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## **Investigative Report Links Three Deaths To Inadequate Discharge Planning**

**Raleigh, NC-**

In the first months of operation as North Carolinas Protection and Advocacy System (P&A), Disability Rights North Carolina investigated several reports of suspicious deaths linked to inadequate discharge planning from the States psychiatric hospitals. Three of those deaths are highlighted in a Disability Rights NC report. "Deadly Transitions: A Devastating Breakdown in Discharge Planning" was released at a News Conference at Disability Rights NCs Office at 10 a.m. on April 15, 2008.

The report highlights events which contributed to the death of three patients: TD, whose discharge plan was to have his parents continue *their* attempts to contact his case manager so his aftercare plan could be developed *after* he was discharged - in spite of his parents efforts TD died two weeks after discharge; LB, who was discharged to a closed homeless shelter and died within days; and TC, who killed himself two days after being discharged from a 36-hour admission to the state hospital. Our investigation of these deaths and others reveal a pattern of dangerously inadequate discharge planning practices at the state-operated facilities.

"Unfortunately the States current plans to address discharge planning are minimal, unfunded, and lack accountability and any urgency," said Vicki Smith, Disability Rights North Carolinas Executive Director. "We believe it is essential that the State achieve legally adequate discharge services in order to prevent unnecessary deaths in the future.

"Effective discharge planning is critical to ensuring appropriate care for each individual. It reduces recidivism and increases the likelihood of an improved quality of life. Not only is adequate discharge planning clearly the responsibility of state hospitals as required by federal statute, rules, case law, and standards of care, it is the right thing to do.

"It is clearly the States responsibility to ensure that patients receive statutorily required discharge planning. This responsibility cannot be divested to the LMEs; rather it must be shared. It is time that determined and focused leadership is brought to this most important step in our citizens' care."

Smith concluded, “If the quality of discharge planning is not immediately improved, efforts to fix mental health reform will continue to fail.”

The report is available at [www.disabilityrightsnc.org](http://www.disabilityrightsnc.org).

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One of the P&As primary federal mandates is to protect and advocate against the abuse and neglect of people with disabilities in the care of state institutions. To ensure North Carolinas P&A is effective, our state legislature amended Chapter 122C to require that the P&A (now Disability Rights North Carolina) receive reports of clients of the state system who die within seven days of a clients physical restraint or seclusion, and deaths that result from violence, accident, suicide or homicide.