now, when a patrol officer encounters someone who appears to be suffering a mental health crisis, a CIT officer is called to assist.

And when these officers come across individuals with whom they have had repeated contact, they’re trained to contact the mental health center to intervene — “before it progresses to the point they get arrested,” Begley said. “Obviously, if they’re in need of services, it’s better to go that way as opposed to incarceration.” Sgt. Peter Kucharski, who took the training, said it “brings a whole new level of professionalism to the agency.” Kucharski said officers learned about different diagnoses and the symptoms that accompany them. CIT trained officers are now assigned to all shifts, he said.

Based on national incidence rates, Kucharski estimates there are about 1,200 people in Manchester with schizophrenia and more than 600 with bipolar disorder. “So you can see how quickly these numbers add up,” he said. The Manchester department keeps track of encounters patrol officers have with individuals who appear to have mental health troubles. And if they start to see a pattern with a certain individual, he said, they’ll contact the mental health center to try to get the person help. One officer recently got a thank-you card from a woman he had helped, Kucharski said.

Charles Reynolds is a former Dover police chief who consults with police departments around the country on use-of-force policies. He said crisis intervention training can lessen the negative interactions police have with individuals with mental illness. Patrol officers have been dealing with such subjects for a long time, Reynolds said. But he said, “Now they’re expected to defuse situations on the street much more effectively, spend much more time on these cases than they would on an ordinary case, and have a much broader understanding of the issues related to mentally ill people than they have in the past.”

Capt. Mark Bodanza, commander of the N.H. Police Academy, said last year, the academy was expanded from 14 to 16 weeks, in part to accommodate additional training on mental health scenarios. They use a training simulator in conjunction with live actors to put the learning into practice. The training helps officers determine whether someone has a mental health condition; assess the threat to self or others; and explore options, such as involuntary commitment. It’s a smarter, safer way to patrol the streets, Bodanza said. “In the past, we would put somebody in jail and then they would get out and they would go back to the same pattern of behavior because we never really addressed the problem.”
“If you put a Band-Aid on the problem, you’re really not taking care of it,” he said. “The more thoughtful officer is looking at the ... more long-term solution.” Rider said he hopes to offer additional training sessions for officers in Manchester and surrounding towns. There are also plans to provide training for corrections officers at Valley Street jail, where many mentally ill individuals end up after encounters with police. This change in how police handle a mental health crisis can be traced to Memphis, Tenn., where a 27-year-old mentally ill man was shot and killed by police in 1987.

In response to community outrage, the police department worked with mental health experts to develop Crisis Intervention Teams. And the results of this new approach were striking, Rider said: Fewer police officers were getting hurt, and there were fewer injuries to individuals in crisis. Folks were being connected with treatment “and they were getting good outcomes,” he said. The Memphis model became a “best practice” for police departments across the country.

Rochester Police Department was the first in New Hampshire to create a Crisis Intervention Team in 2009. Police Chief Michael Allen was deputy chief back then. “We were having some crisis situations that were occurring involving people who were mentally ill,” he recalled. “We heard about this program in Memphis and we wanted to learn about a better way to deal with these situations when they arise.” The department now has a special CIT vehicle, and there are team members assigned to all three patrol shifts. Rochester has helped train officers in other departments, including Manchester.

Allen said he knows the training has prevented deadly-force situations. He remembers one incident years ago involving a suicidal man with a knife who was involved in a standoff with police at the Rochester Fairgrounds. Officers drew on their CIT training to de-escalate the situation and convince the man to give up his weapon, Allen said. “It can make all the difference between having to take a life or saving a life, from my perspective,” he said.

Thomas Kucharski is a forensic psychologist and a professor at John Jay College in New York; he’s also the uncle of Sgt. Peter Kucharski and conducted the training last February in Manchester. Officers, he said, “know how to use force; they know how to use Tasers and weapons and physical skills.” But this new approach, he said, emphasizes “using your communication skills to convince people to come into compliance, and to avoid using force if at all possible.” It’s also about building patience, he said. “Police have historically not been the most patient people. They arrive on the scene, they want it resolved right away.”

In cities such as Manchester and Nashua, Kucharski said, police officers often encounter the same individuals over and over. “And if people are treated fairly and gently and kindly — they’re not wrestled to the floor and Tasered — the second go around with the individual will be easier,” he said. “It’s like putting another tool in the toolbox of the police.”