



DISABILITIES RIGHTS CENTER, Inc.

**Review of the Circumstances Surrounding the Death of
D.M., Former Client of NH's Community Mental Health
System**

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The DRC is the designated federal protection and advocacy system for New Hampshire and is a member of the National Disabilities Rights Network.

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I. Introduction

The Disabilities Rights Center, Inc. (“DRC”) is the independent agency designated by the Governor of the State of New Hampshire pursuant to federal statutes to protect the legal rights of people with disabilities. The DRC’s mandate, in accordance with federal statutes, includes the authority to investigate and/or review violations of these rights. The federal statutory scheme confers upon the DRC broad powers to seek records, conduct interviews, and gather all necessary information in the course of an investigation and/or review of the death of an individual.

The death of D.M.¹ in Late 2007 from diabetic ketoacidosis raised concerns of neglect and abuse. The DRC, consequently, determined that it should review the matter to determine whether the care provided met with acceptable practices.

Based on the results of the investigation and the consultation we received from Dr. Kenneth Duckworth, the Medical Director for the National Alliance on Mental Illness (NAMI), we believe that the tragic death of Mr. M. and this investigation provides an important opportunity to make needed policy and operational changes at the mental health center that served Mr. M. as well as the system as a whole.

At the time of his death, Mr. M. received services through New Hampshire’s Department of Health and Human Services/Community Mental Health System, which was developed to safely integrate individuals with mental illness into New Hampshire communities through provision of treatment and an array of other services depending on need. DHHS oversees and supervises ten regional Community Mental Health Centers. Riverbend Community Mental Health, Inc (Riverbend), which is the community mental health center serving Greater Concord, was Mr. M.’s center.

To review the issues involved in Mr. M.’s death, the DRC requested information from the State of New Hampshire, New Hampshire Hospital; State of New Hampshire, Office of the Chief Medical Examiner; Riverbend; Manchester Community Health Center; and Concord Police Department. The DRC further conducted interviews of Riverbend employees and the lay individual who attempted to assist Mr. M. with medical issues just prior to his death as well as Mr. M.’s landlord.

As noted above, the DRC obtained an analysis from independent consultant Kenneth Duckworth, MD. In addition to serving as the Medical Director for NAMI, Dr. Duckworth is an Assistant Professor at Harvard University Medical School. He has also served as Acting

¹ D.M is not the deceased gentleman’s real initials. Identifying information concerning the deceased has not been used throughout.

Commissioner of Mental Health and the Medical Director for the Department of Mental Health of Massachusetts, as a psychiatrist on a Program of Assertive Community Treatment (PACT) team, and Medical Director of the Massachusetts Mental Health Center.

The DRC relied on Dr. Duckworth's work in developing this report and in reaching its findings and conclusions as to systemic changes that should be made to decrease the chances that the situation faced by Mr. M. will recur. Dr. Duckworth's Report is attached and quoted without individual citations.

II. Summary

The death of D.M. exemplifies the need for a more comprehensive, integrated and coordinated model for the delivery of both mental and physical healthcare as part of its community mental health center model.

Mr. M. died in Late 2007 at the age of forty-three. At the time of his death, he had diagnoses of bipolar disorder with psychotic features and polysubstance abuse. His providers at the time of his death were the New Hampshire Hospital and Riverbend. He last visited a primary care physician approximately two years before his death on November 22, 2005.

At the time of his death, Mr. M. was living in a rooming house near downtown Concord, NH. He was receiving community mental health services from Riverbend. While receiving services from Riverbend and New Hampshire Hospital, he gained a substantial amount of weight from the Zyprexa and other medications he was taking or were being administered, he developed metabolic syndrome, and adult onset diabetes.

Immediately prior to his death, a neighbor, called Riverbend due to changes in Mr. M.'s mental state and Mr. M.'s complaints of thirst. The neighbor. was asked to keep an eye on him, but no one from Riverbend went to Mr. M.'s residence to assess him nor attempted to have any other professional assess him.

The failure to adequately address Mr. M.'s medical crises evidences several areas in New Hampshire's mental health system that should be improved. These areas include informed consent, systems for measuring and monitoring medical risk, prevention strategies, integration of medical care, information transfer, assertiveness as to medical risk, and crisis response.

III. Circumstances Surrounding the Death of D.M.

A. Background

Mr. M.'s parents divorced when he was age 6. His alcohol use began at age 14 (1978) and at age 15, he was using street drugs. He was first hospitalized in 1979 for 6 months with a diagnosis of borderline personality disorder. He dropped out of high school, later receiving his

GED in 1984. He attended a few classes at a Community College in Connecticut but did not get a degree. He worked as a short order cook, dishwasher, and assistant manager at a deli, but reportedly not consistently.

Mr. M. had an extensive psychiatric history, and was hospitalized in Connecticut and Maine prior to his years in New Hampshire. He developed grandiose delusions and became threatening when not on medication. He reported hearing voices like the "voice of God."

He was hospitalized on about 5 occasions at NHH for exacerbation of his psychiatric symptoms, which included agitation, threats, disorganized thinking, mania and psychotic symptoms. Mr. M. did not have consistent insight into his psychiatric condition, and did not seek help for his substance abuse condition. He only intermittently adhered to his psychiatric medications, and his outpatient team focused much effort on this important aspect of his care.

Following the last discharge from NHH to Riverbend, Riverbend requested several times over an eight-month period that Mr. M. seek a Primary Care Physician (PCP). Dr. Robert Murray of Riverbend stated at his interview that there was concern that Mr. M. did not have a PCP. Dr. Murray viewed Mr. M. as being very difficult to connect with a PCP.

Mr. M. did not see a PCP in the intervening months between his discharge from NHH on February 2, 2007 and his death in Late 2007. A case manager from Riverbend took Mr. M. to sign up with Family Health Care, but he did not attend any appointments.

This lack of medical care by a PCP occurred in the context of documented metabolic syndrome and diabetes at NHH, and morbid obesity with grossly elevated Body Mass Index recordings that are visible to the naked eye. Dr. Murray was also aware that Mr. M.'s blood work indicated that he needed attention for diabetes but that the levels were not critical.

The NHH hospital record lists his PCP as William Kassler of Manchester, NH. Dr. Kassler practices medicine at Manchester Community Health Center (MCHC) in Manchester, New Hampshire. Mr. M.'s last visit to MCHC was November 11, 2005. Mr. M. was a "no show" for MCHC appointments that were scheduled for December 22, 2005, October 12, 2006, and May 4, 2007. The last entry on the MCHC records is dated October 18, 2007 and indicates that Mr. M. had transferred his care from MCHC to Capital Region FHC. This was twelve days after his death.

B. The absence of PCP care from November 2005 until Mr. M.'s death in late 2007.

Mr. M. began receiving PCP services from MCHC in April 1998. Mr. M.'s final PCP visit was on November 2005. It was an office visit with ARNP Steve Gutwillig at MCHC. Thus, Mr. M. did not receive care from a PCP from November 22, 2005 until his death in Late 2007².

In terms of Riverbend addressing the absence of a PCP, an October 3, 2006 Riverbend screening form indicates that Mr. M. informed Riverbend that he was "going for eval w/ PCP." Mr. M. had an appointment scheduled for October 12, 2006, but Mr. M. was a "no show" for the appointment. There does not appear to have been any follow up by Riverbend on whether Mr. M. kept the appointment. There does not appear to have been any follow up by Riverbend on any aspect of the scheduled PCP visit.

An April 30, 2007 Riverbend Universal Note indicates that Mr. M. informed Riverbend that he had an appointment with MCHC on May 4, 2007. Mr. M. was also a "no show" for his appointment. There does not appear to have been any follow up by Riverbend on whether Mr. M. kept the appointment. Once again, there does not appear to have been any follow up by Riverbend on any aspect of the scheduled PCP visit.

A July 7, 2007 Riverbend Universal Note indicates that Mr. M. informed his case manager, Celeste Dubois, in June 2007 that he would consider going to Capital Region Healthcare in Concord. MCHC is approximately a thirty minute drive from Concord.

An August 2007 RN Medication Note indicates that Mr. M. did not have a PCP.

On September 13, 2007, Dr. Murray provided a pharmacological management service for Mr. M. At that time, Dr. Murray had "a very long discussion regarding his avoidance of following through with getting a primary care physician." Dr. Murray noted that it was "particularly important given that the patient periodically [ran] a high level of liver enzymes of undetermined etiology has hyperlipidemia and has a documented diagnosis of hypothyroidism . . . which [Dr. Murray,] explained that [he] lacked the expertise to adequately and completely manage."

Dr. Murray ordered a blood work and CM Kim Pica took Mr. M. to that blood test on September 11. It appears that transportation was all that was needed to get Mr. M. this necessary blood work. On September 19, 2007, Dr. Murray reviewed the result and in reference to the CM stated that "pt must get a PCP!"

The previous week, on September 11, 2007, Case Manager Kim Pica met with Mr. M. During the visit, she discussed the importance of getting a PCP. Mr. M. stated that he needed to complete paperwork for Capital Region Healthcare. Ms. Pica helped Mr. M. fill out the paperwork. This actual organization-based assistance with the procedure of obtaining a

² Mr. M. did receive medical care at periods of time while a patient at the New Hampshire Hospital and did receive some minimal medical care from Riverbend.

conveniently located PCP came almost two years after Mr. M.'s last PCP office visit. Mr. M. was, as detailed below and above, a man who suffered from bipolar disorder and had disorganized thinking.

In September, Mr. M. also indicated that he would like a referral to the Riverbend's "in shape" program. Case Manager Pica indicated that a referral could be made. It does not appear that the referral was made prior to Mr. M.'s death a month later.

Mr. M.'s physical-health from late 2005 until his death demonstrates how important it would have been to obtain a PCP at an early stage.

C. Mr. M.'s Physical Health Issues.

Mr. M.'s medical records between 2003 and his death in 2007 indicate that he was obese and, as such, in need of regular PCP care. Mr. M. was six feet and one inch tall.

Mr. M. weighed 266 pounds in August of 2003. His weight was up to 300 pounds by January 2004 according to his PCP records. He attributed his approximate forty pound weight gain to Zyprexa and lack of exercise. Mr. M. had a long history of Zyprexa usage.

In April 2004, Dr. William Kassler became "concerned about weight gain on Zyprexa." He further notes that Mr. M. had been walking a lot at this point. After a June 1, 2004 visit with a recorded weight of 305 pounds, Dr. Kassler was concerned enough to send a letter to Mr. M.'s psychiatrist, Dr. Paul Brown of Riverbend, requesting a change in Mr. M.'s meds. In response, Dr. Brown kept Mr. M. on Zyprexa but lowered the dosage from 20mg to 15mg.

Mr. M. weighed 307 pounds in August 2004, 304 pounds in December 2004, 300 pounds in February 2005, 293 pounds in May 2005, 296 pounds in August 2005, and 300 pounds in November 2005.

On May 26, 2006, Mr. M. asked Riverbend to take him off Zyprexa. He asked that another drug, Seroquel, be increased as an alternative. Mr. M. made the request because he was experiencing what Dr. Robert Murray of Riverbend thought sounded like akathisia symptoms. Akathisia is defined as an inner restlessness and a need for constant movement. Dr. Murray did not view the request as "altogether unreasonable." As such, the Zyprexa was discontinued at Mr. M.'s request in May 2006. Mr. M.'s Riverbend records do not indicate a documented discussion with Mr. M. in regard to the dangers of weight gain and developing diabetes from the use of Zyprexa. Nevertheless, he was taken off Zyprexa at this time.

An October 3, 2006 Riverbend screening form indicates that Mr. M.'s weight was at 342 pounds. The form is a y/n list of possible health problems and comments.

A conditional discharge summary prepared by New Hampshire Hospital indicates that Mr. M. had been diagnosed (Axis III diagnosis) as of February 2, 2007 as suffering from Type II diabetes. This summary was provided to Riverbend; but the diagnosis does not appear to be subsequently documented in Riverbend's own records.

A March 19, 2007 RN Medication Management Note indicates that Mr. M. had lost 19 pounds since November 2006. He was at 321 pounds. It also indicates that the issue of healthy food and exercise was discussed. Positive feedback on the weight loss was provided. And Mr. M.'s weight was recorded by Riverbend in May 2007 at 306 pounds. Unfortunately, his weight was recorded in August of 2007 by Riverbend as back at 325 pounds.

Mr. M.'s PCP records note that both Mr. M.'s parents had diabetes, which increased his risk of developing diabetes. Mr. M.'s parents' diagnosis was not contained in the mental health records that were obtained to prepare this report. It appears, therefore, that the mental health providers may not have been aware of the parents' diagnosis.

Riverbend was, however, knowledgeable as to Mr. M.'s diabetic condition. It further was aware of the complexity of Mr. M.'s medical issues as detailed above as part of Dr. Murray's September pharmacological management service notation. Riverbend did not have the expertise to fully manage the complexity of Mr. M.'s medical issues. Nevertheless, other than when Mr. M. was admitted to the New Hampshire Hospital, he went without PCP-type medical care.

D. D.M.'s Death

At the time of his death, Mr. M. was living in a rooming house near downtown Concord. On the night of his death, another tenant contacted the Riverbend crisis center out of concern for Mr. M.'s mental status change and presentation. The neighbor wrote, "I noticed he was acting psychiatrically off center, shaking all over and had a great thirst." Mr. M. reportedly refused to go to the ER to be evaluated.

The on-call person at Riverbend who spoke with the neighbor asked him to check on Mr. M. during the weekend and, according to Mr. M, stated that maybe on Monday his case manager would call him to talk to him. Riverbend did not send anyone to evaluate Mr. M.. Through a simple conversation with Mr. M, Riverbend concluded that Mr. M. did not pose a threat to himself or others. Mr. M was told by Riverbend to contact the police or ambulance if Mr. M.'s condition appeared to "worsen[]." Mr. M is also a Riverbend client.

The autopsy report showed diabetic ketoacidosis as the cause of death. Mr. M. had profoundly elevated levels of HgbA1c, which indicated 2 to 3 months of very poor sugar control. HgBA1c represents excess glucose in the body's bloodstream that attaches to hemoglobin molecules and can be used to measure the long term control of diabetes. This finding indicates that this was not an overnight episode of diabetic concern; rather the elevation in HgbA1c indicates an active diabetic process that was undiagnosed and untreated for an extended time.

Mr. M.'s thirst was a classic symptom of poorly controlled diabetes, as water leaves the body in concert with the excess sugar and creates a state of dehydration. A change in mental state is also classic for uncontrolled diabetes.

Riverbend did not appear to have a medical resource to back up the first responder. In any case, a medical resource would have been of little use, as Riverbend's emergency services did not have diabetes listed in Mr. M.'s medical problems. His record was devoid of relevant medical concerns, and therefore it would take a medically trained person to identify the possibility of diabetes. Without medical training or back up, many crisis workers would have taken a passive stance similar to that taken by the emergency services worker who handled this matter.

The emergency call failure represents the final missed opportunity to help this man but there were many missed chances prior to the call. When did Mr. M. actually develop diabetes? Clearly he had been in a risk category for many years with elevated BMI and some glucose readings that were out of the normal range. He was prescribed Zyprexa for years, a medication well known to cause weight gain and diabetes. Given the common prevalence of diabetes in people with major mental illness, the lack of surveillance and detection of his condition poses a clear opportunity for systems improvement. Diabetes was but one of many cardiac risk factors Mr. M. had, but as the primary cause of death, it is an important aspect to examine.

Another important aspect of his development of diabetes is that Mr. M. requested to stop Zyprexa due to weight gain. There do not appear to have been other people engaged in assessing the very real risk (weight gain, diabetes, hyperlipidemia) versus benefit (good control of psychiatric symptoms when medication is taken) of Zyprexa for a man with difficult to treat psychiatric symptoms and medical vulnerability.

IV. Riverbend Procedures and View of its Role as to Physical Health Issues

A. Riverbend Physical Health Services

During his interview, Dr. Murray of Riverbend acknowledged and supported the assertion that physical health issues are integrated with mental health issues. Riverbend has made some efforts to address physical health issues. Dr. Murray indicated that physical health issues are considered when a client's medications are reviewed. Riverbend also works to ensure that clients are getting regular physical examinations. If a medical issue is identified, a Riverbend physician or nurse will contact the primary care physician if one exists. The patient's case manager would also become aware of the concern at the team meeting. Riverbend views it as important to let the primary care physician determine when to intervene medically.

1. In-Shape Program

Riverbend provides the "in shape" program that was developed by the Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Institute is part of Dartmouth

College and dedicated to improving healthcare through education, research, policy reform, leadership improvement, and communication with patients and the public. Riverbend's "in shape" program provides eligible individuals with:

- A Health Mentor, a certified personal fitness trainer who offers motivation and wellness education during weekly meetings with consumers
- A free one-year membership to the Concord YMCA
- Advice from a nutritionist
- Health consultations with nurses
- The opportunity to attend group celebrations
- Rewards for achieving fitness objectives
- Opportunity to participate in martial arts training provided by Bodyworks Martial Arts Center
- Educational materials on exercise and healthy eating

The program was started as part of a study by the Dartmouth Institute concluded on September 30, 2009. There does not appear to be any state or other funding to continue the program. In any case there was no evidence that Mr. M. was recruited for the program.

2. Health Buddy Program (Telemedicine)

Riverbend also provides a program called Health Buddy. A telephonic information technology system is placed in the client's home. The client then answers questions, including physical health questions, which are then transmitted via the phone line to a Riverbend nurse. This process permits the nurse to spot issues and respond.

Louis Josephson, Riverbend's CEO, stated in a May 2009 New Hampshire Public Radio Interview that one goal of the Health Buddy system is to reduce emergency room visits for both psychiatric crises and medical crises. Mr. Josephson also stated that "mental illness can get in the way of managing your health condition because you're not thinking clearly about things, you're anxious about things, and that is gonna be confusing for people."

This program was not examined in this review for effectiveness and how many people it was reaching. There is no evidence that Mr. M. was part of it.

B. Riverbend Emergency Services (RES)

Riverbend provides emergency services twenty-four hours a day, seven days a week. RES accepts any mental health crisis of any kind regardless of age, residence, or ability to pay. The program specific services are: (1) 24-hour emergency evaluation and crisis intervention; (2) 24 hour crisis line; (3) Referral to outpatient mental health services; (4) consultation regarding substance abuse treatment; (5) voluntary psychiatric hospitalization referrals; (6) involuntary emergency admission; (7) conditional discharge revocation; (8) complaint and prayer for

compulsory mental evaluation; (9) mental health consultation to primary-care providers; (10) mental health consultation to family members; and (11) short term crisis stabilization.

Riverbend RES Director, Karl Boisvert, indicated during his interview that RES does not provide answers to physical health questions. Rather, it encourages the person who calls to go to an emergency room or to call their primary care physician. This is because the RES clinicians have no medical training. Riverbend patients are also encouraged to seek a primary care physician.

RES does not send clinicians to see individuals in the community, unless the person resides at a Riverbend residence and RES knows the situation at the residence that its employees will encounter. Mr. Boisvert, indicated that there are insufficient funds for clinicians to see people in the community. RES was budgeted to lose between \$400,000 and \$500,000 in 2009. There was also an indication during Riverbend interviews that there was a safety concern with sending personnel into the community to see clients.

C. Riverbend CEO

During his interview for this investigation, Louis Josephson, Riverbend's CEO, indicated that, across the board, mental health entities are trying to see each client as a whole person, integrating both physical health and mental health issues. Riverbend developed a relationship with Capital Region Healthcare with the goal of increasing the embedding of mental health practitioners with physical health practitioners.

However, whether there is sustainable funding for the whole person approach is a major question. For example, Mr. Josephson indicated, as had the program's director, that Emergency Services is a huge burden on the mental health system because of lack of funding. Mr. Josephson asserted that, without funding, there is no way that the services could be expanded to include nursing services.

D. Information Exchange and Liability

Riverbend representatives believe that the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the reluctance of some clients to provide HIPAA releases hamper Riverbend's ability to obtain medical information from PCPs.

There were also issues as to the integration of medical information in Riverbend's possession. Certain Riverbend personnel such as doctors and nurses have access to at least some medical information. However, this information is not in the possession of the RES arm of Riverbend and RES does not have any access to it. No policy is in place which mandates that RES review the contents of medical records when an emergency arises. There was also a related problem of a lack of one single database or multiple databases that could interface with each other.

In Mr. M.'s case, there was some medical information regarding abnormally high blood work levels in the possession Riverbend's medical staff but not in the possession of RES. RES was also not able to access this information.

Riverbend representatives were concerned that Riverbend would incur liability if its non-medical staff were to have access to medical information and began acting on it. This may be one factor as to why the RES person handling Mr. M.'s emergency did not have the information as to Mr. M.'s possible diabetic condition.

V. Applicable Constitutional, Statutory, Regulatory and Generally Accepted Clinical and Professional Standards.

Under New Hampshire's statutory scheme for mental health services, "[e]ach client [of the state mental health services system] has a right to adequate and humane treatment provided in accordance with generally accepted clinical and professional standards." RSA 135-C:13. (emphasis added).

As detailed in Dr. Kenneth Duckworth's attached report, accepted clinical and professional standards would include advising Mr. M. of the risks of medication, using more assertive outreach and preventative strategies, and providing for adequate integration of medical and psychiatric care at all levels.

The integration of medical and psychiatric care at all levels has been recognized as essential because the physical conditions of individuals with mental illness are often not treated. Lutterman, T; Mayberg, S; Emmet, W, State Mental Agency Implementation of The New Freedom Commission on Mental Health Goals: 2004. "In New Hampshire there are an estimated 264,480 adults with a diagnosable mental illness and 59,720 children with a serious emotional disturbance. The population of individuals with mental illness has substantially greater health problems than individuals without mental illness." Antal, P., New Hampshire's Prescription for Mental Health Care: Comprehensive, Integrated, and Coordinated Health Care 8 (2009). "It can be critical – and indeed life saving – for these individuals to have access to health care providers who understand the interactions among physical, mental, or substance use conditions and how these affect the person's ability to manage their illness and move towards recovery." Antal, at 5.

The psychiatric medical profession views the integration of medical and psychiatric care as essential partly because staying physically healthy is particularly challenging for individuals with serious mental illness. Josephson, L., Health and Wellness for People with Serious Mental Illness, New Hampshire Rap Sheet 5 (Winter Ed. 2010). As Dr. Josephson, Riverbed's Executive Director, details in his health and wellness for people with serious mental illness article:

- Adults with serious mental illness die about 20 years earlier than the general population;

- Premature death is attributable to high rates of co-existing medical disorders and unhealthy behavior;
- People with serious mental illness are less physically active than the general population;
- Poor dietary behaviors are more common for individuals with serious mental illness as compared to the general population;
- Metabolic effects of antipsychotic medications contribute to high rates of diabetes, heart disease, and obesity;
- More people with serious mental illness are obese (47%) compared with the general population (27%);
- There are high rates of smoking among people with serious mental illness. Over one half of all cigarettes consumed in the U.S. are used by people with mental illness.

See Id.

New Hampshire has recognized the need to develop a capacity to serve individuals with severe mental illness and complex medical needs. See NH Department of Health & Human Services; NH Hospital Bureau of Behavioral Health; The Community Behavioral Health Association, Addressing the Critical Mental Health Needs of NH’s Citizens, A Strategy for Restoration (Aug. 2008).

The clinical and professional standards that have emerged across the country for individuals with mental health issues is a comprehensive, integrated, and coordinated community-based model that considers *and addresses* the complex needs of the individual, both physical and mental. RSA 135-c:13 *which* requires that eligible clients of the mental health system receive “adequate and humane treatment . . . in accordance with generally accepted clinical and professional standards,” incorporates this integrated standard of care. (underscoring added).

Under the Fourteenth Amendment to the United States Constitution, the state and its licensees such as CMHCs owe a duty to provide adequate medical care and to protect individuals from harm. See *Youngberg v. Romeo*, 457 U.S. 307 (1982). The “do-no-harm” standard is also firmly embedded in the medical profession.

The state administrative rules governing the operation of community mental health centers provide an express right to be free from neglect. See He-M 309.05. This express right includes the right to be free from any act or omission which results or could result in the deprivation of essential services necessary to maintain the minimum physical health of a client as well as prevent death. See He-M 309.02(n). The exact depth and breadth of this obligation must be considered in the context of the definition of mental health.

It is also the role of community mental health centers to maintain a **comprehensive and coordinated** array of programs and services for persons with mental illness. He-M 403.059(a).

As described below, Riverbend's actions toward Mr. M. did not conform to these standards. Riverbend's passive approach to the issue of Mr. M.'s inaction as to seeing a PCP fell short of what could be fairly described as a proactive and integrated approach to mental and physical health issues.

While professional and clinical standards which by virtue of RSA 135-C:13 is the governing standard of care, it should be noted that the statutory and regulatory scheme could be more prescriptive or explicit to ensure that the standards are carried out in practice. For example, RSA 135-C:13 states that clients have a right to treatment in accordance with generally accepted clinical and professional standards but the statute contains a subject to availability of funding qualification. The regulatory scheme for mental health centers similarly calls for a **comprehensive and coordinated** array of programs and services, He-M 403.059(a)(emphasis added), but does not explicitly impose a duty to provide or facilitate related medical care.

VI. Findings, Conclusions and Recommendations

A. Findings and Conclusions

1. General Conclusions and Findings

Psychiatric care needs to include a sense of responsibility for clients' physical health. It is well documented that public mental health clients die on average 20 years earlier than the general population. Most of this difference is due to premature cardiac mortality. Smoking, which contributes to a variety of potentially lethal ailments, is also disproportionately represented in the public mental health population. Leadership at the state hospital and local community level must attend to the health crisis of premature mortality among public mental health clients.

Mr. M. is an example of an early death that could have been prevented if there had been a culture of ownership among the relevant mental health providers as to clients' medical problems. Mr. M.'s death represents an opportunity for New Hampshire and Concord mental health systems to re-evaluate assumptions, systems, and procedures. Although Mr. M. died of undetected diabetes, he was also a classic high risk patient for premature heart disease. He had all 5 risk factors from the classic Framingham Heart Study for a heart attack (morbid obesity, smoking, diabetes, elevated cholesterol, hypertension not diagnosed but implied in his metabolic syndrome diagnosis). Mr. M. also had other factors that contributed to his elevated cardiac risk – poor dentition, poor nutrition, lack of exercise, alcohol and drug use, second generation antipsychotic usage, and lack of follow up medical care. Mr. M.'s death has much to teach us about what mental health care providers can contribute to clients' physical care.

2. Specific Conclusions and Findings

- **Riverbend:** Riverbend failed to integrate medical care and psychiatric care consistent with generally accepted clinical standards by neither providing or facilitating the provision of medical care. If Mr. M. had been provided with adequate medical care during the time leading up to his death, his risk might have been known to the emergency services worker. If there had been adequate transfer of medical information, the emergency services worker would have had valuable information regarding Mr. M.'s medical history.
- **Riverbend:** Riverbend failed to proactively and assertively inform its patient of the risks of the medications so that he could make an informed decision regarding whether to continue medications.
- **Riverbend:** Riverbend failed to properly handle its patient's emergency. Riverbend's emergency services lacked sufficient information, though generally in Riverbend's possession, to properly assess and act upon the medical emergency that was in progress and ultimately resulted in its patient's death. Riverbend should not continue to distance itself from such a critical decision based upon liability and/or funding concerns. This is a population with severe medical issues and those issues must be addressed by community mental health centers. In addition to the above findings, a nurse or doctor back up for the emergency services worker could have been instrumental in preventing Mr. M.'s death. Adopting a routine practice of reviewing crisis response could identify other ways to improve the emergency services system.
- **Department of Health and Human Services and Legislature:** To the extent that funding is an issue in regard to providing or actively facilitating this essential medical care, additional funding should be provided to avoid future tragedies like this one.
- **Department of Health and Human Services:** While professional standards call for the integration of medical care and psychiatric care, the New Hampshire regulatory scheme could be more prescriptive and explicit on this issue to ensure that accepted professional and clinical practices are carried out by the community mental health centers. To the extent that regulations do not provide sufficient guidance on this issue, the Department, after obtaining input from pertinent stakeholders, should amend regulations to provide more salient and explicit guidance, again in an effort to avoid future tragedies.
- **The Department of Health and Human Services** in contracting with, monitoring and in performing quality assurance reviews, does not check for and ensure that community mental health centers have an adequate integrated and proactive approach to promoting good healthcare and an ability to address emergency situations that arise with a combination of medical and mental health signs or symptoms.

B. Recommended Corrective Action for a State Wide Approach

Ken Duckworth produced a full report that details recommendation for corrective action. The entire report is attached. The following is a summary of Dr. Duckworth's recommendations followed by the DRC's supplemental recommendations.

1. Riverbend should improve consent procedures and/or application of informed consent procedures. Had adequate procedures been in place this would have enabled Mr. M. to

focus on medical issues and, as such, increased his ability to anticipate and plan for medical risks.

2. Riverbend should improve its systems for measuring and monitoring medical risk.
3. Riverbend needs to do home medical visits and to take patients to medical appointments as part of a proactive approach to medical care. This approach would include client-centered informed consent as to medical care. The system needs to develop a culture of assertive intervention to address predictable medical risk, just as it assertively intervenes to address psychiatric risk.
4. Riverbend should create a culture that supports and encourages better health choices. Weighing clients and taking their blood pressure are two simple interventions. Other possibilities include the following: Smoking cessation programs (possibly integrated with substance abuse programs) would help reduce the single greatest cardiac risk. Peer led walking groups and specialized services like nutritional consultation could also become part of community based mental health care.
5. Riverbend and New Hampshire Hospital should collaborate on ways to integrate care, communicate, and share information and resources. Concord also has the Dartmouth Psychiatric Research Center (“DPRC”) which offers opportunities to study what systems efforts can work best.
6. It is incumbent on the state and its mental health providers to move forward to adopt an integrated model of medical and psychiatric care. This should include putting in place accountability and quality assurance mechanisms to make sure the models are properly and fully implemented.
7. Clinical leadership at all levels of treatment need to review the processes for communicating psychiatric and medical information to other care providers and to facilitate continuity of care, and implement an adequate system of communication and transfer of information.
8. Riverbend and other community mental health centers should review their training and staffing for emergencies, using failures in the system to devise new strategies for responding to crisis. The physical and mental health integration model most assuredly must include integration at the crisis response level.

C. DRC Additional Recommendations

9. As part of the process of *formulating* an integrated model per 5 and 6 above, the Department and Mental Health Centers should determine what additional start up and continuing *operating* funds are needed to enable the centers and the system to develop and implement a proactive, integrated mental health – medical approach both as part of its ongoing treatment of its clients and in the event of emergencies that are caused in whole or in part by physical conditions. Possible sources of funding to explore would include:
 - Stimulus funding especially for start up measures
 - Medicaid or other federal funding, including grants
 - State funding with or without federal match

10. The Department should clarify regulations to ensure that community mental health centers are aware of their responsibility to take ownership of their patient's medical care as part of an integrated model of medical care and psychiatric care both in terms of prevention and when an acute crisis arises. The regulations should call for the implementation and maintenance of a statewide model of integration.
11. The Legislature should make statutory changes to make it clear that mental health centers must use an integrated model of medical care and psychiatric care.
12. To ensure legislative and regulatory mandate is carried out, the Department should incorporate in its contracting with, monitoring and quality assurance reviews of mental health centers, evaluation measures to ensure that the centers have an adequate integrated and proactive mental health – medical approach both as part of ongoing treatment and in case of emergencies and address emergency situations that arise with a combination of medical and mental health signs or symptoms.

B. Conclusion

This death investigation provides an opportunity to improve the practice of state funded and licensed mental health services. This organization stands committed to working with DHHS, other policy makers, the community mental health centers, consumers and advocacy groups to ensure that the necessary improvements are made.