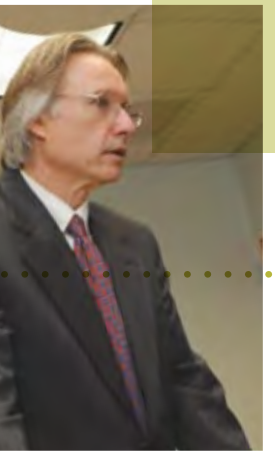
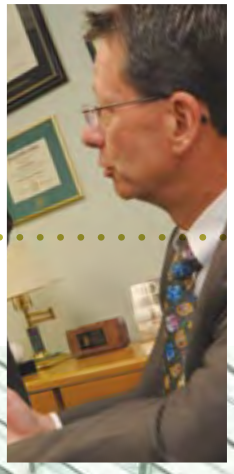
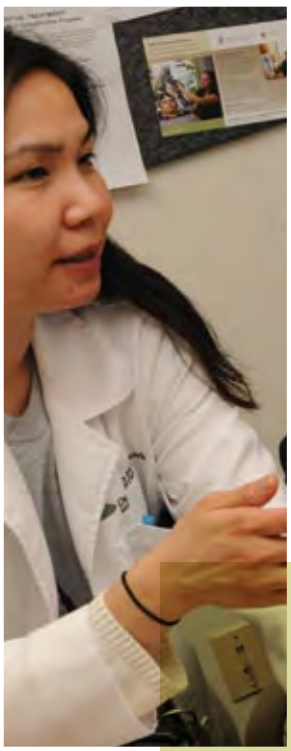




TOP LEFT: Alexander de Nesnera (left), the associate medical director; David Folks (center), the chief medical officer; and Robert MacLeod, the chief executive officer, provide clinical and administrative leadership at New Hampshire Hospital.

CENTER: The greenhouse at New Hampshire Hospital.

BOTTOM: Hun Millard (left), a Dartmouth resident in psychiatry, works with Rebecca Neal, a psychiatrist at the hospital. Millard, like every Dartmouth psychiatry resident, is spending part of her residency at New Hampshire Hospital.



PARTNERS IN HOPE

IN THE 1980S, AN UNUSUAL AGREEMENT BETWEEN THE STATE OF NEW HAMPSHIRE AND THE MEDICAL SCHOOL'S DEPARTMENT OF PSYCHIATRY HELPED REVOLUTIONIZE THE TREATMENT OF MENTAL ILLNESS. | **By Amos Esty**

One day, a few years after he joined the psychiatric staff at New Hampshire Hospital, Alexander de Nesnera, M.D., began working with a patient who wanted nothing to do with him. Like many of the patients at the hospital, which offers care to those with serious mental illness, this patient had been involuntarily admitted. De Nesnera was assigned to treat him, but first he had to win the patient's trust.

Every day for about three weeks de Nesnera saw the patient on rounds, making no apparent progress. "He wouldn't talk to me and he wouldn't take any medications," de Nesnera recalls.

Finally, the patient changed his mind and began accepting treatment. Over the next few weeks, his condition improved remarkably. Eventually he was well enough to leave the hospital. De Nesnera was curious about what had changed the patient's mind.

"Why did you start taking the medications?" de Nesnera asked him. "What prompted you to do that?"

"Because you kept coming back, and you never gave up," the patient replied.

The conversation has stayed with de Nesnera, who is now the associate medical director at the hospital. "That was a really memorable moment," he says. "You never give up, and you continue working with a person even if they seemingly reject you. There is always the possibility that they are listening."

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Other psychiatrists at New Hampshire Hospital have similar stories. "When I sit down with a patient and talk to them about their illness, often they're trying to argue with me, to tell me that they don't belong here," says Rebecca Neal, M.D., who has been a psychiatrist at the hospital since 1993.

"It's not that people are just refusing to accept that they're ill, but that in many cases their brain is not able to recognize that there's an illness happening," explains Wendy Martin, M.D., another psychiatrist at the hospital. That adds to the challenge of providing care and requires a great deal of patience and persistence on the part of the doctors. "You need a different skill set to work with people who are not aware that they have an illness," Martin says.

De Nesnera, Neal, and Martin are three of the 14 psychiatrists who provide care at New Hampshire Hospital. And, as the result of a partnership between Dartmouth and the state, all 14 are on the Geisel faculty. The agreement between Dartmouth and New Hampshire to have Dartmouth faculty members provide care at New Hampshire Hospital grew out of a crisis in the state's mental-health services in the 1980s, and its continued existence is evidence of the success of this unusual relationship.

ABOVE: The tea garden at New Hampshire Hospital.

THE HOSPITAL'S EARLY YEARS

New Hampshire, like the rest of the country, has often struggled to determine the best approach to the treatment of mental illness and the proper role for the state in providing psychiatric care. In New Hampshire, that discussion stretches back to the mid-19th century. In the 1830s, a group of citizens organized to raise money for an institution to treat the mentally ill, and the state legislature discussed whether to provide funding to support such an institution. A report to the state legislature in 1840 detailed the sometimes terrible living conditions faced by the mentally ill, including descriptions of people left homeless or locked in small rooms and neglected.

Letters to the editor of local papers debated the merits of state involvement in providing psychiatric care. In 1838, one such letter cited the success of state hospitals in Massachusetts and elsewhere in support of building such a facility in New Hampshire. "The establishing of hospitals for the insane in several of our liberal and enlightened sister states has settled the question of the curability of insanity," the authors wrote. "Their success has indeed been wonderful. Insanity is a disease; as much so as a fever, and no more."

But an opponent of providing state funding for a hospital responded in the same paper that, while he agreed with the project in principle, economic hardship necessitated putting it off. "Besides," he wrote, "as our legislature holds two sessions this year, we shall probably have state tax enough to pay next year without increasing it by an immediate appropriation for erecting an asylum."

Despite such opposition, the state legislature set aside funds to be used for the hospital, and by 1842 the facility had been built in Concord.

According to Alan Green, M.D., the chair of the Department of Psychiatry at Geisel, state hospitals "were a very humane way to try to treat people with psychiatric disorders." But the problem, he says, is that over the years many of these hospitals became increasingly crowded. The number of patients at New Hampshire Hospital eventually peaked at more than 2,700 in the 1950s. "People were being put there who didn't belong there," Green says.

In 1969, Peter Silberfarb, M.D., spent time at New Hampshire Hospital as a Dartmouth psychiatry resident. "It was quite an eye-opening

experience for us young residents," he says. "I remember there was a ward with a couple hundred patients, and there was only one physician." Two decades later, he would have a chance to help change that state of affairs.

REBUILDING AND REFORMING

By the early 1980s, the state faced a crisis in mental-health treatment. A report commissioned by the state legislature recommended shifting the focus of care at New Hampshire Hospital from long-term treatment to acute care. Most patients would be discharged from the central hospital and treated at one of 10 community mental-health centers around the state. Rather than locking people away, the state would try to help them live in their communities.

"This was a brilliant idea," says Silberfarb, who in 1985 became chair of psychiatry at Dartmouth. "Many of these folks did not need to be locked up."

As the state considered how to carry out these recommendations, Donald Shumway, then the director of the state's Division of Mental Health and Developmental Services, began talking with clinical and administrative leaders at Dartmouth about how the state might work with Dartmouth. The result of these conversations was a partnership by which Dartmouth's Department of Psychiatry assumed responsibility for the clinical care of patients at New Hampshire Hospital. As part of the agreement, all of the psychiatrists at the hospital would be members of the psychiatry faculty at Dartmouth.

To better carry out the hospital's mission, the state constructed a smaller hospital, which opened in 1989. The new facility had 230 beds, and almost all of the patients were housed in the new building. Over time, the units that were initially housed in other buildings were also moved to the main building. The area around the hospital is not as rural as it was in the 19th century, but the design of the building still provides a sense of calm, despite the hectic nature of the care provided there. The open lobby is filled with natural light, and patients can make use of areas such as a tea garden, a greenhouse, and a gym.

According to Silberfarb, the hospital's reputation made it difficult at first to recruit physicians to work there, but it did not take long to turn around that reputation. As the psychiatric staff grew and the hospital began working closely with the community mental-health centers, New Hampshire became a model for the effective delivery of mental-health care. "The care was fabulous," Silberfarb says. "The wards were manageable. It was an excellent hospital."

> "We were trying to bring mental-health care into the modern age"

At the time the agreement between the state and Dartmouth was being forged, de Nesnera was a resident in psychiatry at Dartmouth. In 1990, when he completed his residency, he joined the faculty, and he has been at New Hampshire Hospital ever since. "The main reasons I took this job were the Dartmouth contract and wanting to work in the public sector," he says.

Another aspect of the agreement between Dartmouth and the state was the creation of a research institute that would study and implement best practices in psychiatric care, the New Hampshire-Dartmouth Psychiatric Research Center (PRC). The PRC had lofty goals. "We were trying to bring mental-health care into the modern age," Shumway recalls. "The vestiges of the older state hospital environment were still very present, and yet there was a revolution going on in brain sciences, pharmacology, and best practices in mental-health care."

Robert Drake, M.D., Ph.D., a Dartmouth professor of psychiatry, was named director of the PRC. Under his guidance, the center lived up to its ambitions. "Within two or three years it became a national leader," Shumway says. "It revolutionized care in the state."

Drake and his colleagues worked to develop interventions that would help people with mental illness live in their communities. The interventions included programs such as supported employment, which helped people with mental illness find and keep jobs.

"Prior to the 1950s, most of these people were just in large hospitals for most of their lives," Drake says. "There was the clinical myth that the natural course of these illnesses involved slow deterioration, which actually turned out to be a side effect of institutionalizing people in stultifying environments."

The PRC showed that it was possible for people with serious mental illness to recover and live fulfilling lives. "They needed the things the rest of us need—safe housing, help finding jobs, help recovering their relationships with families, and help managing their illnesses," Drake says. "So we developed basic, simple, direct, inexpensive ways to do those things."

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FORGING ALLIANCES

The development of a strong community mental-health system allowed New Hampshire Hospital to focus on acute care. As a result, the average length of stay is eight days. Most patients are admitted involuntarily, often after an incident that leads a family member to worry about the person's safety. Usually the patients are first sent to a local emergency room, where a physician may make a referral to New Hampshire Hospital if the physician feels they are a danger to themselves or others as the result of mental illness. When talking to physicians at local hospitals, the staff at New Hampshire Hospital checks that the referral is appropriate. "We make sure it's someone we could potentially manage safely and effectively," says David Folks, M.D., the chief medical officer.

If the referral is accepted, the patient is brought to the admitting area, where he or she is met by the psychiatrist on duty. The patient receives an initial assessment of mental and physical well-being, and the psychiatrist makes an initial determination of what the patient needs. The patient is assigned to one of several units at the hospital. There are three admissions units for adults, one for children, and one for geriatric patients or patients who have serious medical conditions other than mental illness that may require more extensive medical attention. Once the patient arrives in the unit, he or she is treated by a team that includes a psychiatrist, a nurse, a social worker, and sometimes other health-care providers, such as a psychologist, therapist, or nutritionist.

The treatment team may also include a Dartmouth psychiatry resident or a Geisel medical student. Every psychiatry resident spends two months working at New Hampshire Hospital, and every year a number of medical students spend time at the hospital as part of their third-year psychiatry rotation. Wendy Martin is now one of the psychiatrists overseeing the residency program, but she also spent time during her residency at Dartmouth working at New Hampshire Hospital, which played an important role in convincing her to stay on at Dartmouth. She says the time at the hospital is often the first exposure for residents to this patient population.

Robert MacLeod, D.H.A., the chief executive officer of New Hampshire Hospital, agrees with Martin about the importance of the hospital for education. "Residents, fellows, and medical students get a great deal of value in seeing a unique set of patients that you might not see in a community setting or you might not see in a small practice," he says.

> "You have to have an alliance with your patient."

Led by the psychiatrist, the team develops a treatment plan for the patient. At the same time, the legal side of the admissions process unfolds. Patients who are involuntarily admitted to the hospital have a right to a hearing within three days of arriving at the hospital. At that hearing, the person who filed the commitment petition testifies about the reasons the patient was brought to the hospital. Often this is a family member. A judge or hearing officer (a lawyer who has been trained to preside over such cases) hears the evidence and decides whether to uphold the petition. If the petition is granted, the patient can be held at the hospital for 10 days from the day of admission, not including weekends.

During that period, de Nesnera says, the staff works to make sure that an appropriate diagnosis is established, that treatment is initiated, and that the patient's symptoms are under good control.

In many cases, the patient can be discharged before the end of the 10 days. But if the hospital staff feels that more time is needed—whether because the patient refuses treatment or for some other reason—the hospital can petition the court to have the stay extended. Under New Hampshire law, the hospital can request a longer hospital stay of up to five years, but usually the request is for less time. Another hearing is held, this time to decide whether to grant the request for an extended admission.

In addition to medications, the staff may try a number of other treatments to help a patient improve, including cognitive behavioral therapy. Folks says that peer support can also be effective. But, he adds, much of the treatment occurs after a patient is discharged. "The goal is to get people enough better so they can return to the community and continue treatment there, because treatment really occurs in the community," he says. "Hospitals are really to address the crisis." After all, he says, the ultimate goal is not just to have the patient function well within a hospital. "They want to be able to get well enough to have some quality of life," he says. "Maybe return to work or be able to go back to school to pursue whatever it is they want to do with their life."

Sometimes patients are looking for help. "Some people are pretty easy to develop a relationship with," Martin says.

Other times, the most difficult—but also most important—aspect of the treatment process is gaining the patient's trust. "You have to have an alliance with your patient," Neal says.

"We try to establish trust with them so they feel comfortable and see that this is a hospital, and there isn't anything particularly special about the people here," Martin adds. "They're just people who had difficulty with an illness."

Persistence is one part of the solution to that problem. Another is simply being honest with patients. "People want to be treated with respect, whether they're involuntarily hospitalized or not," de Nesnera says. "Patients have the right to know what kind of treatment they're going to get."

THE CONSTANT CHALLENGE

Even with the success of the partnership between New Hampshire and Dartmouth, over the past 10 years the challenges of providing mental-health services in the state have multiplied. In 2006, the state ended its involvement in the Psychiatric Research Center. Since that time, the PRC has continued to study best practices in mental-health treatment, and it has worked with many other states and even other countries to implement those practices. Cuts to the budgets of the 10 community mental-health centers have meant that some of the progress made during the 1990s has been undone. At the moment the state faces a class action lawsuit filed on behalf of people with mental illness charging that the cuts to community mental-health centers have been so drastic that the state is neglecting its duty to provide adequate mental-health care. Earlier this year, the U.S. Department of Justice joined the lawsuit on the grounds that the state is violating the rights of those with mental illness under the Americans with Disabilities Act.

At New Hampshire Hospital, the rate of admissions has increased even as budget cuts have led to a decrease in the number of beds, from the 230 originally available when the new hospital opened in 1989 to 152 today. The annual number of admissions has increased to more than 2,400, up from about 850 in 1990. "We're moving people in and out of here much more quickly than has been the case historically," MacLeod says.

Despite the challenges of providing mental-health treatment, MacLeod is proud of the high quality of care provided at New Hampshire Hospital, and he does not believe that the cuts to community mental-health centers have affected the ability of the hospital to care for patients.

After all, psychiatrists are accustomed to difficult circumstances. As the debates of the 1830s, 1980s, and today illustrate, support of mental-health care has often been tenuous. But according to Martin, the relationship with Dartmouth makes these challenges surmountable. "Dartmouth offers a lot of resources that wouldn't be available otherwise," she says.

ABOVE: The lobby of New Hampshire Hospital. This building was constructed in 1989, after a crisis in the state's treatment of the mentally ill prompted a reorganization of the way care was provided and led to the state's partnership with Dartmouth.

It can even help the staff develop stronger relationships with patients. "I've had people who were somewhat suspicious of exactly what my credentials were," Martin says. "When they found out that we're affiliated with Dartmouth they were much more relaxed. Dartmouth has a good reputation, and it's nice to be able to take advantage of that."

The work of Dartmouth psychiatrists at New Hampshire Hospital has done much to enhance that reputation. Progress has been made in understanding the biology of mental illness, and treatments have improved, but when it comes to working with patients, the psychiatrists at New Hampshire Hospital understand that an important part of their job is taking the time to get to know their patients, whether their patients want to know them or not.

"You don't expect that everybody is going to be cured," Neal says. "But the thing to do is not to give up hope."