

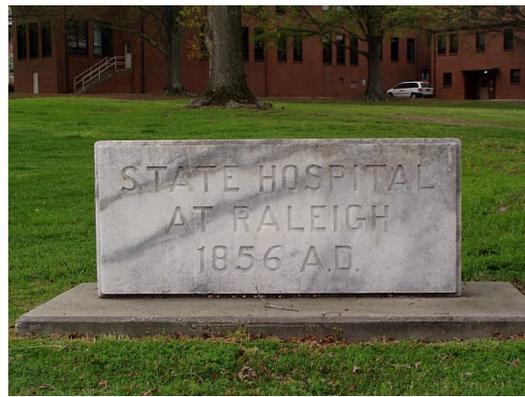
DISABILITY RIGHTS NORTH CAROLINA

Champions for Equality and Justice



DEADLY TRANSITIONS: A DEVASTATING BREAKDOWN IN DISCHARGE PLANNING

April 2008



North Carolina's Protection and Advocacy System

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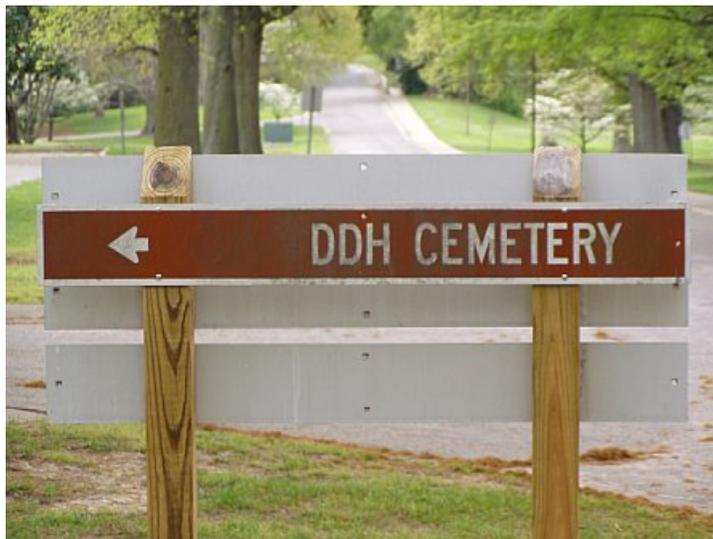
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**DISABILITY RIGHTS NORTH CAROLINA
REPORT**

**Need for Immediate Improvement of
State Hospital Discharge Planning**

April, 2008

On July 2, 2007, Disability Rights North Carolina became North Carolina's Protection and Advocacy system ("P&A"). The U.S. Congress created the nation-wide P&A system to protect and advocate against the abuse and neglect of people with disabilities. To ensure North Carolina's P&A is effective, NCGS Chapter 122C requires that the P&A, (now Disability Rights North Carolina) receive a report of any client of the state system who dies within seven days of the client's physical restraint or seclusion, and any death that results from violence, accident, suicide or homicide. In our first months of operation as the P&A, we received reports of the three deaths we describe below, two pursuant to Chapter 122C and the other from the father of the deceased. Our investigation of these deaths and other cases reveals that the state is operating with an inadequate system of discharge planning that imperils the lives of discharged patients.



CASE SUMMARIES

The Case of TD



TD was a 16-year-old boy who was admitted to John Umstead Hospital the week before Thanksgiving, 2007, due to auditory hallucinations, increased anxiety and thoughts of killing himself. TD was worried that people were trying to poison him through his drinks. He had twice attempted to hang himself, and had been admitted to the adolescent psychiatric ward at the University of North Carolina Hospitals several times. He had also been a patient at a drug rehabilitation facility and was attending outpatient substance abuse counseling. He told doctors at Umstead that illicit drugs gave him relief from his anxiety. He had not been a regular drug user for the eight months prior to his admission. Doctors at Umstead treated him for five days - until the day before Thanksgiving - when they sent him

home with his parents. Two weeks later, on December 6, 2007, he was found dead in a motel from an overdose of morphine and oxycodone.

TD was admitted to Umstead on Friday, November 16, 2007. His parents were surprised when a social worker from the hospital called the following Monday, requesting the parents to come in for a Tuesday meeting to discuss discharging their son. On prior occasions, TD had stayed at UNC for as many as 17 days, and his parents were concerned that his treatment at Umstead was too short. They were also concerned about TD's aftercare plan. TD wasn't in school, but was trying to obtain his GED. He'd been placed in a therapeutic foster home because his parents, both working, weren't able to watch him extensively when he lived with them, and he was able to relapse into drug use.

At the Tuesday meeting, TD's father said he thought they were facing "a fragile, dangerous situation" and voiced his concerns with the Umstead doctor and social worker. The social worker assured TD's parents that she had plenty of resources to keep TD busy in the community. However, when they picked up TD on Wednesday to take him home, the social worker had not been able to arrange any activities beyond TD's previously-scheduled drug counseling sessions and his established relationship with his community psychiatrist.

Before his hospitalization at Umstead, TD had been receiving mentoring and case management services in his community. TD's parents had been unable to reach the case manager since TD was admitted to Umstead, and they told the social worker of this problem. The case manager did

not return calls to the social worker on Wednesday. The social worker tried to reach the case manager's supervisor, but that person was on vacation. The social worker reached on-call staff with the community provider, who reviewed TD's chart and suggested the boy return to the therapeutic foster home until his case manager was available to plan his aftercare. Umstead staff had noted that living at the foster home increased TD's anxiety, and that he had complained that the foster parents were condescending and demanding, and that on one occasion he feared for his physical safety. Neither he nor his parents wanted him to return there. The social worker called the Local Management Entity (LME) liaison, who also suggested that his case manager plan for his aftercare.

TD's discharge plan from Umstead included his parents' agreement to take TD home, a confirmation that TD had a follow up appointment for his substance abuse counseling and the pager number for a director of the outpatient counseling group. The social worker concluded her notes about TD's discharge by writing "SW (social worker) encouraged pt to identify things he can do for himself during the day." Both Umstead and the LME agreed that the family should contact the private provider to arrange an "aftercare plan." The social worker noted on the paperwork several more intensive services to "consider" including as Intensive-in-Home, Day Treatment, Youth Focus and Youth Volunteer. The treating doctor's prognosis for TD at discharge was both guarded and uncertain: "Given his low mood, suicidal ideation, and substance abuse, as well as the uncertainty of his final ... diagnosis, his prognosis at this time is guarded." TD continued to complain of anxiety and vague paranoia, particularly about his drinks being contaminated. He was provided a 30 day supply of his medications, which had been substantially modified while at Umstead in consultation with his private psychiatrist.

Following his discharge, TD's parents left many messages for the case manager to call them. To provide closer supervision, TD's father tried to work at home so he could care for his son during the day. At night, his mother tried to stay awake to make sure he wouldn't hurt himself.

A week later – after nearly two weeks of calling – TD's parents reached the case manager.¹ She said she had turned off the ringer on her telephone because she had been receiving harassing calls. She did not see TD after his discharge. Although 12 hours of mentor services per week had been approved, the mentor saw TD only one time before his death. TD attended all of his outpatient substance abuse counseling sessions.

Following one counseling session, TD slipped away from the house when his mother fell asleep. His parents called the counselors for help, but they did not know where TD might have gone. The parents also immediately called the police to report that TD was missing, had mental illness and was a danger to himself. The police, however, would not issue an alert about his disappearance. Less than two days later, TD was found dead in a motel room.

* * *

¹ The records from the provider are not available because the provider has closed operations, and the records were not secured in a way that permits timely access to them.

The Case of TC



TC was 37 years-old when he was discharged from Broughton Hospital on August 1, 2007, following a 37-hour involuntary commitment. The hospitalization was based on his mother's long distance phone call to police that TC phoned her, was threatening to kill himself, saying he took 100 Valium in an attempt to commit suicide. TC also told his mother he would shoot any law enforcement officers who attempted to intercede. He lived alone in his home and was alone at the time these events took place. A SWAT team forced entry into his house and used a taser to subdue TC so he could be transported to the local emergency room for evaluation. TC had many firearms in his house which the police confiscated. Several hours after his admission, the local hospital arranged for TC to be

involuntarily committed to Broughton Hospital because he was considered "unsafe for discharge. Danger to self and others."

His treatment team at Broughton accepted TC's explanation that the incident was a "comedy of errors," that he hadn't intended to kill himself at all, and that he was merely trying to treat recurrent severe neck pain and had taken only a quarter of the pills his family reported. He told staff he would not accept any community mental health treatment that they offered. Rather, he promised he would see his family doctor when he got home. TC was released with the medications that the police had turned into the doctors, including his bottle of Valium that contained more than 100 pills. Two days following his release, TC shot himself to death with a gun that he had purchased from a gun dealer the day after his release.

At the time of his release, TC's hospital records contained information that TC had a family history of mental illness; that he was being treated with medication for bi-polar disorder; that he had been involuntarily committed once before following a suicide threat; that the current hospitalization had followed a standoff with police who had to taser TC in order to take him into custody; that he had threatened to shoot any officers who tried to intervene; that he told his family he took 100 Valium; that in talking with family his speech was slurred and he was "drifting in and out"; that he was intelligent and would try to minimize the event so he would be discharged; that he lost his job the day of the event; that he and his long-time girlfriend, who had a tumultuous relationship, had recently broken up; that he did not have any local support system; that he had anger management issues; that he had been treated for depression with medications for seven years; that he had access to weapons; and that he was aggressive and combative toward hospital staff.

At Broughton Hospital, TC told staff that if he had intended to kill himself he would have taken the whole bottle of Valium. Instead, he said, more than 100 tablets were left in the bottle. A

doctor also noted he had firearms at the time of the event that he did not use to take his life. TC said he took 25 pills of Valium in order to sleep off the neck pain. His family, he said, “blew things way out of proportion.” TC “adamantly” denied he had attempted suicide. He said he was being treated in his community by a psychiatrist for his mood swings, but he was “unwilling or unable” to provide any specifics about his care. He refused to allow staff to contact his family. He said he needed to get home to take care of his dogs and to find a job. He denied any intention to hurt himself or anyone else. He became calm, cooperative and talkative. He said he would contact his family doctor for follow-up treatment.

The entirety of TC’s discharge plan was his promise to call his family doctor. TC did not call his doctor.

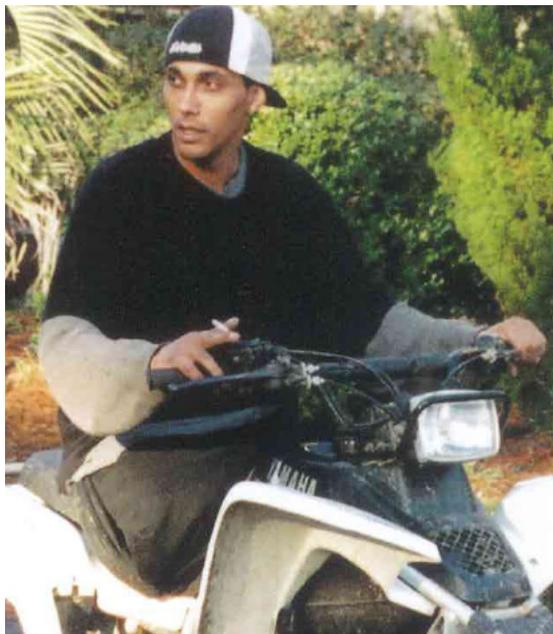
On the day of TC’s discharge, Broughton Hospital was on “delay status,” meaning the hospital was operating above capacity and would not accept any more patients until other patients were discharged.

Following the standoff at TC’s house, the police took all of TC’s guns. The day he was released from Broughton, TC attempted to get his guns back from the police, but they refused because of concerns for his safety and the safety of others. After the police refused to return his guns, TC went to a local sporting goods store and purchased a handgun. On the required form that asks the buyer if he had ever been committed to a mental institution, TC answered “No.” Because TC had a permit to carry a concealed weapon, the normal waiting period was waived, and he walked out the door with a firearm and ammunition.

Less than 48 hours later, TC shot himself in the head with the gun that he had purchased. He was in his truck, in the parking lot of the complex that contained a movie theater and the sporting goods store where he purchased the gun on the day of his release.

* * *

The Case of LB



LB was a 30-year old man from rural eastern North Carolina with a lengthy history of psychiatric and substance abuse problems. Within a six month period, from December 2006 through June 2007, he had five psychiatric hospitalizations, four of them involuntary commitments. On his last hospitalization he was involuntarily committed to Dorothea Dix Hospital after being turned down for admission at three local psychiatric faculties.

LB was admitted to Dorothea Dix Hospital on May 7, 2007. While at Dix, arrangements were approved for LB to enter a substance abuse treatment program on June 11, 2007. After twenty-three days at Dix, and one week prior to his scheduled admission to the treatment center, LB was discharged into the community. Physician's notes document that the "discharge plan" was for LB to await admission to

the treatment center at a local homeless shelter. His motivation to avoid drug abuse during this interim period between programs was described in Dix records as "somewhat suspect." Despite LB's known history of chronic drug abuse, the records reflect no plans to address drug cravings for the week following his discharge from Dix and prior to his admission to the treatment program.

A law enforcement officer transported LB from Dix to the homeless shelter. Upon their arrival, however, LB and the officer discovered the homeless shelter had been closed for two days due to a health concern. The officer contacted Dix staff to advise them the shelter was closed and to ask what to do with LB. LB requested to return to Dix. The officer made a decision to take LB to an emergency room. At some point, LB contacted his private provider of community support services and told her that he was discharged to a closed homeless shelter and that he needed a place to stay. The provider was unaware that LB had been discharged that day.

LB's provider placed LB in a local motel to await his June 11, 2007, appointment at the drug treatment center. LB received a few hours of services from the provider over the next days. On June 9, 2007, a female friend that LB had met at Dorothea Dix Hospital visited him at the motel and stayed the night. When she tried to wake him the next morning, he was dead.

An autopsy determined that LB died of methadone intoxication. There is no evidence in LB's records that he was prescribed methadone and there is no evidence to indicate that the overdose was intentional. The autopsy states that the level of methadone was "sufficient to cause death in a naïve user," meaning one who had not developed a tolerance to the drug. There is an

assumption that LB received the methadone from his woman visitor. LB's family has since tried unsuccessfully to reach her.

Dorothea Dix Hospital was on "delay status" at the time of LB's discharge, meaning the hospital was operating above capacity and could not take any more patients until other patients were discharged.

Medical record entries dated after LB's discharge state that staff would not have discharged LB to that homeless shelter if they had known it was closed. The shelter had been closed for two days when LB was discharged and was to be reopened at an undetermined date in the future. However, even if the shelter had not been closed, this discharge plan would have fallen short of being adequate. Based on this shelter's policy and that of most shelters, beds are assigned on a first-come, first-served basis. Consequently, there is no way to ensure that LB or others like him will have a place to stay when hospitals discharge their patients to homeless shelters.

* * *

THE LAWS AND STANDARDS.

The critical role of discharge planning in securing adequate care for patients is recognized in federal law, state law and professional standards. “Living successfully in one’s community after discharge from a state-operated facility depends on smooth and timely transition to community services/supports.” MH/DD/SAS Community Systems Progress Indicators, Rationale for Indicator 4: Timely Follow-Up after Inpatient Care.

Federal Laws

Patients in state-operated mental health facilities have a 14th Amendment right to adequate food, clothing, shelter, medical care, reasonably safe conditions and adequate mental health treatment. *Youngberg v. Romeo*, 457 U.S. 307 (1982); *O’Connor v. Donaldson*, 422 U.S. 563 (1975).

Public services to individuals with disabilities must be provided in the most integrated setting appropriate to their needs. *Olmstead v. L.C.*, 527 U.S. 581 (1999); Title II of the Americans with Disabilities Act (“ADA”), 42 U.S.C. §§ 12132 *et seq.*, 28 C.F.R. § 35.130(d); and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§ 794 *et seq.*

Federal Rules

Under federal rules, the hospital is responsible for the discharge plan and must have a discharge planning process. The hospital is required to evaluate the likelihood of a patient needing post-hospital services and the availability of the services. The evaluation must be conducted on a timely basis so that appropriate arrangements for post-hospital care are made prior to discharge. The rule requires the hospital to arrange for the initial implementation of the patient’s discharge plan. 42 CFR § 482.43 (Condition of Participation: Discharge Planning).

Professional Standards

Generally accepted professional standards require that discharge planning be a comprehensive process that begins at the time of admission, identifies and addresses the psycho-social needs of the patient, continues throughout the course of in-patient treatment, and includes appropriate community linkage and follow-up supports and services in order to provide the necessary continuity of care.²

N.C. Statutes

N.C.G.S. § 122C-61(2) provides that clients have a right to a discharge plan containing recommendations for further services and that the professionals developing the plan shall contact agencies in each client’s home community before formulating the recommendations.

N.C.G.S. § 122C-115.4 states that it is the LME’s role to coordinate client transitions from one service to another and participate in the development of discharge plans for consumers being

² See March 17, 2004 letter to Governor Easley from Assistant Attorney General Acosta summarizing findings of the U.S. DOJ following investigation of the four state hospitals pursuant to the Civil Rights of Institutionalized Persons Act (“CRIPA”).

discharged from a State facility or other inpatient setting who have not been previously serviced in the community.

N.C. Administrative Code

10A NCAC 28D.0105 requires that any discharge plan be formulated by qualified professionals, inform the client of where and how to receive treatment in the community, identify continuing treatment needs and address issues such as food, housing and employment, and involve the appropriate area program.

Further, the hospital must have a written policy to ensure that “reasonable efforts” are made to assist each client in obtaining needed services in the community upon discharge, including “the designation of qualified professional staff to assist clients in establishing contact with the appropriate area program” and furnishing information to the area program.

10A NCAC 28F.0206 requires the LME to send particular information with the client or to the hospital within one working day of the client’s admission. The information should include, among other things, the release plans, as well as information relevant to placement and other special considerations of the client upon discharge from the hospital.

10A NCAC 28F.0207 requires the LME and hospital staff to communicate with each other, including specifically about client options for receiving services when a client is not accepted for admission.

10A NCAC 28F.0209 requires the hospitals to develop a process to communicate with each area program about the planned discharge of clients. The process is to include specifically designated staff at both the hospital and the area program, routinely scheduled case management meetings at the hospital, hospital staff visitation to the LME, telephone conferences and a joint discharge plan involving the hospital, the LME and the client. The rule requires the process to be incorporated into each LME’s written agreement with the state hospital.

10A NCAC 28F.0210 requires that the hospital give the area program 72 hours notice of a planned discharge of a client, send a “Post-Institutional Plan” within 24 hours of discharge, and to send the discharge summary prior to the first scheduled appointment after the discharge.

Contracts

The contract between DHHS and each LME for 2007 – 2008 includes the following provision: 7.2.1 Care Coordination for Consumers without a Clinical Home. The LME shall provide care coordination services for consumers who are being discharged from state hospitals that do not have a clinical home provider, the LME shall ensure that consumers who are being discharged from state facilities are seen by a community provider within 7 calendar days of discharge and ensure that consumers who do not attend scheduled appointments are contacted to reschedule services within 5 calendar days.

History of North Carolina's Inadequate Discharge Planning

Although these laws and policies have existed for years, North Carolina's state hospitals have failed to protect clients' rights at discharge. More than four years ago, the U.S. Department of Justice ("DOJ") clearly identified North Carolina's discharge deficiencies and required improvement. The tragic experiences of TD, TC and LB demonstrate the lack of action in the past four years and the cost of that delay.

The 2004 U.S. Department of Justice Report.

In March 2004, the U.S. Department of Justice investigated North Carolina's four state- operated psychiatric hospitals pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. The DOJ issued a report identifying many areas in need of improvement including discharge planning at all four state hospitals. The DOJ concluded the planning processes were grossly inadequate and violated clients' rights to lawful and professional treatment:

"North Carolina's discharge planning practices are inadequate and consistently violate both the Americans with Disabilities Act and generally accepted professional standards of care."

The DOJ characterized one hospital's discharge planning as "perfunctory and inadequate."

Records reviewed by the DOJ revealed vague discharge plans that did not adequately address the needs of the patient. The report concluded:

- Progress toward discharge criteria and barriers to discharge are typically not monitored.
- Treatment is often not integrated and directed toward patient discharge.
- Treatment teams generally fail to assess adequately each patient at appropriate clinical intervals to evaluate whether the hospital is the most appropriate setting to meet the clinical needs of the patient.
- Aftercare discharge plans do not adequately address the needs of the patient.
- The State does not provide appropriate community-based treatment for persons with mental disabilities when placement in the community is deemed appropriate.

The DOJ identified uncertainty among staff about the role of the LME and described the relationship between hospital staff and community liaisons as "inadequate;" a failing that "often resulted in a failure to appropriately use available resources in the community."

Moreover, the DOJ found that "[p]rofessionals at the four facilities seem to recognize that their respective treatment planning processes are significantly flawed and in need of serious reform."³ In support of this conclusion, the DOJ pointed to: a 2002 memo from Dr. Harold Carmel and Patricia Christian to all Umstead unit directors stating "[i]t is now the time to review and revise

³ March 17, 2004, U.S. DOJ letter to Governor Easley, p. 7.

our treatment planning. . .”; responses to a 2002 CMS survey of Broughton and Cherry Hospitals acknowledging revisions to the treatment planning process are necessary; and a 2002 acknowledgement from professionals at Dix that they “don’t do treatment planning.”

The 2004 Report specifically outlined the minimum remedial measures that North Carolina should implement to protect the constitutional rights of patients in the area of discharge planning:

1) Develop a plan that identifies the necessary aftercare services the patient will need, that specifies actions necessary to ensure a safe successful transition from the facility to the community including the names and position of those responsible for the actions and the corresponding time frames.

2) Develop and implement a quality assurance/improvement system to oversee the discharge process and aftercare services.

DISCHARGE PLANNING REMAINS INADEQUATE IN 2008

The inadequacies of TD's, TC's and LB's discharge plans, and the resulting tragedy, illustrate the problems that have been repeatedly exposed and repeatedly reported to state officials in charge of mental health services. There can be little doubt that current assessments show no improvement since 2004.

The 2007 U.S. Department of Justice Report.

Last year, the DOJ returned to North Carolina to evaluate the state-operated psychiatric hospitals. They found that two of the four hospitals, John Umstead and Cherry, had shown outstanding improvement and are now in substantial compliance with the relevant standards of care "in most regards." Dorothea Dix and Broughton Hospitals, however, were judged to be "at best at partial compliance." Of importance, the DOJ determined that discharge planning at all of the hospitals remains inadequate.

At Broughton Hospital, the DOJ described discharge planning as "only a good will gesture." Review of the hospital's records still showed significant flaws, including the following remarks concerning specific discharge plans reviewed by the DOJ:

- No follow-up appointment with psychiatrist.
- No follow-up appointment with psychiatrist; [plan] provides no real information to patient; TBI patient provided oxycodone for four days, then what does he do (?).
- No psychiatrist aftercare appointment; Social Work statement reads like standard paragraph with fill in the blanks.
- BH is not adequately addressing persons who return after only brief community stays or who accumulate multiple admissions. The facts are provided, but there is no attention/act in the document that addresses this problem.

At Dorothea Dix Hospital, the DOJ chart reviews included the following comments:

- Ignores recidivism most of the time.
- Plans vary in quality from specific and meaningful to generic statements of no meaning at all, e.g., "supervised setting," "suitable setting," "facility setting able to meet his needs."

The DOJ found the "Aftercare Goals" at John Umstead Hospital to be "uniformly useless."

Chart reviews of discharge plans produced the following comments:

- They are generic, not individualized, not instructive, contribute virtually nothing to adherence or follow-up.
- Mixed results, largely positive; of 15 patients
 - 2 had no follow-up appointment,
 - 3 had no follow-up appointment within 1 week,
 - 10 had follow-up appointment within 1 week.

The DOJ concluded that Cherry Hospital's "discharging process is problematic." A review of 15 Aftercare Plans for Community Follow-Up showed the following problems:

- 5 patients left with MD appointments.
- 6 patients left with an appointment with a staff with full name.
- 3 patients left with an appointment with a staff with first name only.
- 1 patient left with an appointment with unknown.

The DOJ concluded: “virtually no patient was discharged with any more than a list of desired services. Patients did not leave Cherry Hospital with specific services in place other than residence, or more case ACT (which was then the only contact the patient left with). ... This is considerably less than a state hospital should be doing when discharging its patients.”

MH/DD/SAS Report of Community Systems Progress Indicators, December, 2007.

Because follow up care in the community is critical to the success of clients following hospitalization, the DMH/DD/SAS seeks to track the performance of LMEs with respect to one contract requirement – that clients are seen by providers within 7 days of discharge.⁴ The December 2007 MH/DD/SAS Report of Community Systems Progress Indicators for the first quarter of 2007 – 2008 reflected poor results for this indicator of progress. The established 2008 target for follow-up care in the community within 7 days of discharge from a state psychiatric hospital is only 42%. None of the LMEs met or exceeded the target. Data showed only 29% of clients were seen within the 7 day requirement. The same Report for the second quarter of 2007 – 2008 showed 35% of patients released from state hospitals were seen within 7 days of discharge.

North Carolina Continues to Discharge Many Clients to Homeless Shelters.

It is foreseeable that a client discharged to a homeless shelter will not receive the services and supports necessary to live successfully in the community. North Carolina treated and discharged 1,140 patients directly from psychiatric hospitals to homeless shelters in 2004. In 2005 1,231 people were treated and discharged directly to homeless shelters. In 2006 a record 1,485 people were discharged to homeless shelters, and in 2007 1,182 people were discharged to homeless shelters from the four psychiatric hospitals.

⁴ The rationale for this Progress Indicator is that “[r]eceiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system’s community service capacity and coordination across levels of care.” MH/DD/SAS Report of Community Systems Progress Indicators Report for First Quarter SFY 2007 - 2008, p. 21. In the Semi-Annual Report to the Joint Legislative Oversight Committee MH/DD/SAS, April 21, 2008, p.20, the Division notes best practice is for individuals to receive care within 3 days of hospital discharge, and that in the future the Division will “increase expectations for timely follow-up community care.”

2007 Report: The Implementation of Local Management Entities in North Carolina, Dr. Alice P. Lin, Ph.D.

Last year Dr. Alice P. Lin, Ph.D., reviewed LME implementation in North Carolina. She observed the “grim reality” that “consumers continue to fall through the cracks” at both ends - state hospitals/facilities on the one end, and the community-based system on the other. She found a “lack of continuity of care upon discharge” from the state hospitals. (Lin “draft” Report p. 83-84.) One of Dr. Lin’s recommended “short-term tasks” is to improve state hospital – LME collaboration.

Evaluation of LME Hospital Discharge Policies

To better understand the State's discharge planning process, Disability Rights North Carolina requested the hospital discharge policy from each of the 25 LMEs.⁵ Where the information provided by LMEs was unclear or prompted questions, Disability Rights North Carolina staff interviewed line staff, their supervisors, and LME Directors. The overall picture is that of a limited, fragmented system designed neither for success nor accountability.

The Policies.

The discharge policies submitted by the LMEs all contain the minimum statutory requirements. However, very few of the LME policies are specific enough to translate into effective practice. This became most evident when speaking with line staff regarding their policies: in some cases, line staff could not articulate or claimed to be unaware of any formal policy addressing the responsibility of the LME when a client is discharged from a psychiatric hospital; in other instances, it appeared doubtful that any written policy was in place when Disability Rights North Carolina requested a copy of the LME's policy. In more than one case, after trying unsuccessfully to reach the hospital liaison DRNC would speak to the LME Director, who would then inquire what policies other LMEs had provided. This left the impression that the LME had no policy in place. At numerous LMEs, the position of hospital liaison or care coordinator was vacant. In some cases, the individual holding that position also served other professional roles at the LME. There appears to be a full-time, functioning Hospital Liaison/Care Coordinator at only a minority of LMEs.

LME Role in Hospital Discharge Planning.

Despite regulation regarding the role of LMEs in the mental health treatment process, LME participation in the discharge process is not standardized across the State. While all policies state that the LME is responsible to be part of the discharge planning process, only a few LME policies specifically define what the LME should do to fulfill that responsibility. For example, some LMEs require Care Coordinators to attend a quarterly visit with hospital staff to coordinate discharge planning. The policies of other LMEs require the Hospital Liaison/Care Coordinator to attend inpatient client treatment team meetings. While this would seem a more effective approach to participating in discharge planning, the policies do not provide guidance on how often or to what extent attendance is required. Further, while a policy may be in place, if the position is not filled or filled by someone with other competing responsibilities, the difficulty in attending treatment team meetings becomes obvious. At one LME, the policy states that providers are to work directly with the hospital to coordinate the discharge plan. We learned that in cases where the provider does not cooperate, the hospital social worker may or may not contact the LME.

⁵ Despite written requests and telephone messages spanning a three month period, five of the LMEs never responded.

The inconsistency in LME discharge planning policy statewide as well the overall lack of specificity in defining roles and obligations of LME personnel are areas of great concern in establishing and maintaining an effective continuum of treatment for North Carolinians with mental illness.

Information Exchange.

Unfortunately, many North Carolina mental health professionals, including LME staff, can attest that the LME frequently does not know about the discharge of a patient from a psychiatric hospital into their catchment areas. This deficit of knowledge is directly tied to one of three things: 1) the lack of a reliable mechanism for the exchange of information between the psychiatric hospitals and the LMEs despite the regulation requiring it; 2) the failure of the LME to track patients for whom it authorizes inpatient treatment; or 3) the failure of the hospital to notify the LME when a patient is discharged.

The method of information exchange is as unique as each LME. According to the policies, some LMEs rely on inpatient psychiatric social workers to inform of pending discharges via telephone or a referral form. In the case of substantially fewer LMEs, the policy requires the Care Coordinator to track clients admitted to inpatient through discharge. While there appears to be some instances of effective communication between hospitals, LMEs, and providers, by and large communication throughout the mental health process from admission to follow-up is fragmented. These issues become increasingly problematic when patients are discharged to outpatient psychiatric care in counties where they are not residents.

LME Follow-Up.

Another area of concern involves the continuity of service for patients discharged from a psychiatric hospital. According to state rules and contract, each LME is responsible for oversight of the initial outpatient appointment by a client with a provider within one week of discharge. Disability Rights North Carolina staff learned that in the typical case, the LME is alerted to a patient's pending discharge by hospital staff. Then, depending on its policy, the LME either schedules the outpatient appointment with the provider or calls the provider within a few days of the scheduled appointment to see if the client attended. For one LME, determining whether the patient attended the initial appointment with the provider is the LME's first contact with the client's discharge planning. According to State rules and policies, if the appointment is not attended the LME is to follow up. As in the case of discharge planning between the hospital and the LME, there is ambiguity between the role of the LME and the provider in the initial stages of outpatient care. Some policies provide a timeline for follow-up, normally within one week of a missed appointment. That follow-up often includes a discussion between the LME and provider regarding the missed appointment and what will occur next. In some cases a "reasonable effort" to contact and reschedule care for the client is required. The definition of reasonable effort may be "documentation" of a home visit, a rescheduled appointment kept by the client, a phone conversation with the client about what services are offered, or at least three attempts to contact the client at his or her last known address. Markedly absent from this definition of "reasonable effort" is the discernment of barriers that may exist to appointment attendance and attempts to eliminate those barriers. Based on this policy, a staff member is free

to choose which of these “reasonable efforts” will be employed and need not attempt more than one.

Although it is well-recognized that mental illness is over-represented in the homeless population, these policies nearly guarantee there will be no follow-up care for individuals discharged to homeless shelters should they miss their initial appointments.

Summary.

Improvement in LME policies and practices concerning discharge is critical. A client’s current path from admission to a psychiatric hospital to successful follow-up care is tenuous. The current system is rife with ambiguity and is without accountability. Greater attention must be given to defining specific responsibilities to ensure accountability between the participants in the process – psychiatric hospitals, LMEs and providers. Standardized methods of communication between hospitals, LMEs and providers must be established. Most important, a policy should be adopted that emphasizes the identification and elimination of barriers to outpatient treatment services and compliance with realistic assessments and interventions.

THE STATE CAN AND MUST ACT NOW

Despite the dangers to clients and at least four years notice of a systemic failure in discharge planning, the Division's Strategic Plan 2007 – 2010, pps. 29, 21, is, by June 30, 2008, (three months from now) to “develop and implement processes and procedures for care coordination between state operated facilities and LME community services,” and plans by that date to “provide guidance on the standardized person centered plan including...transition plan for individuals discharged from inpatient care.”

On April 3, 2008, Dr. Lancaster issued a Memorandum to LME Directors requiring all LMEs to assign care coordinators to be on site at the state facilities that serve consumers from the LME catchment area. The memorandum implies that LME inaction is the root of the discharge planning failure in North Carolina, rather than acknowledging the State's responsibility for the shortcomings of the system and for its improvement. For example, the memorandum does not indicate there will be any funds to support the requirement. Nor does the memorandum require that LME personnel be present at the facilities for any particular amount of time. In fact, it states that the number of days and hours a care coordinator must be on-site is dependent on the number of admissions and discharged for that LME, but fails to establish specific guidelines for LMEs to follow. Finally, the memorandum fails to provide any direction regarding the role and responsibility of the LME care coordinator in the discharge planning process. Nothing less than a significant and committed campaign by leaders at DHHS to create, fund and staff discharge planning processes at the hospitals will change the dangerous status quo.

The timeline set out by the State is not acceptable. Neither is the slow approach of the LMEs response to the critical need for competent discharge planning. On February 29, 2008, the Division submitted its report on LME Crisis Service Plans to the Legislative Oversight Committee for MH/DD/SAS, as required by Session law 2007-323. Of the 25 LME Crisis Plans submitted, only **one** LME might have a current staff position dedicated to discharge planning from state operated facilities (it is unclear whether the staff person is responsible for both state-operated and local hospitals, or just local hospitals). LME crisis plans touching on discharge planning included:

- two plans that identified current staff positions as “hospital liaisons,” although one of them specified the discharge planning work is with two local hospitals in their area (Guilford (local only) and Piedmont Behavioral Health).
- four plans referenced hospital discharge planning work as *future plans* or *next steps* (Cumberland, Durham, Sandhills, and Smokey Mountain).
- one plan describing a process whereby the LME meets monthly with the local General Hospital to assure effective transitions from that Hospital to the community (Onslow Carteret Behavioral Health Care Services).

This level of response to the crisis of inadequate discharge planning on the state and LME level is unacceptable. The current discharge planning failures create real risks to people with mental

illness who are trying to live and survive in our communities. Disability Rights North Carolina urges the following actions be taken immediately to prevent additional deaths upon discharge from state hospitals.

The State needs to implement the recommendations made in the 2004 U.S. DOJ Report:

- **The hospitals must develop and implement a quality assurance/improvement system to oversee the discharge process and aftercare services.**

Comment:

The only hospital with a “system to oversee the discharge process” mentioned in the 2007 U.S. DOJ Report was John Umstead Hospital. The system in place at John Umstead Hospital is reported by the U.S. DOJ as follows:

- Audit one chart per social worker per month. Ten items on audit specifically address discharge.
 - Social worker supervision specifically addresses discharge. Unit social worker supervisor meets individually with Unit social workers monthly.
 - Unit social worker Supervisor has meeting with Unit social workers twice per month.
 - Director of Social Work has individual meeting with each social worker Supervisor twice per month. Group meeting twice per month.
 - Patients discharged with one week of pills and script for one month.
- **Develop plans that identify the necessary aftercare services the patient will need, that specify actions necessary to ensure a safe successful transition from the facility to the community, including the names and position of those responsible for the actions and the corresponding time frames.**

Comment:

Accountability is essential if discharge planning is to improve. There must be identified individuals who are responsible for specific actions in the discharge process. Lessons from the Cherry Hospital Recidivism Team may help:

- The Recidivism Team meets monthly to examine potential contributing factors, and explore intervention strategies.
- The Recidivism Team address recidivism issues in the treatment plan.
- A protocol has been developed for teleconferencing with the LMEs to enhance collaboration on recidivism cases.
- The Peer Bridge program has demonstrated success in reducing readmissions for patients served. Program data reports typical patients served by the program averaged 5.08 hospitalizations in a year prior to receiving services compared to .23 hospitalizations.

In conclusion, Disability Rights North Carolina recommends that the following steps be taken immediately:

- Hire additional staff at hospitals and LMEs who are dedicated only to discharge planning.
- Develop detailed and specific responsibilities to “discharge specialists” who are assigned to each patient when admitted through discharge from the hospitals.
- Implement a discharge system at each hospital which includes specific attention to reducing recidivism.
- Implement a quality assurance review of the discharge systems at each hospital and in each LME.
- Implement consistency in LME discharge policies statewide including specificity in defining roles and obligations of LME personnel.
- Define specific responsibilities to ensure accountability between the participants in the system – the psychiatric hospitals, LMEs and providers.
- Standardize methods of communication between hospitals, LMEs and providers.
- Require discharge policies that emphasize the identification of barriers to outpatient treatment services, plans to systematically overcome those barriers and compliance with realistic assessments and interventions.

Mission Statement:

The mission of Disability Rights North Carolina is to protect the legal rights of people with disabilities through individual and systems advocacy.

Purpose/Vision:

We value the dignity of ALL people and their freedom to control their own lives. We work for justice upholding the fundamental rights of people with disabilities to live free from harm in the communities of their choice with the opportunity to participate fully and equally in society.

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