INTRODUCTION

New Hampshire statutes describe a clear mechanism for involuntary hospitalization of individuals suffering from mental illness who are a danger to themselves or others. These statutes provide for involuntary admission to New Hampshire Hospital (NH Hospital) or other designated receiving facilities (DRFs) with defined due process rights, ensuring appropriate judicial review. Burns provides a detailed legal description of the New Hampshire involuntary admission process for the mentally ill. De Nesnera and Vidaver describe the process from a clinician’s perspective, delineating the care received by mentally ill individuals who meet the criteria under state law.

Involuntary hospitalization to a DRF does not equate to involuntary treatment. Individuals involuntarily admitted cannot leave the hospital voluntarily, but have the right to refuse psychiatric treatment, unless an acute psychiatric emergency is declared. The individual can be treated against his wishes when imminent risk of harm to self or others is present.

The New Hampshire Code of Administrative Rules, under the Department of Health and Human Services He-M Chapter 300 on Rights (Former Division of Mental Health and Developmental Services) describes two rules that define how an individual may receive treatment against their will.

- He-M 305 authorizes short-term involuntary emergency treatment for no longer than is necessary to resolve an emergency, but in no case for more than 24 hours in accordance with He-M 305.04(k).
- He-M 306 allows for involuntary treatment, up to 45 days, of individuals hospitalized on a non-emergency involuntary admission.

We describe the evolution of the He-M 306 rule allowing longer term involuntary treatment of mentally ill individuals who are involuntarily hospitalized at NH Hospital.

ESTABLISHMENT OF THE HE-M 306 RULE

In the mid 1980’s, mental health statutes governing the involuntary hospitalization of mentally ill New Hampshire citizens were significantly revised. The new laws established a process of evaluation, emergency and non-emergency involuntary admission and release of psychiatric patients from NH Hospital allowing a maximum of five years of treatment in collaboration with a community mental health center via a “conditional discharge.” These laws did not set forth a process for involuntary treatment of individuals with medication administered against their will after admission to NH Hospital. A significant minority of NH Hospital patients refused psychiatric medication and experienced substantial and progressive deterioration due to serious mental and/or physical illness associated with a mental disorder.

In 1985, the first He-M 306 rule established procedures to determine incapacity for individuals admitted involuntarily to NH Hospital to administer emergency treatment (medication) without the individual’s consent. The first iteration of this rule described a psychiatric emergency as “a mental status and act or pattern of behavior by an individual who lacks capacity to make an informed judgement which, if not treated, will result in an immediate, substantial and progressive deterioration of a serious mental illness.”

For involuntary treatment to proceed, the attending physician is required to submit a “request for emergency treatment authorization” form for a review committee providing:

1. The reasons why a treating physician believes that the individual is unable to make an informed judgement with respect to treatment;
2. Facts that support a finding that a medical or psychiatric emergency exists;
3. A description of the proposed treatment, including its therapeutic benefit and potential risks, and the nature and severity of possible side effects;
4. A statement affirming that the proposed treatment is the least restrictive available; and,

5. A statement asserting that a reasonable person would consent to the treatment.

A treatment review committee of three was required to convene within 24 hours of the filing of the request for emergency treatment authorization. The committee would be comprised of the NH Hospital medical director or designated psychiatrist; a legal advocate actively involved in the representation of clients who are mentally disabled; and a psychologist, social worker or registered nurse employed at NH Hospital. A majority of the treatment committee must find that all five categories outlined in the request form were met, and if so, the involuntary treatment was authorized for seven days, and for medication only. Psychosurgery, electroconvulsive therapy, sterilization, or experimental treatments of any kind were not considered for emergency treatment. Finally, under this rule, a guardianship petition needed to be filed within 72 hours after the treatment review committee determined that the individual was indeed incapacitated. Individuals admitted on an Involuntary Emergency Hospitalization or and Involuntary Admission could be treated involuntarily via the He-M 306 rule.

FIRST REVISION OF HE-M 306

In 1989 the rule underwent its first revision. This version defined psychiatric emergency as “a mental condition of an individual resulting in mental illness which if not treated promptly, likely would result in either: imminent danger of harm to the individual or others or as evidenced by symptoms that in the past have immediately preceded acts of harm to self or others, or by a recent overt act including, but not limited to, a credible threat of bodily harm, an assault, or self destructive behavior when the likelihood of preventing such harm would be substantially diminished if treatment is delayed; or serious deterioration of the individual’s mental status from his/her usual mental status as manifested by exacerbation of psychotic symptoms such as delusions, hallucinations, disorganized thought, stupor, panic state or profound disturbances of affect when the likelihood of stabilizing or reversing such deterioration would be substantially diminished if treatment were delayed.” Involuntary treatment proceeded, if and only if, the treating physician submitted a “request for emergency treatment authorization” form to a treatment review committee. The request form was similar to the previous version of the form, with the added requirement that the physician must delineate the reasons why a delay in treatment would substantially diminish the likelihood of preventing harm to the patient, or to others, or stabilizing or reversing the patient’s deteriorating condition.

The treatment review committee members had one change: the NH Hospital psychologist, social worker or registered nurse was replaced by the NH Hospital liaison from the community mental health center in the patient’s region of origin. The committee convened a hearing within three days of filing of the request form. Individuals admitted on either an Involuntary Emergency Admission or a Non-Emergency Involuntary Admission could be treated involuntarily under the He-M-306 rule.

Four major changes were instituted in the 1989 revision:

1. The treatment review committee authorized treatment by unanimous (not majority) decision;
2. If approved, treatment was authorized for 21 days;
3. The NHH medical director monitored treatment provided pursuant to this rule at least every seven days; and
4. It was not mandatory to pursue guardianship if treatment was approved, but assessment for this option was encouraged.

SECOND REVISION OF HE-M 306

The rule underwent its second revision in 1999. In this revision, psychiatric emergency was defined as “a mental condition of a patient, resulting from mental illness, which if not treated promptly will likely result in either: imminent danger of harm to the patient or others; deterioration of the patient’s mental status from his/her usual mental status as manifested by exacerbation of psychotic symptoms when the likelihood of stabilizing and reversing such deterioration would be substantially diminished if treatment is delayed; or continued decoupling of the patient’s mental status from his/her usual mental status as manifested by persistent psychotic symptoms when there is a reasonable likelihood that such symptoms could be alleviated if treatment could be administered to the patient.” For involuntary emergency treatment to proceed, the treating physician submitted a “request for emergency treatment authorization” form to the Director of the Division of Behavioral Health of the Department of Health and Human Services. The written request was significantly expanded. The rule required the physician to determine that the involuntarily admitted patient cannot make a decision regarding their treatment; that a medical or psychiatric emergency exists; that the patient does not have a guardian; and that a reasonable person would consent to the administration of emergency treatment including medication. The request asked the physician to provide extensive clinical information, including efforts made to inform the patient of the nature, effects, and risks of the proposed treatment; a description of the proposed treatment; a statement indicating what supports or treatment, if any, the patient has agreed to accept, and, why provision of such treatment would not ameliorate the emergency; and, why a delay in treatment would substantially diminish the likelihood of preventing imminent harm to self or others, substantially diminish the likelihood of stabilizing or reversing the patient’s deteriorating mental status, or result in continued decoupling of the patient’s mental status.

Six major changes were implemented in the 1999 revision:

1. The treatment review committee was abolished and replaced with one decision maker: the Director of Behavioral Health of the Department of Health and Human Services.
2. There is a provision requiring legal counsel to represent the patient (prior to this revision, the patient had an advocate from the Disability Rights Center, family member, or friend present at the hearing).
3. The State of New Hampshire had to demonstrate by clear
and convincing evidence that all He-M 306 criteria were met (prior to this revision, no legal threshold was established).

4. Treatment was authorized for up to 45 days.

5. The patient could have no more than one He-M 306 involuntary treatment order authorized during their non-emergency involuntary admission time. So, if the patient had a five year non-emergency involuntary admission order, only one He-M 306 treatment order could be authorized during that five-year period (prior to this revision, no specific number of He-M authorizations were specified).

6. Only individuals admitted on a Non-Emergency Involuntary Admission Order could be treated involuntarily via the He-M 306 rule (prior to this revision, individuals admitted on an involuntary emergency admission were also eligible for involuntary treatment under this rule).

THIRD REVISION OF HE-M 306

The third revision of this rule of law occurred in 2001. This iteration of the rule was an administrative clarification. No change in the definition of psychiatric emergency or request for treatment authorization was done. The rule was revised to reflect that a Hearings Officer of the Department of Health and Human Services’ Administrative Appeals Unit (AAU), not the Director of the Division of Behavioral Health, was authorized to render decisions on He-M 306 petitions.

FOURTH REVISION OF HE-M 306

The fourth and most current revision of this rule occurred in 2009. In this iteration, psychiatric emergency is defined as “a mental condition of a patient, resulting from mental illness, which, if not treated promptly likely will result in either: imminent danger of harm to the patient or others; deterioration of the patient’s mental status from his/her usual mental status as manifested by exacerbation of psychiatric symptoms that potentially endanger self or others, or lead to severe self neglect, or lead to a failure to function in a less restrictive environment when the likelihood of stabilizing and reversing such deterioration would be substantially diminished if treatment is delayed; or continued decompensation of the patient’s mental status from his/her usual mental status as manifested by persistent psychiatric symptoms that potentially endanger self or others, or lead to severe self neglect, or lead to a failure to function in a less restrictive environment when there is a reasonable likelihood that such symptoms could be alleviated if treatment could be administered to the patient.” The physician request for emergency treatment authorization was revised to reflect the change in the definition of psychiatric emergency, but otherwise, is just as rigorous as the third revision. Upon receipt of the physician request, a hearing must be scheduled within three working days, and the AAU Hearings Officer renders a written decision on the request within two working days of the hearing.

Three major changes instituted in the 2009 revision are:
1. The definition of psychiatric emergency incorporated a description of a patient’s exacerbation of psychiatric (not psychotic) symptoms, and pointed to decompensation and/or deterioration of a patient’s mental status leading to severe self-neglect and failure to function in a less restrictive environment as a serious condition that warrants immediate intervention.
2. The total number of He-M 306 treatment authorizations during a patient’s non-emergency involuntary admission period was increased from one to four.
3. A patient could have two He-M 306 treatment authorizations during one continuous NH Hospital hospitalization.

CONCLUSION

The He-M 306 rule delineates a process allowing for involuntary administration of psychiatric (or medical) treatment to patients lacking capacity and who refuse treatment that is clinically necessary in order to alleviate their psychiatric (or medical) symptoms. The evolution of this rule shows the careful balance sought between allowing the involuntary treatment of a severely ill population, while ensuring their civil rights. This comprehensive review of He-M 306 points out parallel processes: The development of increasingly rigorous administrative and legal oversight (ensuring appropriate due process rights for the patient); the demand for substantive clinical information justifying the request for involuntary treatment; and,
the formation of more clinically relevant definitions of psychiatric emergency with appropriate time frames for treatment of patients suffering severe psychiatric symptoms linked to their mental illness.

Incidentally, the number of patients receiving He-M 306 treatment authorizations is small compared to the total number of patients admitted to NH Hospital. In 2007, out of a total of 2,123 admissions, only 17 He-M 306 treatment authorization petitions were submitted, of which 15 were granted. In 2008, out of a total of 2,260 admissions, 15 petitions were submitted and 14 were granted. In 2009, out of a total of 2,278 admissions, 24 petitions were submitted and 22 were granted.

Twenty five years have passed since the initial He-M 306 rule was established. The fourth revision of this rule is the cumulative work of clinicians, attorneys, administrators and legislators, who all strive to strike a balance between an individual’s rights and the need for involuntary treatment. We trust that the balance has been achieved.

**ENDNOTES**

1. New Hampshire Revised Statutes Annotated, 135-C: New Hampshire Mental Health Services System.
5. State of New Hampshire, Office of Legislative Services, Administrative Rules, Chapter He-M 300 (Rights), Part He-M 306 (Medical and Psychiatric Emergencies).
6. He-M 306, Medical and Psychiatric Emergencies, Document # 3096, eff. 08-19-85; Expired 08-19-91.
9. He-M 306, Medical and Psychiatric Emergencies, Document # 4708, eff. 12-1-89; Expired 12-1-95.
14. He-M 306, Medical and Psychiatric Emergencies, Document # 7559, eff. 09-25-01.
15. He-M 306, Medical and Psychiatric Emergencies, Document # 9520, eff. 08-04-09.