



## DISABILITY LAW CENTER INVESTIGATIVE REPORT

Issued: June 8, 2021

# **OUT OF TIME:**

**THE TRAGIC DEATH OF CASONYA KING  
AND THE PRACTICE OF  
PATIENT DUMPING**



CaSonya King  
(1974 - 2018)

In Memoriam

***“I want the world to know what happened to my daughter. She was very kind. She was a great human being. I still have two mentally disabled children and I don’t want what happened to my daughter to happen to them.”***

**Angela King**

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## I. Executive Summary

It has been said that “America’s health care system is neither healthy, caring, nor a system.” However, even in this flawed, challenging environment, we ask our health care providers to avoid predictable and preventable harm. The story of CaSonya King’s final days is about her discharge from a private psychiatric hospital onto the streets of Boston. It asks us to consider how we protect personal liberty and autonomy for people who are experiencing mental distress, while also ensuring their safety.

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CaSonya L. King, known to most as simply as “Sonya”, was known to her family and friends as a natural leader, who had the special gift of making environments and people better than they were when she first encountered them. She had very strong work ethic and loved her immediate and extended family and friends. CaSonya was the eldest and the only daughter of the four children born to Ms. Angela King and Mr. King.<sup>1</sup>

She was born in Boston, Massachusetts and went to high school in the Lincoln-Sudbury and Northbridge public schools. After taking college classes and working on Wall Street, CaSonya attended Macon State College in Macon, Georgia. Later, by profession, she worked as an Information and Data Specialist for one of the largest corporations in the world, headquartered in Atlanta, Georgia. She purchased a home in Douglasville, Georgia and lived comfortably, providing assistance to her family whenever possible, and mentoring friends.

Inspired by her experience in caring for her grandmother, CaSonya created a business that became licensed to provide nursing and personal care assistance to senior citizens. She had discovered from caring for her grandmother that better services for seniors, especially those with Alzheimer’s, were deeply needed. Her mother recalls:

*“...[S]o she invented a solution, and she started her business. This was the type of person she was: forever courageous and a lover-of-life who believed anything can be accomplished with the right mix of action and faith. Most of the family regards Sonya’s life as an example that all girls in the family should follow and build upon.”*

CaSonya then began experiencing mental health issues. She decided to return to Massachusetts to live in Northbridge, Massachusetts with her mother to address her own health. Upon moving to Massachusetts, CaSonya had planned to start a similar health services business in her home state. However, by the spring and summer of 2018, CaSonya had become a client of the Department of Mental Health (DMH) and was twice hospitalized for reasons related to her mental health.

On June 8, 2018, CaSonya was admitted to High Point Hospital (“HPH” or “High Point”), a private psychiatric facility in Middleborough, Massachusetts<sup>2</sup> licensed by DMH. The hospital was informed that CaSonya’s mother, Angela King, was legal guardian.<sup>3</sup> Ms. King has said that her daughter had been quite unwell and was in need of effective mental health treatment when she entered High Point. Ms. King was hopeful that CaSonya would get the help she needed and come out of treatment as the happy and healthy Sonya she knew and loved.

Three weeks after she entered HPH, the hospital discharged CaSonya to the streets of Boston, even though she remained in a decompensated and disoriented state, unable to think clearly or care for herself. This occurred notwithstanding a DMH regulation requiring CaSonya’s competent refusal of alternative options.<sup>4</sup> CaSonya did not wish to go to a homeless shelter.<sup>5</sup> She wanted to be discharged to the DMH-licensed respite home run by Riverside Community Care (RCC), which was, according to the respite and CaSonya’s mother, willing to accept her in the near term.<sup>6</sup> As her legal guardian, Ms. King, also disagreed with the hospital’s plan to bring her daughter to a Boston shelter.

At the time she was hospitalized at HPH, CaSonya was not homeless. Instead of returning to the community happy and healthy, High Point’s decision to discharge her to the street left her in far more dire straits than when she was first hospitalized.

Within thirty hours of her discharge, at age 44, CaSonya King died.



(CaSonya (far left) pictured with her mother and one of her brothers)

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CaSonya King was presumably provided transportation by HPH to a Boston homeless shelter on June 28, 2018, although she never signed in. She was found by police and EMS in front of a drug store the next morning, six miles from that shelter, and in critical condition, having ingested excessive amounts of over-the-counter pain and cold medication. She died hours later in the hospital. CaSonya King’s life ended tragically, prematurely and without justification.

**Finding: After a comprehensive investigation, undertaken as the Commonwealth's Protection and Advocacy ("P&A") system, DLC finds that the actions of High Point Hospital, in discharging CaSonya King without a meaningful and effective discharge plan, constituted neglect and a dangerous practice that contributed to CaSonya King's tragic death.**

DMH conducts investigations of certain deaths involving DMH clients. All licensed acute private and general hospitals with inpatient psychiatric units are required to notify the DMH Licensing Division of incidents or conditions that occur on the unit no later than the next business day. When a serious incident or death is known to have occurred within thirty (30) days after discharge, it must be reported to DMH immediately and in writing by one business day.<sup>7</sup> One type of incident that requires notification to the Licensing Division is what is referred to as a medicolegal death. DMH Regulations (104 CMR § 32.02) define medicolegal death as:

- (a) any death required by M.G.L. c. 38 § 3, to be reported to the Medical Examiner;
- (b) a death in which the Medical Examiner takes jurisdiction.

Massachusetts General Laws Chapter 38 § 3 includes a long list of circumstances that may qualify a death as medicolegal for reporting purposes and one of those is "death by accident or unintentional injury."<sup>8</sup>

CaSonya's death was considered a medicolegal death and DMH conducted a thorough investigation pursuant to these requirements. The DMH investigation resulted in a recommendation by the investigator<sup>9</sup> and subsequent finding on August 30, 2018 by the DMH Director of Licensing,<sup>10</sup> that:

*High Point Hospital staff acted in a manner that was dangerous (as the term is defined in DMH regulation) in regard to the care and treatment of the client. [11]*

Despite its finding, the DMH only directed HPH to review a variety of policies and practices and to report any changes that were or would be made to hospital policies and practices, "as well as provide verification that all hospital staff have been fully educated about the above policies and the hospital's expectation of staff."<sup>12</sup> It asked HPH to respond by September 13, 2018.

The Department did not expressly require specific corrections or revisions to these policies. Nor did it ask HPH to address unanswered factual questions identified in its own investigation, or in the factual record generally. Such questions should have included:

-- Why CaSonya was discharged to the street against her will, and against the will of her guardian mother?

- Why this discharge to the street took place in light of HPH's own clinical findings, and in light of other available options for placement for CaSonya?
- Where exactly CaSonya was brought on the streets of Boston?
- Why did CaSonya not check into the shelter?

Nor, in the absence of answers to these questions, did it ask HPH to assess the need for disciplinary action against any employee.

On September 20, 2018, the HPH Hospital Administrator responded in writing by confirming that they had reviewed hospital policies and practices in four areas identified by DMH. HPH also confirmed that had revised one policy on discharge and aftercare planning and written another policy on discharges to shelters. They stated they reviewed and educated hospital staff about four other policies and reviewed with staff a fifth policy related to medication management, providing individual education to the doctor in question. They also provided three dates in September 2018 when staff education had taken place. No other action was required of the hospital.

**Finding: DLC finds that the steps taken by DMH were insufficient in light of the Hospital's actions, and the resulting tragedy. DMH's measures fell far short of the strong enforcement action against HPH that was warranted.**

## II. Investigative Procedure

The Disability Law Center (DLC) is a private, non-profit organization designated by the Governor of Massachusetts as the Protection and Advocacy ("P&A") system for the Commonwealth. One of the of the federal statutes creating the P&A system protects individuals with mental health issues, and is known as the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. §§ 10801 *et seq.* Pursuant to this federal mandate, DLC is authorized to "investigate incidents of abuse and neglect of individuals....if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.").<sup>13</sup>

DLC, in our capacity as the P&A, received a "Complaint to the System"<sup>14</sup> regarding the death of CaSonya from her mother, Ms. Angela King, who had been temporary legal guardian and was now personal representative of the estate of CaSonya.<sup>15</sup> DLC preliminarily interviewed Ms. King, and reviewed the limited documentation available at the time. Based on that information, DLC decided to investigate the circumstances of CaSonya's death and obtained signed Authorizations for Release of Information from her mother and personal representative.

DLC then began requesting and reviewing medical records from relevant institutions. Specifically, DLC reviewed records from CaSonya's inpatient stay at HPH as well as medical records for CaSonya's last few hours of life from St. Elizabeth's Medical Center and Carney Hospital. DLC was also able to review the related DMH

death investigation report provided by CaSonya's mother; the coroner's report; the police report, guardianship records, billing records supplied by Beacon Health Options and HPH; and the file of CaSonya King's court appointed lawyer for her civil commitment case. We gathered all information for this investigation with the written permission of the personal representative for CaSonya King's estate, Ms. Angela King.

Finally, after analyzing the HPH records and all other available material, DLC contacted High Point Hospital and the Department of Mental Health to offer to discuss in more detail its investigation, ask questions and to obtain their reactions to DLC's preliminary concerns. HPH and DMH were provided with an authorization for release of information from CaSonya King's estate. Comments received from HPH and DMH and DLC's responses are summarized in Section VI of this investigative report.

### III. Introduction to Patient Dumping

**The tragedy of CaSonya King's unnecessary death appears attributable to, an all-too-common practice called *patient dumping*. Patient dumping occurs when a hospital, denies emergency medical care or inappropriately discharges a current patient, either upon learning that the individual is unable to pay for treatment, or for another reason.**

Patient dumping typically occurs when a patient is uninsured or the patient's insurance coverage runs out before treatment is fully rendered<sup>16</sup> or where the patient is otherwise discharged suddenly, inappropriately or without adequate supports. It is estimated that 250,000 incidents of patient dumping occur annually despite legislative efforts to curb the practice.<sup>17</sup> Behavioral health patients are often discharged to shelters or the street with no protocol in place to provide further treatment.<sup>18</sup>

In 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) in an effort to "ensure public access to emergency services regardless of ability to pay."<sup>19</sup> EMTALA applies to all state-licensed, Medicare participating hospitals that operate a "dedicated emergency department (DED)."<sup>20</sup> CMS defines a DED as meeting at least one of the following requirements:

- (1) A Department which is licensed under applicable State law as an emergency room or emergency department;
- (2) A department that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- (3) A department that treats at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.<sup>21</sup>



The United States Commission on Civil Rights 2014 Statutory Enforcement Report, *Patient Dumping*, outlines the four basic statutory obligations of EMTALA as explained below:

<b>Medical Screening:</b>	Hospitals must provide an appropriate <b>medical screening</b> examination to any individual who arrives at the emergency department seeking medical treatment.
<b>Stabilization:</b>	If it is determined that an emergency medical condition exists, hospitals must provide further examination and treatment to <b>stabilize</b> the medical condition.
<b>Appropriate Transfer:</b>	If the hospital cannot stabilize the patient, the hospital must provide an <b>appropriate transfer</b> to another medical facility.
<b>Recipient Hospital:</b>	Hospitals with specialized capabilities, regardless of whether they have a dedicated emergency department, are required to accept an appropriate transfer of an individual requiring such capabilities, if it has the capacity to treat the individual.

*Note:* Words bolded above are defined in the EMTALA Statute Table in *Appendix A*.  
[https://www.usccr.gov/pubs/docs/2014PATDUMPOSD\\_9282014-1.pdf](https://www.usccr.gov/pubs/docs/2014PATDUMPOSD_9282014-1.pdf) at p. 7.<sup>22</sup>

EMTALA does not apply to CaSonya King's discharge because she was in an in-patient unit in a private psychiatric facility and not admitted through an Emergency Department. See 42 C.F.R. sec. 489.24(b). However, the underlying fact pattern and the public policy concerns are similar.<sup>23</sup> HPH inappropriately discharged CaSonya when she was not stabilized. Hospitals should not discharge patients without ensuring that they can adequately care for themselves or that appropriate care will be available to them.

DMH regulations, however, do apply. These rules require that licensed hospitals providing mental health services comply with the following discharge procedures:

(1) Discharge Procedures.

(a) A facility **shall arrange for necessary post-discharge support and clinical services**. Such measures shall be documented in the medical record.

(b) A facility shall make **every effort to avoid discharge to a shelter or the street**. The facility shall take steps to identify and offer **alternative options** to a patient and shall **document such measures, including the competent refusal of alternative options by a patient, in the medical record**. In the case of such discharge, the facility shall **nonetheless arrange for or, in the case of a competent refusal, identify post-discharge support and clinical services**. **The facility shall keep a record of all discharges to a shelter or the street, in a form approved by the Department, and submit such information to the Department on a quarterly basis.** ‘

(c) When a patient in a facility operated by or under contract to the Department is a client of the Department pursuant to 104 CMR 29.00: Application for DMH

Services, Referral, Service Planning and Appeals, the service planning process outlined in 104 CMR 29.00 shall be undertaken prior to discharge.

(d) A facility shall keep a record of all patients discharged therefrom, and shall provide such information to the Department upon request.<sup>24</sup>

In sum, state regulations require that hospitals make every effort to prevent discharges to the street or homeless shelters, require competent refusal of alternatives which must be offered to the individual. Where such discharges nonetheless take place, the hospital must document that supports and services are in place.

## **IV. The Facts of CaSonya's Story**

### **A. Background**

CaSonya King was described by her mother as someone who loved life, a person with a bright smile and a "kind human," loved deeply by her close family and her friends. CaSonya was the eldest and the only daughter of the four children born to Ms. Angela King and her husband.<sup>25</sup> Her mother is originally from Trinidad, and CaSonya grew up with a deep attachment to her mother's family and culture.

She was born in Massachusetts and attended high school in Lincoln-Sudbury and then graduated from high school in Northbridge MA. A bright student, CaSonya took college classes in Massachusetts and later moved to New York, where she worked on Wall Street, and survived working inside the World Trade Center on September 11th. Later, she moved to Georgia and attended Macon State College in Macon, Georgia. By profession, she became successful working as an Information and Data Specialist for two large corporations based in the Atlanta area. She was able to purchase a large comfortable home in Douglasville, support her brother, and support and mentor colleagues and friends. CaSonya provided care for her grandmother, an experience which prompted her to start a business providing nursing and personal care services, especially for seniors with Alzheimer's.

After she began to experience mental health issues, in 2016, she moved back to Northbridge, Massachusetts to be close to her mother and take better care of herself. She was planning to start her own business to provide nursing services as she had begun to do in Georgia. CaSonya was found eligible to receive DMH services.

She entered High Point Hospital on June 8, 2018 and after not significantly improving, was suddenly discharged nineteen days later, on June 27, 2018, to Boston streets, 39 miles away from the hospital. This happened despite CaSonya's own objections; the objection of her mother and guardian; CaSonya's severely compromised mental state; her absence of meaningful ties to and supports in the Boston area; the availability of a current or imminent placement at a respite facility; and DMH policies prohibiting discharges to the street under these circumstances.

Within thirty hours of her discharge, she had passed away, at age 44.

## **B. Chronology**

Following our investigation, DLC has made the factual findings listed below, representing the general timeline of events in June 2018. These findings provide a chronology, based on first-hand accounts and contemporaneous records, of how CaSonya's last weeks of life transpired. In many instances, we have adopted findings made by the DMH, following our own review of medical records and other evidence.

1. June 4, 2018: CaSonya King is discharged from Bournewood Hospital, (where she was treated from May 2018 to June 2018) to a respite home in Milford, MA administered by Riverside Community Care ("Riverside"). Riverside's assessment notes that her "baseline appears to be that she exhibits auditory hallucinations and engages in self-dialogue."
2. June 8, 2018: Through action taken by Riverside, CaSonya King was involuntarily committed to HPH pursuant to G.L. c. 123, § 12. The grounds for her civil commitment fell under the third prong of the definition of likelihood of serious harm under G.L. c. 123, § 1., i.e., that there is a very substantial risk of injury to the patient, given her inability to protect herself in the community. The application notes that she is experiencing behaviors and symptoms including the following: paranoid/delusional, [with] auditory hallucinations, increased agitation; [and a] response to auditory hallucinations. HPH apparently believed that CaSonya required in-patient hospital level of care.
3. June 8, 2018: CaSonya King then signs an application for conditional voluntary status pursuant to G.L. c. 123, § 10 and 11. As a conditional voluntary patient, she is required to give three days' notice of her intention to leave, whereupon the hospital must file for commitment if they wish to detain her. Later that day, she signs such a request for discharge, also known as a 3-day note.<sup>26</sup>
4. June 8, 2018: Early afternoon treatment notes indicate that CaSonya . King is self-isolated, refusing medication, and "self-dialoguing all shift." Evening treatment notes state that she is tangential, disorganized and hyper-verbal, self-dialoguing and yelling. She is specifically observed to be yelling back at auditory hallucinations.
5. June 9, 2018: Treatment notes again observe self-dialoguing, foul language, pacing behavior. She is found to be "too psychotic/manic at this time to provide a lucid interview...."
6. June 11, 2018: Treatment notes again observe self-dialoguing with foul language, grossly impaired insight and judgment and being fully engaged in an internal conversation.

7. June 12, 2018. HPH files a timely petition for civil commitment of CaSonya under G.L. c. 123 § 7 and 8. The medical and legal records note that the hearing on this commitment petition is scheduled for June 20, 2018.<sup>27</sup> If at that hearing, HPH prevails, CaSonya will be civilly committed for a period of time not to exceed six (6) months. If HPH does not prevail, it must discharge CaSonya on that day. The petition notes a diagnosis of schizophrenia and mood disorder and the presence of behavior that is paranoid, bizarre and intrusive to others. Of particular note, one of the three stated grounds for the commitment alleged is:

A very substantial risk of physical impairment or injury to the Respondent himself or herself as manifested by evidence that the Respondent's judgment is so affected that he or she is unable to protect himself or herself in the community, namely: ***cannot care for herself in the community.***<sup>28</sup>
8. June 12, 2018: HPH also files a petition for involuntary administration of antipsychotic medication ("*Rogers* petition"), noting that the respondent denied having a mental illness or psychiatric symptoms requiring treatment, and noting that her prognosis without medication was poor. A proposed treatment plan is filed with the *Rogers* petition listing only proposed and alternative anti-psychotic medications, to be administered voluntarily or involuntarily, if the petition is allowed.
9. June 13, 2018: The civil commitment hearing is scheduled for June 20, 2018.
10. June 13, 2018: HPH medical records indicate that CaSonya King is walking quietly and self-dialoguing. They are unable to assess her anxiety or depression "due to ongoing psychosis." She is characterized as being "disheveled and unkempt and slightly odorous." Her thought process, insight and judgment are recorded as "grossly impaired."
11. June 15, 2018: Treatment note states that CaSonya is more cooperative but continuing with self-dialoguing.
12. June 15, 2018: An attorney is assigned by the Committee for Public Counsel Services (CPCS) to represent CaSonya at her civil commitment hearing under G.L. c. 123, § 7 and 8, then scheduled for five days later on June 20, 2018 at 3:00 pm. The court date is recorded on a June 15, 2018 8:25 am treatment note. It is unclear if the court appointed attorney ever meets with CaSonya.
13. June 19, 2018, 6:48 pm. HPH Clinician writes a treatment note stating the following Plan: "If she continues to do her ADL's, not dangerous to self or others she will be discharged tomorrow morning."

14. June 20, 2018: The date of original commitment hearing. No hearing is held. CaSonya King is not discharged.<sup>29</sup>
15. June 21, 2018, 7:26 am, HPH clinician writes an incorrect treatment note stating that CaSonya King was “discharged” yesterday (June 20, 2018), but had nowhere to go and stayed at HPH for that reason without any commitment status.
16. June 21, 2018, 1:20 pm, HPH clinician writes a treatment note with following Plan: “She agrees to go to a dmh [sic] setting.”
17. June 21, 2018: The attorney for the hospital files a motion to continue (postpone) the June 20, 2018 commitment hearing to Friday June 29, 2018. (It is unclear why this motion was not filed before the original hearing date or why the hearing was not held on June 20, 2018.) The grounds stated in the motion is “so that the hospital can continue to work with DMH to put together a safe discharge plan for Ms. [CaSonya] King.”
18. June 25, 2018, 9:08 am: Treatment note includes the following as part of her patient Plan: “work with CM [presumably, case manager] and outside providers @ aftercare planning.”
19. June 25, 2018, 5:25 pm: HPH clinician’s treatment note includes the following as part of CaSonya’s Assessment: She is looking forwards [sic] going to respite tomorrow.” In the section for Plan, the clinician writes: “DMH meeting also with her mother...Prepare for discharge.”<sup>30</sup>
20. June 26, 2018: A discharge meeting takes place with clinical staff, CaSonya, her mother, and a clinician from the respite. DMH did not attend, for reasons that are unclear. The participants have different versions of part of this meeting. HPH believes that the respite clinician declined to take CaSonya back “at this time.” CaSonya’s mother and the respite clinician both state that, after learning that the hospital intended to discharge CaSonya to a shelter, that they offered to take her back and stated that they would call the next day.
21. June 26, 2018 In summary of the discharge planning meeting written on the following day, clinician in charge, Dr. A<sup>31</sup>. is described as arriving late to the meeting. Thereafter she informs the treatment team that CaSonya “must be discharged because she no longer requires inpatient level of care.”
22. June 26, 2018, 4:58 pm: HPH clinician includes the following in CaSonya’s Plan: “Prepare for discharge. Her mother has financial guardianship [<sup>32</sup>] and she is in need of placement.”

23. June 27, 2018, 6:12 am, Treatment note states “PT had meeting with DMH [33] and she was reportedly agitated afterwards.”
  24. June 27, 2018, 11:30 am. A discharge note states “Continue to attempt to reach DMH worker [Name omitted].”
  25. June 27, 2018: According to the medical record from HPH, CaSonya was discharged on June 27, 2018 at 12:45pm.<sup>34</sup> A discharge note states she was “discharged as per treatment plan to Shelter/Barbara McGinnins [sic] House Boston.” She is given prescriptions and is “escorted via staff to transport.” There is no indication from the record of notice to her guardian, Ms. Angela King, on June 27, 2018 of the anticipated discharge.
  26. June 27, 2018, CaSonya reportedly does not sign discharge papers and indicates her refusal to being discharged to a shelter.<sup>35</sup>
  27. June 27, 2018: Hospital records indicate that she was to be discharged by HPH to a homeless shelter in Boston, the Pine Street Inn; however, she appears to have never checked in. Her medical records do not explain why. Nor do her medical records, from our review, establish the place on the streets of Boston to which she was left. Therefore, she might very well have been dropped off somewhere else and ended up 6 miles west of the shelter. She is left with a debit card, but no state-issued identification.<sup>36</sup>
  28. June 27, 2018: HPH attorney moves to withdraw petition for civil commitment case scheduled for June 29, 2019 because CaSonya King “has been discharged.”
  29. June 28, 2018: After taking an excessive amount of pain and cold medication, CaSonya King is found outside of a Brighton MA CVS drug store in critical condition, about six (6) miles from the Pine Street Inn. Police report begins at 10:00 am.
  30. June 28, 2018: CaSonya King is brought by ambulance to St. Elizabeth’s Hospital on June 28, 2018 at 12:56pm<sup>37</sup> and is pronounced dead at Carney Hospital on June 28, 2018 at 7:07pm.<sup>38</sup> This is just over 30 hours after her discharge from HPH.
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## **V. *The Death of CaSonya King Was Tragic and Avoidable:* Detailed Factual Findings, Analysis and Conclusions**

This section discusses in greater detail DLC's two main areas of concern with CaSonya's stay at High Point Hospital prior to her death: (1) the apparent lack of appropriate mental health treatment and (2) inadequate and dangerous discharge planning. DLC also reviews the findings and corrective action requested by the Department of Mental Health (DMH) and the strengths and deficiencies in its response.

### **A. High Point Hospital Did Not Provide Effective Mental Health Treatment**

CaSonya King was treated as an in-patient at High Point Hospital from June 8, 2018 until June 27, 2018. HPH provided CaSonya with medication, room and board. However, during her three-week stay, HPH did not provide treatment that was effective in substantially improving her condition.

The HPH medical records indicate that throughout CaSonya's inpatient hospital stay, she was almost constantly responding to internal stimuli. Her psychiatrist at HPH often noted that CaSonya was "talking to unseen people."<sup>39</sup> She was often described by HPH staff as disheveled, loud, malodorous, pacing, and delusional.<sup>40</sup> From the notes reviewed, it appears that CaSonya was out of touch with reality and not consistently able to complete her activities of daily living (ADLs) throughout most of her stay.

HPH records revealed that the mental health treatment provided to CaSonya consisted almost entirely of medication. In fact, aside from involuntary medication listed on the *Rogers* petition, there was no Treatment Plan created for CaSonya, even though state regulations require one.<sup>41</sup> The written patient 'History and Physical Assessment' was also not completed; there was a note that indicated the staff person would try to get it completed the next day because CaSonya was refusing to do it upon admission, but it appears that it was never finished.<sup>42</sup>

Further, the records received by DLC indicate that, in the three weeks she was there, CaSonya did not attend therapy groups,<sup>43</sup> although the DMH investigation report does mention that she may have attended a handful or less.<sup>44</sup> While there is a note from a nurse in a discharge summary document indicating that she received treatment in the form of group therapy, this is not easily corroborated by the rest of the records DLC received from HPH.<sup>45</sup> Additionally, to our knowledge, CaSonya did not receive individual therapy from a psychologist. She met briefly with HPH staff who checked in with her, including her psychiatrist, Dr. A. A. but there are no medical records describing any therapeutic discussions.

Staff notes repeatedly indicate that CaSonya could intermittently respond to questions despite her internal stimuli, and she would sometimes take some of the medication prescribed. Some of these check-in notes are near-identical, which indicates that some staff were likely copying/pasting from prior notes and adding a few

words at the end of the note, making it difficult to ascertain the accuracy of these entries. For example, this note is entered on June 26:

Description:

Patient remains on IPU2. Patient is eating meals and staying hydrated, visualized on the milieu pacing. Patient continues to self-dialogue, with fowl [sic] language has been noticed today, when patient is approached by this writer, patient stops and makes eye contact, patient will then quiet her voice and is receptive to what is being stated to her. This transition occurs smooth – fantasy to reality. Patient is encouraged to express cares and emotions appropriately. Please reference medication note for medication compliancy.

[HPH Records. DAP Note] Electronically signed [Name Redacted] 6/26/18 2:05 PM

This note is almost identical to another:

Description:

Patient remains on IPU2. Patient is eating meals and staying hydrate, visualized on the milieu pacing less continuously. Patient is self-dialoguing, with fowl [sic] language, when patient is approached by this writer, patient stops and makes eye contact, patient will then quiet her voice and is receptive to what is being stated to her. This transition occurs smooth – fantasy to reality. Please reference medication note for medication compliance”

[HPH Records. DAP Note] Electronically signed [Name Redacted] [Note, 6/15/18 5:55PM

Similar notes are found by this staff person on five other occasions<sup>46</sup>, and by other staff.

In sum, from the records that are available, there is no substantial improvement in CaSonya’s condition through her hospitalization at HPH. In fact, from the first day of her admission, June 8, 2018, to the day of her discharge, June 27, 2018, her clinical notes continuously observe that she is engaged in self-dialogue, or responding to internal stimuli, or demonstrating a grossly impaired thought process. In reviewing the clinical (DAP) notes, DLC found separate clinical references to CaSonya self-dialoging, responding to internal stimuli, and/or having a grossly impaired thought process on each of these days, as set forth below:

6/8/18 --	4 times
6/9/18 --	5 times
6/10/18--	4 times
6/11/18--	4 times
6/12/18--	3 times
6/13/18--	4 times



6/14/18-- 1 time  
6/15/18-- 2 times  
6/16/18-- 3 times  
6/17/18-- 3 times  
6/18/18-- 3 times  
6/19/18-- 3 times  
6/20/18-- 3 times  
6/21/18-- 4 times  
6/22/18-- 4 times  
6/23/18-- 3 times  
6/24/18-- 4 times  
6/25/18-- 5 times  
6/26/18-- 3 times  
6/27/18-- 4 times<sup>47</sup>

The observations noted above of CaSonya's whole clinical team are difficult to reconcile with other treatment notes of the discharging clinician, Dr. A. We noted a significant disparity in her conclusions, compared with notes from other members of the clinical team, even those made on the same day. The chart below captures several examples:

<u>Date</u>	<u>Excerpts of observations made by Dr. A.(and time entered).</u>	<u>Excerpts of observations made by other clinical staff (and time entered).</u>
6/16/18	[A]ppropriate affect, linear....able to participate in a conversation... compliant...well kempt (8:25 am)	[S]elf-dialoguing with fowl (sic) language... affect is flat with limited expression...appearance/hygiene are poor...Judgment grossly impaired... responding to internal stimuli (5:48 pm)
6/21/18	Stable...Good ADLs... Residual psychosis not impairing ability to care for self (7:26 am)	[P]acing the unit agitated w/outbursts ....yelling and self-dialoguing...expressing tangential thought process...asked if I could help pt states "I'm worried about discharge" ...continues to refuse [medication]...dressed in the same clothes... blunted affect..thought content appears paranoid (2:19 pm)  All shift pacing the hallways and audibly self-dialoguing and responding to IS [internal stimuli]...does not interact with other patient[s] or attend any group activities (9:01 pm)
6/22/18	ADL's much improved...(4:16 pm)	[C]onfused...continuing with self-dialoguing... several loud outbursts (6:55 am)  Poor hygiene (and disheveled...thought process is not intact....grossly impaired insight/judgment... not been attending or participating in groups (11:05 pm)
6/25/18	[D]iscussed her appropriate conversations with staff or peers however her returning to talk to unseen people....She is looking forwards (sic) going to respite tomorrow.... Prepare for discharge (6:25 pm)	[O]bserved pacing about the unit yelling to self, self-dialogue, appearing to be responding to internal stimuli...able to re-direct and de-escalate but quickly returns to tangential thought process and angered mood...increased volume the longer it continues...thought content appears paranoid... (4:08 pm)

		[A]ll shift loudly responding to IS...screaming episodes of self-dialoguing...vulgar at times aimed at males...very disconnected...15 minute safety checks in place....(4:08 pm)
6/26/18	Under stress...talks louder however she have (sic) not been intimidating to others...no immediate risk of harming to self and others...residual psychosis not dangerous to self or others. Compliant with her psychosis treatment consistently. (4:58 pm).	[L]oudly responding to IS...can respond appropriately...but immediately returns to own conversation...continues to pace...doesn't see to notice she is having these conversations..... screaming conversation with herself that was frightening other patients...loudly responding to IS again...15 minute safety checks in place... (5:46 pm)

It is also significant that the amended Physician Discharge Summary of Dr. A., dated June 27, 2018, concludes that CaSonya's "residual psychosis [is] not interfering with her ability to care for self...." This appears in stark contrast to the observations of the CVS employee on the following day (reported in the Boston Police Department incident report and quoted on p. 11 of the DMH Investigation Report), that CaSonya. was eating medication out of the package while stating "I need to do this" "I am making the right choice," and "I can't stop him."

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To be clear, in stating that the record reflects that CaSonya King was decompensated and disoriented at the time of her discharge, DLC is not criticizing HPH for failing to cure or significantly mitigate the effects of CaSonya's psychiatric disability during her short two and a half week stay there. Some individuals have mental health conditions that take months to abate, or which are not amenable to conventional approaches, including medication and group therapies. Rather, our point is that CaSonya was ultimately discharged directly from the hospital in her acute state – not to step down to a DMH group home, respite or other community program with supervision and supports – but to live on the street, or at best, to sleep at night in a homeless shelter. In this context, HPH's inability to mitigate her symptoms takes on great significance.

As noted above, on June 12, 2018, only fifteen (15) days before discharging her, the hospital sought CaSonya's commitment under G.L. c. 123, § 7 and 8, among other reasons, on the basis that there was a

*[V]ery substantial risk of physical impairment or injury to the Respondent himself or herself as manifested by evidence that the Respondent's judgment is so affected that he or she is unable to protect himself or herself in the community, namely: cannot care for herself in the community.<sup>[48]</sup>*

In the days that followed, HPH staff treatment notes support or repeat this concern. Against this backdrop, a hospital that seeks to discharge a person to the street or to a homeless shelter, faces a heavy burden. Where an individual who meets the description above is not being discharged to other DMH funded supports, the hospital should be obligated to show that it has provided effective treatment, such that this person is no longer at very substantial risk of self-injury or harm, or that they can care

for themselves in the community. Certainly, as part of that showing, the hospital should have developed a formal Treatment Plan, - a necessity for every in-patient– and a coherent, structured discharge plan (something which should begin shortly after admission), that included active involvement of the individual, her guardian, DMH, available community based mental health providers, and other family and community supports. This did not happen for CaSonya King. HPH's failure to fulfill these obligations makes the discharge decision itself deeply and tragically flawed, a problem discussed in more detail in the next section of this report.

## **B. High Point Hospital Engaged in Inadequate Discharge Planning and Dangerous Discharge Practices.**

### **1. Discharge Requirements for High Point Hospital as a Private Psychiatric Facility**

#### **a. Federal Requirements**

As a hospital participating in Medicare, HPH must abide by the Centers for Medicare & Medicaid Services (CMS) requirements outlined in the agency's Conditions of Participation (CoP). Under 42 CFR § 482.43, hospitals are required to identify at an early stage of hospitalization those patients who are likely to suffer adverse health consequences without adequate discharge planning.<sup>49</sup> Hospitals must provide a discharge planning evaluation upon the individual's request or the request of a representative or physician acting on the individual's behalf.<sup>50</sup>

The discharge planning evaluation must include an evaluation of the person's capacity for self-care or of the possibility of their being cared for in the environment from which the individual entered the hospital.<sup>51</sup> These evaluations must be performed in a timely basis so that appropriate arrangements of post-hospital care are made before discharge.<sup>52</sup> The hospital must discuss the results of the evaluation with the patient or individual acting on their behalf.<sup>53</sup> The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as need, for follow-up or ancillary care.<sup>54</sup> As needed, the hospital should counsel the patient and family members or interested persons to prepare them for post-hospital care.<sup>55</sup>

#### **b. State Requirements**

Similarly, hospitals accepting Medicaid (MassHealth) are required by state regulations to screen for discharge within 24 hours and commence discharge planning within 72 hours. If additional care and resources are required after discharge, a written plan must be developed.<sup>56</sup>

In addition, HPH is subject to similar DMH regulations, as a private psychiatric hospital licensed to provide in-patient psychiatric treatment and services, including regulations concerning discharge protocols.<sup>57</sup> Under 104 CMR § 27.09, mental health

facilities are required to arrange for necessary post-discharge support and clinical services and document such measures in the medical record.<sup>58</sup> A facility must make every effort to avoid discharge to a shelter or the street, take steps to identify and offer alternative options to patients, and document those measures.<sup>59</sup>

## **2. Lack of Discharge Planning and Inappropriate Decision to Discharge**

The prevailing standard of care requires that discharge planning begin on day one of an in-patient admission. This is especially so in licensed acute care facilities, where in-patient stays are typically no longer than two or so weeks on average.

CaSonya had community supports that should and could have been involved from the very beginning. Her mother, Angela King, was actively involved in her life and had become her temporary legal guardian.<sup>60</sup> The HPH treatment team, or at least some of the staff involved in her care, seemed to have the erroneous impression that Ms. King only had “financial guardianship” and therefore, her opinion regarding discharge planning did not need to be considered.<sup>61</sup> This is incorrect. Ms. King had temporary, but full guardianship of her daughter.<sup>62</sup> Ms. King was also included in CaSonya’s list of contacts. Despite this, Ms. King was unable to reach anybody at HPH for approximately two weeks after CaSonya’s admission.<sup>63</sup> This would have been about June 22. CaSonya also had a DMH case worker, who was interviewed by the DMH Investigator who stated that she had tried to contact HPH for approximately two weeks as well, to no avail.<sup>64</sup>

Nevertheless, the records do not mention any contact with CaSonya’s community supports for a significant period of time between her admission and when the commitment hearing was supposed to take place. This indicates a lack of proactive planning and person-centered approach on the part of the staff at HPH.

CaSonya’s civil commitment hearing was scheduled for June 20, 2018, but never occurred, resulting in confusion by the hospital as to her legal status. The DMH Investigation report notes the lack of clarity about the circumstances surrounding the June 20, 2018 hearing that never took place.<sup>65</sup> On June 21, 2018, at 7:26 am, Dr. A. entered a treatment note recording a conversation between her and CaSonya. She states that the “court case was postponed.” It is unclear from the medical records and the DMH investigation report, what exactly happened with that commitment hearing. It certainly did not occur, but the record is inconsistent and unclear as to the reasons why. One note suggests that CaSonya’s appointed attorney continued the case, yet there was, apparently, no information available to hospital staff regarding the identity of her attorney.<sup>66</sup> During the course of our investigation, DLC was able to determine what really happened. (The court documents we obtained show that the hospital filed the motion to continue the hearing. Another treatment note seems to indicate the case was continued to plan for a placement. However, HPH should have been working on this continuously since her admission.)<sup>67</sup>

In her June 21, 2018 treatment note, Dr. A. also notes that “CaSonya wants to be discharged and we discussed that she was discharged yesterday and there was no place to sent [sic] her.” In the “Plan” field of the treatment note, she wrote that the “Plan” for CaSonya was “Discharged.” This characterization of CaSonya’s legal status is incorrect. Discharge only happens when the individual leaves the hospital.<sup>68</sup>

Thereafter, several days went by with not much changing in the way of CaSonya’s presentation.<sup>69</sup> Legitimate discharge planning did not begin several days before her actual discharge date of June 27, 2018.<sup>70</sup> A discharge planning meeting was finally scheduled, apparently thanks to the work of the DMH case worker..<sup>71</sup> Although there is sporadic mention of discharge by members of the treatment team throughout the records received by DLC, there is no mention of any meetings with CaSonya and other team members to specifically and meaningfully discuss discharge until the day before she was actually released to the street, on June 26, 2018.<sup>72</sup> This means that even despite the fact that CaSonya had a commitment hearing scheduled for June 20<sup>th</sup>, no one had sat down to plan for the possibility that CaSonya would have to be discharged if the hearing had taken place and commitment was *not* ordered.<sup>73</sup>

Based on the records available, it appears that this single meeting on June 26, 2019 was fraught with problems. First, participants misunderstood what each other were saying, resulting in HPH failing to consider discharge options available to CaSonya. CaSonya’s mother was there as well as a clinician from the Milford Respite run by Riverside Community Care. Both Ms. Angela King and the respite clinician indicated to the DMH investigator that the respite was willing to accept CaSonya into its program, but both also expressed concerns about CaSonya’s mental status and readiness to be discharged. The respite clinician stated that she would call HPH the next day to discuss discharge. However, HPH’s notes reflect that Ms. King and the respite declined to take CaSonya in again; they failed to mention the respite’s stated willingness to accept CaSonya in the very near future.<sup>74</sup> In actuality, per DMH’s investigation, had the respite known that the hospital would discharge CaSonya to a shelter, they would have intervened and taken her instead.

***“During the discharge planning meeting on June 26, 2018, CaSonya couldn’t even sit down at the meeting; she was disengaged. She left and was walking up and down the hall and we could hear her from the meeting room.”***

**Angela King**

Additionally, the records indicate that Dr. A. was absent from the meeting when it began, missing the full conversation. According to a note by a LICSW, Dr. A. “eventually join[ed]” the meeting and said that CaSonya was discharge ready and would have to be discharged the following day.<sup>75</sup> Only then did HPH staff address discharge planning, quickly settling on discharging her to a homeless shelter. Finally, the DMH case worker was not in attendance, for reasons that are unclear.

The idea of discharging CaSonya to a shelter had not been planned or well thought out. In fact, Ms. King reports that Dr. A. told her “She’s been here too long” and “we already kept her long enough”. To this, Ms. King says she responded by asking Dr. A. if she truly believed CaSonya could make it out in the community, and according to Ms. King, Dr. A. replied that she thought CaSonya could and she would make sure to write that in the medical record. Angela King did not agree. She knew her daughter and she could see that her daughter was in the same psychotic state she had been in at the time of her admission. She recalls telling Dr. A. and others in the room, “I’m just trying to fight for my daughter’s life.”


So, although the hospital was supposed to be planning CaSonya’s discharge with her participation and in conjunction with her DMH case worker,<sup>76</sup> neither appears to have taken place. Acting on the discharge decision of Dr. A., the HPH treatment team determined that CaSonya would be discharged to the Pine Street Inn shelter for women on Harrison Avenue in Boston the following day. HPH staff were aware from previous contacts with the shelter that no bed could be assured for CaSonya there. Moreover, HPH staff made no appropriate arrangements for further care, aside from providing CaSonya with phone numbers she could call to make appointments.<sup>77</sup>

Indeed, the DMH Investigator concluded, insofar as discharge planning is concerned, that “several of the indicated assessments were found to be incomplete” and “the client was discharged with an aftercare plan that was evidently not achievable through means immediately available to her.”<sup>78</sup>

### **3. Lack of Consent by CaSonya King and Lack of Notice to Her Guardian**

The patient record indicates that CaSonya clearly said to a staff person during the afternoon of June 26, 2018 that she did not want to go to a shelter, but she wanted to go to the RCC Milford Respite program<sup>79</sup> where she had spent a few days prior to this hospitalization. As discussed above, this respite was willing to accept CaSonya upon her discharge. They just had expressed some concern about CaSonya’s readiness to be discharged but they had not refused to accept her. Had they known that the hospital would discharge CaSonya to a shelter, they would have intervened and taken her instead.<sup>80</sup> Still, HPH proceeded to discharge CaSonya on June 27, 2018. CaSonya refused to sign the Clinical Discharge Summary and also refused to sign the Nursing Discharge Summary.<sup>81</sup>

Her objections are plainly recorded in her medical records, in which she stated she wanted to go to respite, and not to the shelter:

 <b>DAP NOTE</b> <b>High Point Treatment Center</b>			
<b>Client #:</b> 27538314	<b>Name:</b> King, CaSonya	<b>DOB:</b> 3/9/74	<b>DOC #:</b> 28146925
<b>Date:</b> 6/27/18	<b>Time In:</b> 12:22 pm	<b>Time Out:</b>	<b>Discipline:</b> Clinician
<b>Prog:</b> Inpatient Psychiatric Unit		<b>Type:</b> Discharge	
<b>Treatment Objective:</b>			
<b>Description:</b>			
<p>Met with pt for discharge meeting. clinician informs Pt that her discharge is scheduled for today and Mom and respite are unable to take her at this time. Clinician states that Pt's only option is to go to a shelter at this point. Pt states "I don't want to go to a shelter. I want to go to the respite," and leaves the office.</p> <p>Pt later meets with another CM to process discharge. Pt refuses to sign discharge summary. Pt is discharged to Pine St. Inn shelter in Boston, MA. Pt is provided with a copy of her discharge summary and number to ESP (BEST Boston Emergency Services (BEST) Team: 1-800-981-4357). Pt is also informed of aftercare appointments/walk-in hours at Barbara McGinnis/Healthcare for the Homeless in Boston.</p>			
<b>Assessment:</b>			
<p>Pt is alert and oriented x 3  Mood is somewhat anxious  Self-dialoguing  Future-oriented to discharge</p>			
<b>Plan:</b>			
Discharge to the community with providers at Barbara McGinnis			
<b>Electronically Signed By:</b>		<b>(6/29/2018 1:47:17PM) LICSW</b>	

(Treatment note related to discharge, (with author's name redacted), dated 6/27/18, 12:22 pm.)

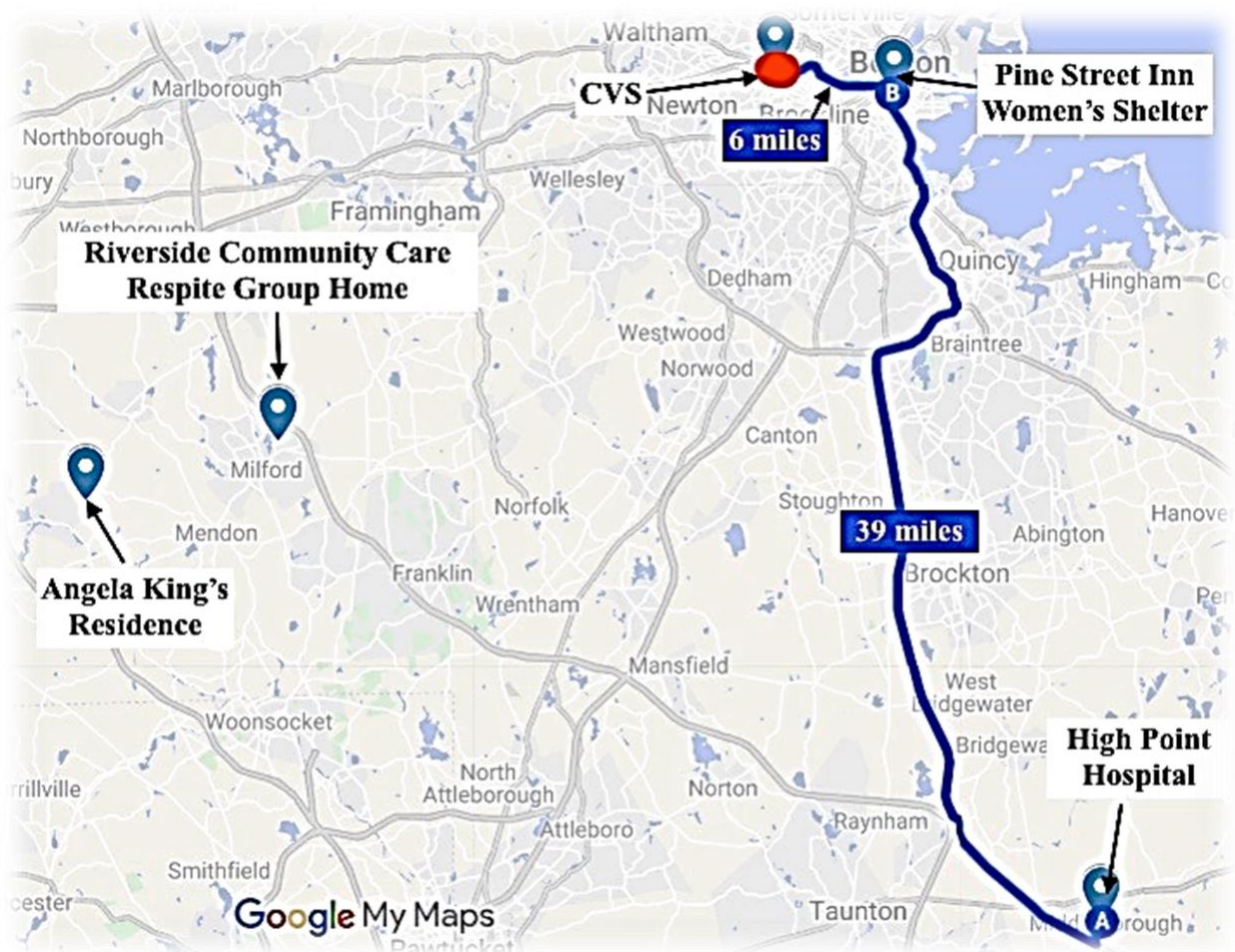
It appears that HPH did not contact the respite staff concerning CaSonya's discharge ahead of time. In fact, staff from the respite contacted HPH to follow up the day after the discharge planning meeting only to find out that CaSonya had already been discharged.<sup>82</sup> Had HPH done so, CaSonya may have ended up at her preferred discharge placement instead of the streets of Boston.

Ms. King also reports that she was not notified of her daughter's discharge until she called the hospital to inquire, even though she had temporary guardianship of CaSonya and had conveyed her concerns about her daughter's safety to the treatment team. As soon as she and DMH found out that CaSonya had been discharged, they alerted the medical alert system (known B.E.S.T.) whose staff began trying to locate CaSonya.<sup>83</sup>

#### 4. CaSonya King's Tragic Death

CaSonya was transported from HPH to an urban neighborhood in Boston for reasons that are unclear. She had minimal ties to the Boston area, and no friends or service providers there.<sup>84</sup> Her mother lived in Whitinsville, MA which is close to the location of CaSonya's DMH site office and to the Milford Respite program run by RCC. Nonetheless, HPH decided to drop CaSonya off 39 miles away, in a different direction, at a shelter in Boston (see map detail below), against her will and that of her parent and court-ordered guardian. It does not appear that she was offered any alternative options pursuant to 104 CMR 27.09(1)(b).<sup>85</sup>





(Relative locations of HPH, CaSonya's family and respite, Pine Street Inn and CVS)

CaSonya was given prescriptions she was directed to fill herself and told to go to Barbara McInnis House open clinic hours.<sup>86</sup> However, there were no appointments made for her, and no arrangements made for providers, despite the availability of services in the area such as other services offered by the Boston Healthcare for the Homeless Program (BHCP).<sup>87</sup>

Based on the information available to DLC, she was brought to Boston by transportation employees of HPH and never made it to the shelter.<sup>88</sup> At the least, it is clear that she did not check into the shelter in order to be assigned a bed.<sup>89</sup> There is no indication in the patient record of who transported her and where exactly she was dropped off. It is DLC's position that discharging hospitals like HPH should be required to record the exact location where someone is discharged in the patient file. If, for example, an individual being provided transportation asks to get out of the car before reaching a planned destination, the note should then also include the circumstances surrounding that and why the hospital staff transporting the individual complied with this request.





(View of the main entrance to the Pine Street Inn – The Women's Inn



(The CVS on Market Street, Brighton, MA, where CaSonya was found on June 28, 2018)

By the next morning, CaSonya was at a CVS on Market Street in Brighton, MA (pictured above), where she spent the morning buying and ingesting over the counter pain and cold/allergy medication, while also speaking incoherently in response to internal stimuli.<sup>90</sup>

06/28/2018	CVS/PHARMACY #03 POS	\$81.01
	Brighton MA US 039416	
	*****8078 30389003	
06/28/2018	CVS/PHARM 03890- POS	\$11.68
	Brighton MA US 119746	
	*****8078 30389001	
06/28/2018	CVS/PHARM 03890- POS	\$9.76
	Brighton MA US 516991	
	*****8078 30389001	
06/28/2018	7-ELEVEN POS	\$1.89
	BRIGHTON MA US 912835	
	*****8078 00N1BG01	
06/28/2018	CVS/PHARM 03890- POS	\$16.46
	Brighton MA US 520286	
	*****8078 30389001	
06/28/2018	CVS/PHARM 03890- POS	\$12.00
	Brighton MA US 522856	
	*****8078 30389001	

(Excerpt of receipt showing five purchases of over-the-counter medication at CVS)

This CVS is located six (6) miles from the shelter where CaSonya should have spent the night. CaSonya was found by the police and EMS 24 hours after her

discharge from HPH, in critical condition, after a CVS employee called 911 concerned about CaSonya's behavior throughout the morning.<sup>91</sup>

Public Narrative

About 12:25PM on Thursday, June 28, 2018, Officer Drew in the K425D and Officer Hadzi in the K415D responded to a call for a female who was possibly overdosing at 207 Market St., Brighton.

Upon arrival, Officers entered the CVS store and encountered the victim (CaSonya King). Ms. King appeared disoriented, unable to focus on officers presence, and had a visibly elevated pulse and respiratory rate. The victim's nose was also running profusely and she was speaking to herself in a low tone, making statements that were inaudible to officers. Officers asked the victim if she had taken any medication today, to which the victim replied "yes, just aspirin." The victim stated she had hurt her ankle at the gym and denied taking any additional medications today.

The CVS employee on site who called 911 ( ) stated that the victim had been in the store 8 or 9 times that morning and was buying various over-the-counter pain relief substances, including Excedrin Migraine, Benadryl, and Z-Quil and "eating them out of the package." The caller also stated that she heard the victim saying "I need to do this," "I'm making the right choice," and "I can't stop him." The victim also told the CVS employee that she was buying medications "for my son." The caller stated that they denied sale of any additional medications to the victim, and that prior to officers arrival, the victim was sitting in the medication aisle, staring at the shelves.

Boston EMS A-14 arrived on scene and transported the victim to St. Elizabeth's for further evaluation.

(Excerpt of police report recording comments by CaSonya indicating disoriented speech and behavior)

CaSonya died six (6) hours after being taken to St. Elizabeth's Medical Center by ambulance, being treated there and subsequently getting transferred to Carney Hospital for admission in the Intensive Care Unit. CaSonya had very quickly developed aspiration pneumonia which was discovered at Carney Hospital and ruled to be a consequence of the significant amount of vomit that she produced. While awaiting emergency hemodialysis she went into cardiac arrest and was unable to be resuscitated.<sup>92</sup>

Her death was ruled accidental and attributed to "acute intoxication due to combined effects of ibuprofen, acetaminophen, salicylate, diphenhydramine, and benzodiazepines."<sup>93</sup> Four of these five drugs are primary ingredients in over-the-counter medications.<sup>94</sup> While the cause of death also reflected the presence of benzodiazepines in her system (presumably prescribed for anxiety), the description of her injury (death) identified in the autopsy report was "ingestion of excess non-prescription medications."

## **5. Lack of Justification for the Rush to Discharge**

All of the above begs the question, why did the hospital staff seem to be in a rush to discharge CaSonya, no matter what? Why exactly was she discharged on June 27, 2018? And why was this done without notifying her guardian, her prospective community provider, or any of her other community supports?

CaSonya's legal status did not require a rush to discharge. She was originally admitted on June 8, 2018, pursuant to G.L. c. 123, § 12. The same day, she filed papers to change to conditional voluntary status under G.L. c. 123, §§ 10 and 11. She then filed also, on June 8, 2018, a three-day notice. This required the hospital to file a petition to civilly commit under G.L. c. 123, §§ 7 and 8 if they sought to keep her confined. They promptly did so, on June 12, 2018, also filing for permission to involuntarily administer anti-psychotic medication under G.L. c. 123, § 8B (a *Rogers* petition). As required, a hearing was scheduled within five days, for June 20, 2018. After the hospital filed for civil commitment, they were permitted to retain CaSonya regardless of her three-day notice.<sup>95</sup>

Once the hospital sought to retain CaSonya, they had several options:

1. Resume conditional voluntary status. At any time prior to discharge, the hospital could have asked CaSonya to revoke her three-day notice or sign new papers for conditional voluntary status. This would have allowed CaSonya to stay indefinitely while HPH pursued further discharge planning. This is not a perfect solution for all circumstances. If the hospital believed that CaSonya lacked the mental capacity to seek conditional voluntary status or to revoke the three-day notice, then they would have needed to pursue civil commitment under G.L. c. 123, §§ 7 and 8 instead.<sup>96</sup>
2. Proceed to a civil commitment hearing. HPH could have sought commitment under G.L. c. 123, §§ 7 and 8, the third prong of the civil commitment standard, requiring "a very substantial risk" of injury from an inability to protect oneself in the community. See G.L. c. 123, § 1 (defining "likelihood of serious harm applicable to G.L. c. 123). In its filing on June 12, 2018, HPH alleged that CaSonya was subject to commitment under the third prong of the statute and stated that she required anti-psychotic medication and was not competent to refuse it. Without any significant change in her condition between June 12 and the time of her discharge on June 27, 2018, the hospital presumably would have been able to proceed to hearing. If the hospital were unable to establish any of the three prongs of the statute, CaSonya would be released. See *Connor v. Donaldson*, 422 U.S. 563 (1975) (finding that there is no constitutional basis for confining persons with mental health issues if they are not dangerous and can live safely in freedom).<sup>97</sup>
3. Postpone the commitment hearing by agreement, until such time as a respite and/or DMH community placement were available. DLC believes this to be the most prudent, least restrictive, and most economical option. In fact, it was the option that the hospital and CaSonya and her attorney presumably chose in postponing the hearing from June 20 to June 29, 2018. If no respite placement was available before that time – while the record suggests it very well may have been available – then the parties could have continued the case once or even several times, to acquire additional time needed to facilitate transfer to a respite or DMH community placement. See G.L. c. 123, § 7(c) (allowing for delay of the hearing when requested by the individual or their counsel). Since the record

reflects that CaSonya wanted a discharge to a respite or community placement and not to a shelter, it is fair to assume that she would have consented if this option were presented. This option presents a best practice consistent with DMH regulations that strongly disfavor discharges to the street or to homeless shelters and direct providers to find “alternative options” absent a “competent refusal.” See 104 CMR § 27.09(1)(b); see also 130 CMR 423.417(B)(3) (MassHealth regulation permitting continued hospitalization to integrate gains and prepare for the transition to outpatient care or a residential setting). So long as a civil commitment hearing was scheduled at a future date, CaSonya would be able to be legally held at the hospital. See G.L. c. 123, § 6.

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Instead of pursuing these alternatives, the hospital scheduled the commitment, extended it, and then discharged CaSonya to the streets of Boston before the hearing could take place.

Given these failures to act, and given CaSonya’s compromised state, this discharge fell below the requirements of DMH regulations cited above, and reasonable expectations of mental health providers in hospital settings. DLC concludes that the manner in which the discharge took place was at the very least negligent and may also have been a reckless act constituting abuse.<sup>98</sup> It placed CaSonya in circumstances that she was unable to manage alone and, more likely than not, contributed to her death.<sup>99</sup> In the absence of any other information furnished by the hospital, we find High Point Hospital’s decision to discharge CaSonya King to the street on June 28, 2018 with only a plan to go to a shelter, contributed to her tragic death approximately 30 hours later. DLC also agrees with DMH that the hospital’s actions amount to dangerous practices, but in CaSonya’s case, these consequences were deadly.

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A licensed clinical social worker employed at HPH is quoted in the DMH Investigation Report as stating that she “was getting pressure from multiple places[/people]” to discharge CaSonya, and that Dr. A. had said CaSonya “needed to be out before the court date [because otherwise] it would be considered a frivolous lawsuit...”<sup>100</sup> Additionally, the LICSW also told the DMH investigator: ***“I did not have a safe plan for the discharge of [CaSonya King] and one other patient that same date. I didn’t like it.”***<sup>101</sup>

Additional cause for concern regarding HPH’s motivation for discharge stems from notes in medical records from both St. Elizabeth’s and Carney Hospitals, stating as follows: ***“44 yo F w/PMH of schizophrenia recently discharged from an admission after insurance ran out (but apparently was still felt to be unsafe for discharge and BEST team was notified to be on the look-out for patient.”***<sup>102</sup> DLC has been unable to determine the original source of this information, but it seems most likely to have come from HPH. Without definitive information available in the records from any

of the three hospitals, we explored whether financial interest or financial pressure could have been responsible for HPH's sudden decision to discharge CaSonya King.

We found during our investigation, that CaSonya King's medical insurance was MassHealth through BMC HealthNet Plan, and this particular managed care plan's behavioral health services managed by Beacon Health Options ("Beacon"), formerly known as Beacon Health Strategies.<sup>103</sup> After requesting bills from CaSonya King's hospital stay from HPH, we received only one bill, pictured below, for "inpatient Psych Unit" services between June 8, 2018 and June 25, 2018, sent to Beacon Health Strategies, in the amount of \$27,115.00.



(Image of bill in the amount of \$27,115.00)

DLC also requested all financial and billing records from Beacon for CaSonya King, during this time period and under her BHS[Beacon Health Strategies]/BMC Health New Plan Policy. In response to this request, we received records from Beacon indicating three bills were sent by HPH to Beacon for services it says it provided to CaSonya King during the relevant time period:

M2581002238	6/8/2018 - 6/25/2018	114-00 (Inpatient Mental Health)	F20.9 (Mental Health Services)	\$27,115.00	\$0.00	21	\$0.00	High Point Treatment Center, Inc.	TOB (Type of Bill) and discharge status combination is invalid. Resubmit with valid information.
M2551001047	6/12/2018 - 6/12/2018	114-00 (Inpatient Mental Health)	F20.9 (Mental Health Services)	\$1,595.00	\$0.00	21	\$0.00	High Point Treatment Center, Inc.	Claim received more than 60 days after date of service.
M2331040808	6/7/2018 - 6/7/2018	S9485-HE (Adult ESP Community Based)	F20.9 (Mental Health Services)	\$600.00	\$0.00	11	\$0.00	Riverside Community Care	Claim received more than 60 days after date of service.
M2271009161	6/26/2018 - 6/26/2018	114-00 (Inpatient Mental Health)	F20.9 (Mental Health Services)	\$1,595.00	\$737.00	21	\$737.00	High Point Treatment Center, Inc.	Approved

(Image of paid and unpaid charges for in-patient services at HPH.)

The first line in the above document relates to in-patient mental health services provided to CaSonya King between June 8, 2018 and June 25, 2018. The charge amount of the bill was for \$27,115.00, the same as the amount of the bill we received from HPH. Beacon's records state that the Approved Amount (column six) and Amount Paid (column eight) were both \$0.00. The Final Status (column eleven) or reason for declining payment is that the "TOB (type of bill) and discharge status combination is invalid. Resubmit with valid information." There is no indication from the Beacon records sent to us that this bill had been re-submitted again.



The second and fourth line of the document above indicate that HPH did send to Beacon other bills for services rendered during overlapping days covered by the first bill. The second line reflects a bill sent by HPH to Beacon for in-patient mental health services delivered on June 12, 2018. This claim was also not approved and not paid because the “Claim [was] received more than 60 days after date of service.” (See line two, column eleven). The final bill, on the fourth line of the record shown above, indicates that HPH billed Beacon for in-patient mental health services on June 26, 2018. This bill, in the amount of \$1,595.00 (column five) was approved for the amount of \$737.00 (column six) (presumably the Medicaid contract rate) with Beacon’s records indicating payment in the same amount (column eight).

In sum, review of the available records indicates that HPH was paid for only a fraction (\$737.00) of the amount it billed CaSonya King’s insurer (at least \$27,115.00). These records are not sufficient for us to conclude that CaSonya’s discharge was attributable to financial reasons. However, in combination with notes in the St. Elizabeth’s and Carney Hospital records that CaSonya’ King’s discharge from HPH was because her “insurance ran out,” we believe that this topic warrants further investigation by DMH.

### **C. DMH Failed to Respond with Meaningful Corrective Measures and Sanctions**

DMH conducts investigations of certain deaths involving DMH clients. All licensed acute private and general hospitals with in-patient psychiatric units are required to notify the DMH Licensing Division of incidents or conditions that occur on the unit no later than the next business day. When a serious incident or death is known to have occurred within thirty (30) days after discharge, it must be reported to DMH immediately and in writing by one business day.<sup>104</sup> One type of incident that requires notification to the Licensing Division is what is referred to as a medicolegal death. DMH Regulations (104 CMR § 32.02) define medicolegal death as:

- (a) any death required by M.G.L. c. 38 § 3, to be reported to the Medical Examiner;
- (b) a death in which the Medical Examiner takes jurisdiction.

M.G.L. c. 38 § 3 includes a long list of circumstances that may qualify a death as medicolegal for reporting purposes and one of those is “death by accident or unintentional injury.”<sup>105</sup>

CaSonya’s death was considered a medicolegal death and DMH conducted a thorough investigation pursuant to these requirements. The DMH investigation resulted in an investigation report with findings and recommendations by the investigator<sup>106</sup> issued on June 28, 2018.

The DMH investigation following CaSonya King’s death was largely speedy, thorough, and accurate. In the space of less than sixty (60) days, the DMH

investigators reviewed and analyzed over 400 pages of records, interviewed an array of witnesses (about fourteen (14) persons or agencies) about a complex factual story, and made detailed factual findings in an eighteen (18) page report. While DLC has had much more time to review the evidence, we found that the findings made by the DMH investigators were close to our own conclusions, with relatively few exceptions. We believe their work should be commended.

The DMH Director of Licensing, approved the investigator's report on August 21, 2018, and on August 30, 2018 issued a decision letter,<sup>107</sup> finding that

*High Point Hospital staff acted in a manner that was dangerous (as the term is defined in DMH regulation) in regard to the care and treatment of the client. [<sup>108</sup>]*

The Department ultimately concluded that HPH's care and treatment of CaSonya King was dangerous and made specific subsidiary findings,<sup>109</sup> including:

- The patient did not get to see a commitment attorney and the three-day notice was missing from her file;
- Her mother/guardian and respite staff clearly state that at the close of the discharge planning meeting they informed HPH that the respite would take CaSonya back, yet HPH disputes this;
- CaSonya was discharged to Boston, a large urban environment with which she was unfamiliar and lacking in close family or other supports;
- HPH records show that the Pine Street Inn told HPH that they "cannot accommodate hospital discharge" and there is "never a definite opening for a bed" and that her best chance would be arriving by 3 p.m.;
- Important documents in the file were incomplete, including even the Treatment Plan;
- Records concerning prescribed medication were unclear;
- Records concerning whether or not the patient attended groups were unclear; and
- The client was discharged with an aftercare plan that was evidently not achievable through means immediately available to her.

Again, these findings, based upon the strength of the Department's investigative work, were well formulated conclusions based upon the factual evidence. *But to what end?* Our strong objections relate to what followed.

*Where DMH fell short, we believe, was in not formulating a rigorous corrective action plan for HPH.* Despite its finding, the DMH only directed HPH to review a variety of policies and practices and to report any changes that were or would be made to hospital policies and practices, "as well as provide verification that all hospital staff have



been fully educated about the above policies and the hospital's expectation of staff."<sup>110</sup> It asked HPH to respond by September 13, 2018.

*DMH did not call the licensing authority of HPH into question, conditioning their license upon specific remedial measures. The Department did not even require specific corrections or revisions to HPH policies. HPH was left to conduct its own review of its policies and the sufficiency of its training program for staff. Nor did it ask HPH to address unanswered factual questions identified in its own investigation, or in the factual record generally. The questions left unanswered by DMH included:*

1. Why was CaSonya discharged to the street?
2. Does HPH claim that this was with her consent? If so, why? Where is CaSonya's consent recorded in the record and how can it be reconciled with records in the file that explicitly reflect that CaSonya did NOT want to be discharged to the street or a shelter?
3. Is it HPH's position that CaSonya was capable of consent at the time of discharge? How can this position be reconciled with other parts of the record that reflect that she was delusional and disoriented?
4. Do they agree that CaSonya was discharged without notice to her guardian? Is this because HPH did not understand she was guardian? Why did staff misunderstand the nature of that relationship in spite of the documents provided?
5. Was CaSonya's discharge an error by one employee, or many employees? If so, will the hospital be taking personnel action and why or why not?
6. Was CaSonya's discharge a failure to comply with a known policy or a failure to understand the policy? Or was the policy or practice itself inadequate? If so, in what way(s)?
7. Had HPH's training been insufficient, and if so, why? What specifically would be necessary to improve it beyond a general admonition to retrain staff?
8. Was HPH paid? Does the complete record reflect a decision by the insurer not to pay in whole or in part? How much was HPH paid and when and what charges were not paid? If the insurer declined payment for all or part of CaSonya's stay, did this affect their decision to suddenly discharge her?
9. Were HPH's erroneous decisions with respect to CaSonya influenced by actual or perceived pressure from management?
10. Which HPH staff spoke with staff at Carney and St. Elizabeth's, and why did those hospitals then record that the HPH discharge was because CaSonya's "insurance ran out?"
11. Why was HPH unwilling to wait another day to discharge CaSonya given that a community provider had been identified?

12. Did Dr. A. believe that, if HPH had cancelled the pending court date, “we have to discharge her in the moment?” Did Dr. A. believe that medical staff had potential liability? If so, why?
13. To exactly what location was CaSonya discharged? Why was Boston chosen, and why was this location chosen? Why was she not brought to the shelter itself or why did she not check in? What protocols are in place for recording this type of information and why were they not followed?
14. Has HPH conducted any internal investigation of CaSonya King’s discharge and her death one day later? If so, with what results?
15. In doing so, did HPH determine why two discharge documents were electronically signed a day after CaSonya’s death, and not before her discharge? Were any prior drafts of those documents reviewed?
16. Have other HPH in-patients also been discharged to the street or to shelters unnecessarily? If so, with what results? What happened to the other patient referenced by HPH’s LICSW who had been discharged at around the same time as CaSonya?

Nor, in the absence of answers to these questions, did it ask HPH to *assess the need for disciplinary action against any employee*. Finally, the Department did not (to our knowledge) undertake an *internal inquiry to answer the question why its own representative did not attend the HPH discharge meeting*.<sup>111</sup>

On September 20, 2018, the HPH Hospital Administrator responded in writing to the DMH August 30 decision letter by confirming that they had reviewed hospital policies and practices in four areas identified by DMH. HPH also confirmed that they had revised one policy on discharge and aftercare planning and written another policy on discharges to shelters.<sup>112</sup> They stated they reviewed and educated hospital staff about four other policies and reviewed with staff a fifth policy related to medication management, providing individual education to the doctor in question. They also provided three dates in September 2018 when staff education had taken place. To our knowledge, no other action was required of the hospital. Although DLC agrees with the requirements that DMH imposed on HPH, DLC finds that they were insufficient in light of such a significant tragedy. DMH’s measures fell short of the strong measures against HPH that were warranted.

***In light of this tragic and senseless death, we find the Department’s remedial action to be vague and incomplete, especially in light of their zealous and commendable investigation and detailed factual findings that preceded it. DMH made no meaningful effort to answer, or more aptly, to require the hospital to investigate and to answer for itself, and for DMH, these critical questions. This lack of rigorous oversight devalues the lost life of CaSonya King and undermines the Department’s core mission: to provide access to quality treatment and supports to meet the needs of individuals with mental health challenges, enabling them to live, work and participate in their communities.***

## V. Comments by High Point Hospital and the Department of Mental Health and DLC's Responses and Recommendations

### A. High Point Hospital (HPH)

We had telephone calls and a virtual meeting with HPH counsel and staff, including the Chief Quality Officer and the Chief Human Resources Officer to discuss our preliminary findings. As noted above, HPH has since stopped providing in-patient mental health services and staff stated that as a result there was no one currently on staff with any knowledge of CaSonya's story. HPH stated that Dr. A was no longer working there, and that they had no knowledge of her treatment or discharge beyond what was recorded in the medical file. They also could not say if HPH conducted any internal review in light of CaSonya passing away a day following her discharge, or in response to the DMH investigation done after her death.

It was particularly concerning that HPH had no record of the location to which CaSonya was brought on her day of discharge. Our records request was well within the time period under which the hospital was required to retain these and other records.<sup>113</sup> Yet, they were unable to tell us the location to which CaSonya had been brought; the reason(s) why she had not been brought to, or at least admitted to, the Pine Street's Women's Inn, as planned; who brought her to Boston and when, or any other relevant details. We find this response baffling. Nor were they able to explain if the hospital had protocols for recording this information in CaSonya's file.<sup>114</sup> DMH was also unable to obtain this information from HPH, when investigating shortly after CaSonya's death. The result, is that after extensive reviews, DLC has not been able to answer one of the most critical questions surrounding CaSonya's last days: ***Why did CaSonya not check into the Pine Street Inn, and at what exact location nearby was she left by HPH staff, and why?***

In the course of drafting this report, we have not actively solicited comments from HPH, because we previously met with their staff and counsel to relay our preliminary findings, and more importantly, because they repeatedly maintained that they had no knowledge of the treatment CaSonya received or her discharge, beyond the information recorded in her medical file. They have told us that they have nothing else, they are no longer providing in-patient mental health services, that staff working there at the time are no longer employed, and they are unable to provide more on the subject. We have, however, provided a draft copy of this report to HPH counsel over two weeks in advance of its public release, asking for questions or concerns.

Given that High Point Hospital no longer provides in-patient mental health services, it is difficult to propose a corrective action plan for HPH. As we have explained, DMH's remedial plan for HPH, developed while HPH was still providing outpatient services, lacked sufficient content and rigor, and was not appropriately tailored to address the scope of deficiencies illustrated by these tragic events.

All DMH facilities and all DMH licensed hospitals should adopt the best practices listed below to facilitate hospital discharges which are safe and effective for the person served. If HPH seeks to obtain a license in the future for delivering in-patient mental health services, it should be required to demonstrate its ability to comply with these practices.

#### Best Practices For Licensed Facilities:

1. Develop and implement policies and procedures to ensure that the individual's **individualized treatment plan** is completed as soon as possible following admission. The individualized treatment plan must capture all pertinent information and data regarding the person's recent history, including but not limited to, age, medical status, vital signs, recently prescribed medications, current diagnosis, risk assessments, medical history, substance abuse and trauma history;
2. Develop and implement policies and procedures consistent with state regulations to ensure that, prior to starting a individual on a medication regimen, **all risks and benefits associated with both the proposed medication**, including all potential interactions, and all medications taken on or before admission are fully discussed with the individual. Where the person is not competent to consent, the protections of a *Rogers* guardianship must be undertaken, in situations whether the patient's spoken position is one of assenting to or rejecting the medication. Additionally, hospital must ensure that all prescribing staff are trained as to the importance of a clear medical record that details why each medication has been prescribed and whether or not each medication is necessary or considered a PRN;
3. Develop and implement policies that facilitate **timely and effective communication between treatment teams in the facility and each patient's service providers in the community**, when applicable and when the individual or their legal guardian signs an authorization for release of medical information. Hospitals must ensure the policies and training is clear regarding the treatment team's duty to attempt to open this line of communication as soon as possible;
4. Develop and implement policies that ensure that treatment teams **begin the discharge planning process for each individual immediately upon admission, or as soon as possible thereafter**, and that the process is conducted in a person-centered manner, **including the patient, any guardian, family members the person chooses to participate, and community support persons or staff** that the person is working with through state or other relevant agencies.
5. Train hospital staff, including, but not limited to, all attending physicians, nurses, psychologists, social workers, and mental health workers on the different definitions and requirements of G.L. c. 123, where applicable, as

well as **the definitions and requirements related to temporary and permanent guardianships**. This training should be given to all staff at orientation and at least once a year.

6. Develop and implement a **“No Patient Dumping” policy, precluding discharge to a homeless shelter or to the street, in all but extraordinary circumstances**, to be narrowly defined in writing in keeping with 104 CMR § 27.09(1)(b).
7. Implement a written policy **precluding discharge to the street or a homeless shelter where there is a very substantial risk of physical impairment or injury to the individual** because their judgment has been affected and so they are unable to protect or care for themselves in the community and that reasonable provision for their protection is not available in the community, in keeping with G.L. c. 123.
8. Develop and implement a policy of **requiring informed consent by the individual as to any discharge to the street or to a homeless shelter, and notice to any guardian, absent extraordinary circumstances**.
9. Require all hospital staff providing transportation to discharged individuals to **maintain a transportation log showing** the time and location where the individual leaves the hospital vehicle and to record any reason for any deviation from the discharge plan.
10. Develop and/or strengthen and implement **any written policy related to whistleblowers, including the ability of staff to object without fear of retaliation** to decisions which may place individuals at risk of harm.<sup>115</sup>
11. Develop and implement written **policies precluding the copying and pasting of previous treatment notes** to avoid confusion and ensure accuracy of the medical record.
12. Ensure that **discharge summary notes clearly identify the treatment** that an individual did or did not receive, rather than only providing a form statement as to what was offered.
13. Develop **necessary training on implementing each of these policies** and procedures. All staff, including administrative staff, should receive training in these policies and procedures both when initially launched and every six months thereafter. In formulating its training programs, hospitals should ensure that the training is **effectively presented and received**, including a robust testing/monitoring plan to ensure that the critical lessons learned from this tragic death are not repeated in the future;
14. **Report to state licensing agencies providing relevant documentation, the dates of the trainings**, names and positions of persons trained, and the

training curriculum used in implementing these policies and procedures no more than thirty days after the completion of each training.

## **B. Massachusetts Department of Mental Health (DMH):**

We acknowledge with appreciation the cooperation of DMH counsel and staff with this investigation, including their candor and transparency, and willingness to receive comments about their investigation and larger policy issues in the interest of strengthening the Department's important work.

DLC staff had two virtual meetings with DMH counsel and the director of their licensing division, in which we discussed our preliminary findings. Overall, DMH responded in three ways to the concerns we voiced. First, DMH expressed regret over not following up on certain issues raised by their decision letter and the hospital response, including whether any disciplinary or corrective action (other than the policies and staff trainings described above) were taken by the hospital as a result. DLC appreciates this candid response from the Department, as well as their expressed commitment to this needed level of oversight.

Second, DMH explained to us that it struggles with defining its role as a licensor, and what it may require of hospital "licensees," noting that they are not a malpractice tribunal. Their role, they maintained, centers instead on "did they have policies, were the policies adequate, and did they follow those policies," with the Department taking a limited role in the absence of a gross dereliction of duty.

We respectfully disagree.

DMH is granted broad powers by the legislature to "take cognizance of all matters affecting the mental health of citizens of the Commonwealth..." Specifically, the Department is granted "general supervision of all private facilities..."<sup>116</sup> It also may designate those private facilities that are admitted for the purpose of voluntary or involuntary hospitalization under G.L. c 123.<sup>117</sup> DMH correctly points out that the concept of "general supervision" likely does not include the ability to oversee daily decisions made by private hospital clinicians, as they are executed. However, DMH has broad statutory authority to investigate hospitals to enforce compliance and has adopted extensive regulations to that end.<sup>118</sup> Its statutory licensing authority includes the ability to grant or suspend, revoke, limit or restrict licenses for cause, to adopt licensing regulations, to supervise, to visit and inspect and to adopt operational standards, to impose civil fines for a failure to remedy, and to seek judicial relief.<sup>119</sup> As the SJC noted last year,

Facilities are heavily regulated for the particular mental health services they provide. To obtain a license from DMH, a facility must submit an extensive application including written plans for delivery and supervision of clinical services by qualified personnel, its plan for assuring adequate and appropriate staffing, and plans for physical adaptations.....Facilities

are required to have sufficient trained staff and to maintain staffing to meet the operational capacity of the facility at levels deemed appropriate by DMH.<sup>120</sup>

These operational standards include, as discussed above, defining the circumstances under which a private hospital may discharge a resident to the street or to a homeless shelter.<sup>121</sup> The existing statute provides DMH with ample authority to take a hands-on approach in requiring additional fact-finding by the licensee, and crafting a specific enforceable corrective action plan, or requiring the hospital to undertake this task.

Finally, to its credit, the Department expressed a willingness to look more closely at “third prong cases,” the adequacy of services and supports and the frequency with which discharges have been made to homeless shelters or the street, notwithstanding DMH regulations. DMH staff stated that anecdotally they do not believe that large numbers of people are being discharged to the shelter or the street. Specifically, they stated that quarterly reports showed some facilities with fewer than 5 such discharges per quarter per facility (i.e. fewer than 20 per facility), and some facilities with more than 5 such discharges per quarter (i.e., greater than 20 per year per facility), with the variation correlating with facilities in urban areas and larger facilities with larger numbers of admissions and discharges. (There are about 16 DMH licensed freestanding psychiatric hospitals, in addition to about 8 DMH run units or hospitals, and about 41 DMH licensed psychiatric units located within acute care hospitals.<sup>122</sup> Both DLC and DMH agreed that more data collection may be necessary. We have addressed this subject in more detail below.

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We recommend DMH require that as a condition of being granted any license to provide in-patient mental health services in the future, that **HPH demonstrate its ability to comply with the best practices above, and that DMH exercise its licensing authority to require all of its facilities to follow the practices set forth above**, where applicable, to inpatient or outpatient facilities licensed by the Department.

**We further urge DMH to strengthen its regulations that are designed to deter or prevent discharges to the street or to shelters.** These regulations should explicitly require informed consent by the individual and/or their guardian. They should also require documentation by the provider concerning the basis for believing that the individual will not face a likelihood of very substantial risk of serious harm from being discharged to the street or to a shelter. In our comments submitted to DMH on May 1, 2019, regarding proposed changes to DMH regulations, DLC requested this change be adopted. DMH declined to do so at that time.<sup>123</sup> We request that they reconsider this decision.

In undertaking this action, **we also urge the Department to guard against any unintended consequences from more scrutiny brought to this question.** It is important that providers not discriminate against unhoused persons, or be prevented or deterred from providing mental health services to them for fear of being questioned by the Department if, following services, the person served voluntarily returns to a shelter or to the street.

In addition, **we recommend that DMH modify the form already used by hospitals to provide DMH with notice of an “incident,” including a death, occurring within 30 days of discharge.** The form<sup>124</sup> contains short blanks for the “description of the incident” and the “review and findings” but does not require the hospital to state if the individual had been discharged to the street or to a homeless shelter, and if so, why. It should do so.<sup>125</sup>

DMH must also **adopt policies to ensure that unnecessary and unavoidable deaths of Department clients following discharges to the shelter or the street are addressed by detailed and sweeping corrective and enforcement measures.** The hospital certainly should be **required to make its own factual findings regarding important questions that were left unanswered in DMH’s own investigative reports** and to relay those answers back to DMH. It is difficult for DMH to formulate effective remedial measures without either the hospital or DMH knowing exactly what went wrong, when and why.

In some serious cases, the Department’s measures **should include conditioning continued licensure on changes in managerial or direct services staff.** Other approaches include **document review; rigorous but time-limited oversight of certain functions (discharge, treatment, etc.); requiring the hospital to obtain expert assistance or an expert review; unannounced inspections, and, potentially, probationary status for the program, or a loss of a DMH license.** *Retraining, or merely directing a hospital to “[r]eview the hospital policy and practice...” is a woefully insufficient response.*

Finally, we recommend that **DMH engage in data collection and analysis to measure more precisely the extent to which involuntary discharges to the street or homeless shelters are taking place.** DMH receives quarterly self-reported data from hospitals, which should be disclosed publicly in aggregate form, at the hospital level. DMH explained that a larger number of persons discharged to shelters or the street come from hospitals in urban communities. Considering this, we are also concerned that **these practices may disproportionately impact individuals from communities of color or other marginalized communities who are already disproportionately represented** within the population of unhoused persons in Massachusetts. We would therefore **strongly recommend that demographic information be included in any data analysis and publicly disclosed.**

We would also encourage DMH to work with the Department of Housing and Community Development (DHCD) to review and analyze data gathered from the Homeless Management Information System (HMIS), the computerized data collection system used by state and federally funded shelters working under the Continuum of



Care program at HUD. This information, if completed in a comprehensive manner, should identify the prior residence or circumstances of the unhoused person, and whether they were discharged from a DMH licensed or other hospital. This will allow the Department to **assess the accuracy of its own quarterly reports from providers, and to take any remedial action necessary.** In the interest of transparency, aggregate client-level data from HMIS should also be **reported out to the public, showing the frequency and circumstances of discharges to the street or to shelters** from DMH administered or DMH licensed hospitals, on a hospital-level basis, and **should also include data from shelters on race, ethnicity, gender identity and age cohorts.**

DMH should **survey intake staff of homeless shelters and outreach workers** who serve unhoused persons who live on the street, to identify the extent to which those populations are comprised of individuals who are recently discharged from hospitals providing mental health services, and whether this data matches data reported by hospital licensees. Intake and outreach workers should be invited to assist their clients in contacting DMH area offices when their clients are DMH eligible and are otherwise at risk, to file licensing complaints, in addition to receiving services.

DMH should **undertake a deeper analysis of the underlying circumstances beneath these discharges.** Are these involuntary discharges to the street or to shelters, and if so, why were no other options made available? If they are classified as “voluntary” discharges, was there fully informed consent, freely given by individuals with other available options, who could understand and weigh the risks and benefits of their decision?<sup>126</sup> DMH could also use this opportunity to **identify whether there are sufficient supportive housing resources available** and whether enough placements are being freed up within its ACCS program.<sup>127</sup> Addressing this issue may require additional resources from the legislature for DMH supported housing in the community, as well as coordination with other agencies, such as the Department of Housing and Community Development, which administers much of the Commonwealth’s affordable housing resources.

DLC offers its cooperation to both HPH and DMH in addressing the recommendations outlined above.

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DMH Comments:

During May 2021, DLC provided DMH with a draft of this report. DMH then provided us with the following statement:

*DMH appreciates the DLC’s thoughtful and thorough investigation into the tragedy that Ms. King and her family suffered. We also appreciate the opportunity to provide our response to the DLC’s investigation report. The Department of Mental Health (DMH) agrees with the facts outlined in the DLC investigation. These facts are consistent with DMH’s findings. We*

do, however, respectfully differ on some of the conclusions drawn by the DLC after analysis of those facts:

- *DMH agrees that discharge to shelters should be a last resort, and except in cases where a discharge is ordered by the court and there is no alternative, should not happen in the absence of a patient's consent.*
- *Like DLC, DMH cited HighPoint Hospital for its failures in discharge planning, assessment, and documentation. DMH ordered corrective action in policy and training and had HighPoint remained in operation, we would have monitored its implementation of those corrective actions in an ongoing fashion. If HighPoint failed to properly follow through with any corrective action or if a pattern of deficiencies had developed, DMH would have had the opportunity to impose additional sanctions and possibly fines.*
- *We respectfully do not agree that Ms. King's tragic story is properly related to the phenomenon of patient "dumping" that DLC describes. That phenomenon, which is related to emergency care and covered by federal law (see EMTALA), is not relatable in this case. We believe that the extensive discussion of "dumping" dramatizes Ms. King and her family's tragedy, but for the wrong reasons.*
- *We look forward to working with the DLC to discuss its additional findings and to determine the viability of specific recommendations within DMH's licensing authority.*

While DLC has differing views on some of the points made above,<sup>128</sup> we appreciate the openness of the Department's response, and going forward, the willingness it expressed to review the scope of its licensing authority.

### C. A Final Observation

*Out of Time* was a project that proved to be longer, more time consuming and more detailed than many of our investigative reports as the Protection and Advocacy system for Massachusetts. We combed through extensive medical records and investigative documents, conducted interviews, undertook legal and factual research, consulted with the hospital and state oversight agency, discussed policy issues with experts and advocates, and attempted to make careful, deliberate, measured factual findings supported by citations to available records. Our goal was to tell CaSonya's story and call out the wrongs we concluded had been inflicted upon her. We also sought to bring attention to the untenable choices between institutionalization and homelessness faced by many people undergoing emotional distress. And we hoped to offer closure to CaSonya's family members, suffering with anguish over their loss.

After many pages written however, it may be more significant to note what still has been left unsaid and undone. We know a great deal about CaSonya's state of mind in the days before her discharge, enough to know that she did not want to be brought to a shelter, that she wanted to go to the respite instead. We know that CaSonya remained disoriented at the time of her discharge. She needed to be transferred to a location that would provide community-based, person-centered services and supports, so that her recovery could continue. Instead, she was left on the streets of Boston, and her life ended prematurely and needlessly, a day later.

But what we still do not know, after all of this effort, continues to weigh heavily upon CaSonya's family, as well as DLC staff who worked on this report. ***First, how can***

***it be that we do not know the location to which HPH brought CaSonya and why did she not make it into the shelter? Why does the hospital not have this information and why was DMH unable to obtain it during the investigation conducted immediately following CaSonya's death? And second, in response to DMH's decision letter issued after its investigation, what actions if any, did HPH take besides reviewing and revising its policies? Did the hospital undertake an analysis of why this discharge happened or take any personnel action as a result? Why do we not know the answer to this question, and why was this information not required by DMH, the licensing agency? CaSonya's family deserves answers to these questions, as does the public at large.***

Hospitals providing mental health services, including hospitals that hold and treat people involuntarily, are acting under legal authority granted by state government. They are not fully autonomous private businesses competing in a free market economy. If they act in our name, and at public expense, then we collectively ought to expect accountability. And if the system that empowers and regulates hospitals cannot deliver accountability, because hospitals are only "licensees," then it may be time to rethink how and where we deliver services to people who are experiencing extreme distress, or how we regulate providers.

DISABILITY LAW CENTER, INC.  
Boston, Massachusetts  
June 8, 2021

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## APPENDIX A: BACKGROUND ON PATIENT DUMPING

### 1. National Practices

Across the country there are plentiful examples of psychiatric facilities and hospitals who discharge patients onto the street or homeless shelters.

In 2007, the Hollywood Presbyterian Medical Center dumped a paraplegic man in skid row without a wheelchair and with no shelters or services around.<sup>129</sup> Witnesses describe a horrifying scene as the man crawled along with a colostomy bag while wearing a soiled hospital gown and clenching a bag of his belongings between his teeth.<sup>130</sup> Police were able to trace the incident back to the Hollywood Presbyterian Medical Center thanks to witnesses who wrote down the phone number and license-plate number on the van that dropped him off.<sup>131</sup> The hospital later paid \$1 million to settle this case.<sup>132</sup>

In 2009, the L.A. District Attorney's office reached a settlement with College Hospital in Los Angeles related to 150 people with mental health challenges whom the hospital dumped on L.A.'s Skid Row between 2007 and 2008. The hospital agreed to an injunction and to pay \$1.6 million dollars.<sup>133</sup>

In 2016, Good Samaritan Hospital in Los Angeles, California settled a lawsuit for \$450,000 based on allegations that, after treating a man for a severe infection, the hospital gave the man a bus token and discharged him with no plans for future care.<sup>134</sup> The man had to be hospitalized again after his infection worsened.<sup>135</sup>

In January 2018, The Baltimore Sun and the Associated Press reported an incident in which four security guards from the University of Maryland Medical Center Midtown in Baltimore dumped a 22-year-old woman on the street wearing only a hospital gown on a night with below freezing temperatures.<sup>136</sup> She had no shoes and no underwear.<sup>137</sup> The woman's mother reported that her daughter was mentally ill and suffered from Asperger's syndrome.<sup>138</sup> A passerby stopped to film the incident. The footage follows the woman getting dropped off and then stumbling to a nearby bench.<sup>139</sup>

In July 2018, the *LA Times* reported that the Silver Lake Medical Center in Los Angeles, settled a lawsuit for \$550,000 after allegations of more than 750 cases of illegally dumping patients.<sup>140</sup> The medical center produced documentation in which mentally ill, homeless patients consented to being dropped off at shelters.<sup>141</sup> However, the patients were actually dropped off at bus and train stations.<sup>142</sup>

In November 2018, a jury awarded \$250,000 to each participant in a class-action suit against Rawson-Neal Psychiatric Hospital in Las Vegas, Nevada.<sup>143</sup> The hospital regularly discharged patients by busing them across state lines and "dumping" them in unfamiliar cities.<sup>144</sup> Between 2008 and 2013, Rawson-Neal bused 1,500 patients out of Nevada.<sup>145</sup> Without any plans for further care in place, some of these patients died or went missing.<sup>146</sup> A class action related to these practice remains on appeal.<sup>147</sup>

In January 2019, the Arizona Republic reported that a nurse in Phoenix stopped to check on a man lying on a bus-stop bench to see if he was breathing.<sup>148</sup> The man had one swollen, red foot and the other was covered in gauze that was black with grime.<sup>149</sup> Half of the foot wrapped in gauze had been amputated.<sup>150</sup> An *Arizona Republic* investigation determined that at least two medical facilities had discharged the 67-year-old, mentally impaired man while he was injured.<sup>151</sup> Consequently, the man suffered an infection and required amputation again, this time up to the knee.<sup>152</sup>

In 2019, the Associated Press reported that the Oregon Health Authority (OHA) was reviewing a contractor's determinations regarding 1,600 patients in state-funded residential facilities.<sup>153</sup> The contractor was hired by OHA to determine whether these patients needed to continue care within these facilities.<sup>154</sup> Following disturbing reports of patients suffering serious harm after being discharged, the OHA has three mental health professionals reviewing all of the contractor's determinations.<sup>155</sup> Thus far, the OHA has reversed the contractor's decision to discharge 17 mentally ill patients.<sup>156</sup>

## **2. Examples of Patient Dumping in Massachusetts:**

A 2017 study from Clark University details some of the issues regarding patient discharge in the city of Worcester, Massachusetts. The study reported that, when homeless patients present for care, hospital staff are often too focused on getting the patients discharged as soon as possible.<sup>157</sup> This leads to premature discharges that often fail to account for the likelihood of the patient being cared for in the environment to which the discharge returns them.<sup>158</sup> This is one of the issues that CMS sought to address by requiring mental health facilities to evaluate the likelihood of a patient's capacity for self-care or the possibility of the patient being cared for in the environment from which the patient entered the hospital.<sup>159</sup>

According to the Clark study, one instance of inappropriate discharge involved a middle-aged homeless man who presented to UMass Memorial Medical Center for respiratory symptoms in February 2017. Following treatment, the hospital failed to follow the discharge plan that social workers, members of the hospital's medical team, and Police CIT officers had designed to keep the man from ending up on the streets.<sup>160</sup> The man was found under a bridge, "unable to stand and frozen to the ground after urinating on himself and it freezing him to the concrete." The man was taken back to UMass, treated for frostbite and necrosis and discharged two days later with instructions to "follow up with plastic surgery."<sup>161</sup> The man was later found with both feet necrotic and black in color. Consequently, the man had to have both feet amputated and, because the infections spread up his legs, he was "fighting for his life" at the time of the Clark University study.<sup>162</sup>

### **3. Risks and Costs Associated with Homelessness and Life on the Street and in Homeless Shelters**

Homelessness census research done by the Massachusetts Housing and Shelter Alliance in the 1990s helped to dispel the myth that people experiencing homelessness are unknown persons who have fallen through gaps in the social services safety net.<sup>163</sup> In fact, many of these individuals are very well known to human services systems and arrive on the street after failures in discharge planning.<sup>164</sup> While only a segment of the homeless population has mental health issues, individuals who do are often cut off from desperately needed supports. One study revealed that fewer than half (41 percent) were successfully connected to outpatient services within thirty days of discharge from a prior hospitalization.<sup>165</sup> The interventions that should be made available for these individuals include a choice of supportive or supported housing, more intensive case management, appropriate outpatient services, and self-help groups.<sup>166</sup>

Whatever the risks are for persons without disabilities living in homeless shelters<sup>167</sup> and on the street<sup>168</sup>, the risks for homeless persons with disabilities are exponentially higher. They are more likely to experience risks to their health and safety and gaps in medical and mental health care,<sup>169</sup> often with dangerous consequences.<sup>170</sup> They are more likely to be victims of crime.<sup>171</sup> And, they are less likely to be able to alter their own circumstances, to return to a safe and stable living environment.<sup>172</sup> For these reasons, people who are discharged to shelters or the street may experience relapses in their mental health issues that essentially reverse the stabilization previously achieved during a hospitalization. Thus, the human toll of poor discharge planning is obvious.

In addition, when people with mental health challenges become homeless, we shift additional burdens onto our already strained mental health system. The previous efforts of other mental health professionals and care providers may need to be repeated.<sup>173</sup> And the discharging hospital is now exposed to liability, including the possibility of sanctions and civil litigation.<sup>174</sup>

From the perspectives of the shelter provider and the homelessness advocate, individuals with complex disabilities will also need greater resources from the human services system. Many will face greater stigma in obtaining permanent housing. Others will need greater financial resources or accessibility features not often found in the private marketplace. Finally, when, as here, individuals are shipped to urban centers where they have no meaningful ties, human services workers will be taxed with additional burdens either in finding housing in that new community, or elsewhere in the individual's hometown.<sup>175</sup>

*Dr. Jeffrey Geller, director of public sector psychiatry at the University of Massachusetts Medical School, has observed that profound consequences ensue when psychiatric patients are bused out of town, without proper treatment or arrangements for future care. These include: "New jail and hospital occupants. Burdens to general hospital emergency departments, courts, sanitation departments and mayor's office." For the affected individuals, "there is a further estrangement from any natural supports that might exist, and an increasing sense in the individual with mental illness of being unwanted and unworthy."*

--United States Commission on Civil Rights, Statutory Enforcement Briefing, March 14, 2014, Comments by Staci Pratt, Legal Director, ACLU of Nevada (footnote omitted).



## ENDNOTES

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<sup>1</sup> Given that both mother and daughter share the same last name, we will refer to Angela King using that name or as “Ms. King” and will usually refer to CaSonya King by her first name only (“CaSonya” or “Sonya”), to avoid confusion. We intend no disrespect or informality in doing so. Names of individual clinical staff have been omitted or changed to pseudonyms or job titles (“Dr. A.”, “LICSW” etc.).

<sup>2</sup> See <http://www.hptc.org/hospital.php> for more information about this facility. At the time of CaSonya King’s death, High Point Hospital (HPH) was a private, DMH-licensed psychiatric facility in Middleboro with in-patient capacity to serve 72 individuals. It also had other substance abuse units. Since then, in the early fall of 2019, HPH closed its Middleboro in-patient psychiatric unit due to a decrease in admissions and financial losses, while maintaining outpatient services there. We believe that it remains important nonetheless to issue this public investigative report, both because HPH administers other in-patient units, and because the policy issues that gave rise to this tragedy are not specific to this one provider.

<sup>3</sup> See Appendix 1, Order of Temporary Guardianship

<sup>4</sup> High Point Hospital DAP Note, at 6/29/18 1:47 PM. A hospital has the right to discharge a patient who has signed a three day note, even when it has then sought civil commitment, but it does not ordinarily have the right to discharge this person to a shelter or the street, absent efforts to identify and offer “alternative options” and the “competent refusal” of such “alternative options,” documented in the medical record. See 104 CMR 27.09(1)(b). A “competent refusal” is best understood within the context of the definition of informed consent found in 104 CMR 27.02: “**Informed Consent.** The knowing **consent**, voluntarily given by the patient,... who can understand and weigh the risks and benefits of the particular treatment, including medication, being proposed.” An admission to a psychiatric facility, or even a civil commitment, does not alone establish that one is incapable of giving informed consent. G.L. c. 123, § 24.

<sup>5</sup> On June 25, 2018, DPH’s discharging clinician met with CaSonya and stated that she is “looking forwards [sic] going to respite tomorrow.” High Point Hospital DAP Note, Dr. A., 6/25/18 5:25 p.m. The following day, in a note from June 26, 2018, HPH’s discharging clinician, states that CaSonya that she “have [sic] asked to be discharged to a shelter.” High Point Hospital DAP Note, Dr. A., 6/26/18 4:58 p.m. However, another treatment note explains that two minutes later, at 5:00 p.m., she as given Valium because of “a screaming conversation with herself that was frightening other patients.” High Point Hospital DAP Note, 6/26/18 5:46 p.m. In addition, the following day, June 27, 2018, the date of her discharge, CaSonya was informed by her clinician that a shelter was her “only option.” According to HPH’s own records, CaSonya stated in reply. “I don’t want to go to the shelter. I want to go to the respite.” She left the office and she refused to sign the discharge summary. High Point Hospital DAP Note, 6/27/18 12:22 p.m.

<sup>6</sup> As discussed below, this is a subject of dispute between the CaSonya’s mother and the respite staff, on the one hand, and HPH staff on the other.

<sup>7</sup> See 104 CMR 27.03(23)(h)(1) and (2); <https://www.mass.gov/service-details/dmh-licensed-inpatient-facility-incident-notification-forms>.

<sup>8</sup> See Mass. Gen. Laws c. 38 § 3(2).

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<sup>9</sup> Department of Mental Health, Investigation Report # 18-HPH-004, dated August 21, 2018 at p. 15.

<sup>10</sup> See Department of Mental Health Decision Letter on Complaint Log #18-HPH-004, dated August 30, 2018.

<sup>11</sup> 104 CMR 32.00 defines ‘dangerous’ as posing “a danger or the potential of danger to the health or safety of a client.”

<sup>12</sup> See Department of Mental Health Decision Letter on Complaint Log #18-HPH-004, dated August 30, 2018.

<sup>13</sup> 42 U.S.C. §10805(a)(1)(A).

The PAIMI regulations define the terms “abuse” and “neglect” as follows:

*Abuse* means any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes but is not limited to acts such as: rape or sexual assault; striking; the use of excessive force when placing an individual with mental illness in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue.

42 C.F.R. § 51.2.

*Neglect* means a negligent act or omission by an individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes but is not limited to acts or omissions such as failure to: establish or carry out an appropriate individual program or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care; and the failure to provide a safe environment which also includes failure to maintain adequate number of appropriately trained staff.

42 C.F.R. § 51.2.

<sup>14</sup> 42 U.S.C. §10805(a)(1)(A)

<sup>15</sup> Sources of complaints made to the P&A are ordinarily kept confidential. In her capacity as Personal Representative of the estate of CaSonya King, Ms. Angela King has consented to our disclosing her identity as a complainant as well as all of the specific information released in this public report.

<sup>16</sup> U.S. Commission on Civil Rights, *Patient Dumping*, at 13 (2014), available at [https://www.usccr.gov/pubs/docs/2014PATDUMPOSD\\_9282014-1.pdf](https://www.usccr.gov/pubs/docs/2014PATDUMPOSD_9282014-1.pdf). Patient dumping has been defined as “the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere.” Pithia, “Patient Dumping: The Cobra That Never Struck,” 24 S. Cal. Rev. L. & Soc. Just. 109, 111 (2014), quoting David A. Ansell & Robert L. Schiff, “Patient Dumping: Status, Implications, and Policy Recommendations,” 257 J. Am. Med. Ass’n 1500, 1500 (1987). While the colloquial term “patient dumping” is most commonly associated with EMTALA, it is equally applicable to other situations where patients who have not been stabilized are transferred without adequate supports and services in place.

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<sup>17</sup> Thomas L. Stricker Jr., *Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 Notre Dame L. Rev. 1121, 1129 (1992).

<sup>18</sup> Rebekah L. Sanders, Arizona Republic, *A Good Samaritan Found Martin with an Amputated Foot at a Bus Stop. Why Was He There?* (2019) available at <https://www.azcentral.com/story/news/local/phoenix/2019/01/08/phoenix-hospitals-dumping-homeless-patients-martin-amputated-foot-health-care-medicare-medicaid/1861487002/>.

There are many upstream, systemic causes of discharges to the street and to shelters, all beyond the scope of this Investigation Report. These include care providers that operate under cost pressures without adequate and coordinated community resources for stepping down patients, an absence of tools to hold beds or units in the community, and a fragmented and medicalized fee-for-service care system that prioritizes short term hospitalization over long term community supports and services. See generally, Sidney Watson, *Discharges to the Streets – Hospitals and Homelessness*, 19 St. Louis Pub. L. Rev 357, 367, 369 (2000).

The lack of affordable and accessible housing is also a major contributing factor, as is the lack of a right to counsel in summary process eviction cases or in civil cases seeking injunctions that will dispossess the tenant. Tenants facing a mental health crisis are likely to go unrepresented at exactly the time when they are most at need of legal assistance. After recovery, they may have no home to which to return. Every week, 750 tenants face eviction in Massachusetts, with 80% of landlords and only 9% of tenants being represented by counsel. See <https://bostonbarjournal.com/2019/11/14/where-a-lawyer-makes-all-the-difference-and-only-one-side-has-one-adjarte-y-and-the-urgent-need-for-court-reform-and-a-right-to-counsel-in-eviction-cases/>

It is also important to note that there are different types of former patients placed at risk by these practices. This includes people who were previously housed prior to their mental health care such as CaSonya King. There also many who lose their housing while hospitalized. In addition, there are previously homeless people who become hospitalized, and are then discharged back onto the street, unhoused, sometimes now less likely to survive either life at a homeless shelter or exposure to the elements.

For the purposes of this report, “homelessness” refers to the experience of unhoused single (“unaccompanied”) persons who may rely upon a decentralized system of public and private shelters that may receive a mix of public and charitable funds and which are relatively unregulated. Of the 18,000+ people experiencing homelessness in Massachusetts, about one-third of them fall into this category. Jolicoeur, “Overwhelmed Mass. Homeless Shelters Call for New Vision, Funding from State,” *WBUR News*, February 7, 2020. This stands in contrast to the experiences of unhoused families with children, who attempt to navigate through a very different system which has more resources and great governmental role.

<sup>19</sup> 42 USC sec 1395(dd). See also <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>.

<sup>20</sup> 68 FR 53222 at 53234 (clarifying 42 CFR § 489.24(b)) (2003).

<sup>21</sup> *Id.*

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<sup>22</sup> U.S. Commission on Civil Rights, *Patient Dumping*, at 7 (2014), available at [https://www.usccr.gov/pubs/docs/2014PATDUMPOSD\\_9282014-1.pdf](https://www.usccr.gov/pubs/docs/2014PATDUMPOSD_9282014-1.pdf).

<sup>23</sup> EMTALA differs from CaSonya's tragic story because EMTALA applies to emergency departments, rather than in-patient units in hospitals. It creates an obligation to stabilize or transfer, and generally limits the ability to transfer until the individual has been stabilized. Psychiatric patients are considered to have emergency medical conditions and not be stabilized when they are dangerous to themselves or others. And there is at least some legal authority for the proposition that a hospital cannot circumvent EMTALA by admitting the individual as an in-patient. See Martell, "*EMTALA & Psychiatric Patients*" 21 DePaul. Health Care L. 1 (2019). Our point is not that HPH is liable under EMTALA; in fact, she was never admitted into an emergency department. Rather, it is that EMTALA represents broader public policies that conflict dramatically with this discharge.

There is compassionate and quality behavioral health care at all levels of our system that merits praise. However, when people with mental health issues are in crisis, where staffing is short and funding is thin, it is also commonplace for those with time-consuming and challenging behaviors to be transferred or "dumped" into other more restrictive systems, or into no system at all. School children are pushed into restraint, seclusion or school disciplinary/expulsion processes and the juvenile justice system. Young people in the juvenile justice system are pushed into mental health programs and the adult criminal justice system, People receiving community mental health treatment are pushed into mental health institutions and *Rogers* guardianships. Individuals treated in mental health hospitals are pushed into more restrictive programs, the criminal justice system, and into homeless shelters. People living on the street unhoused, and people in homeless shelters are pushed backward into the civil commitment system or forward into prisons and jails. People in prisons and jails are pushed into long term isolation in segregation cells or pushed into Bridgewater State Hospital. And the data shows that most of these adverse outcomes tend to fall disproportionately on people of color, and/or individuals with other marginalized identities, or without adequate socio-economic resources.

We concede that sometimes relocating people to new settings is unavoidable. But transfers should move in the direction of more independence whenever possible, and more skilled, person-centered supports, whenever it is not possible. And we are transferring vulnerable people and not boxed cargo, and so each "transfer" leaves a person in crisis exposed to the possibility of falling between the cracks, in ways that will further undermine mental health and otherwise pose a risk of grievous harm or loss of life.

<sup>24</sup> 104 CMR 27.09(1) (emphasis supplied).

Current DMH regulations restricting discharges appear to have been adopted following public hearing in 2000. While there has been a long standing policy prohibiting such discharges dating back to 1983, <https://www.mass.gov/doc/policy-83pdf/download>, a 1998 census of Massachusetts emergency shelters reported over 800 unlawful discharges from psychiatric hospitals. As a result, DMH adopted a policy that prohibited DMH-run hospitals from discharging people to shelters or the street. According to one report, this reduced the number of such discharges to almost zero. However, discharges to the street continued at private hospitals, accounting for 650

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discharges in 1999. Sidney Watson, “Discharges to the Streets: Hospitals and Homelessness” 19 St. Louis Pub. L. Rev. 357, 381 (2000) (citations omitted).

<sup>25</sup> Given that both mother and daughter share the same last name, we will refer to Angela King using that name or as “Ms. King” and will usually refer to CaSonya King by her first name only (“CaSonya”), to avoid confusion. We intend no disrespect or informality in doing so. Names of individual clinical staff have been omitted or changed to pseudonyms or job titles (“Dr. A,” “LICSW” etc.).

<sup>26</sup> HPH Records, 6/8/18. 3 Day Notice at page 1. The form only reflects an electronic signature.

A person admitted to a facility on *conditional voluntary* status shall be discharged by the facility upon their request provided, however, the patient gives three days written notice of intent to leave the facility to the facility director. 104 CMR 27.09(4). The patient may be retained at the facility for such three-day notice period, during which time the facility director may require an examination of such patient to determine their suitability for discharge. *Id.* Such patients may be retained at the facility beyond the expiration of the three-day notice period if the facility director files a petition for the commitment of such patient at the facility. *Id.*

In this case, CaSonya King had been admitted on June 8, 2018, on a conditional voluntary status, and had immediately submitted a Notice of Intent to Leave the Facility. This prompted HPH to file a petition for commitment on June 12, 2018. Although the legal section of CaSonya’s medical record does not include a Notice of Hearing, treatment team members mention in their notes that the hearing had been scheduled for June 20, 2018. HPH Records, DAP Note, 6/19/18, 6:55:38 PM, Dr. A., We were able to confirm this through her court appointed lawyer’s records. Ms. Angela King, CaSonya’s mother and guardian, reports that she was never informed of this hearing date until long after CaSonya’s death.

<sup>27</sup> HPH Records, Physician Discharge Summary, 6/20/18.

<sup>28</sup> Italics supplied. The italicized portion of this sentence represents information added to the form in handwriting, by the petitioner.

<sup>29</sup> At no point does it appear from the record or the investigation report, that CaSonya spoke or met with an appointed attorney, or that anyone went to court on June 20, 2018 to have the matter heard or continued. The DMH Investigation report indicates that CaSonya’s attorney asked to postpone the hearing to allow for time to plan discharge, but the DMH investigator could find no information about this and nothing to indicate that there was an attorney involved who had been in contact with CaSonya. DMH Investigation Report, p.7. DLC located CaSonya’s court-appointed attorney and reviewed his file. We learned that it was the attorney for the hospital that postponed the hearing, and that he did so a day after the hearing was to have taken place. It is possible that this was done by agreement of counsel, although the document itself does not reflect that this was a joint or agreed upon motion. The records also do not show what, if anything, took place on the original hearing date.

<sup>30</sup> Additionally, at no point does it appear from the record that CaSonya retracted her 3-day Notice of Intent to Leave the Facility. No discharge plan was in place prior to June 20, 2018, and the first and the discharge planning meeting took place on June 26, 2018. There were also discussions between CaSonya staff about her discharge on June 27, 2018, before she was brought to Boston, that morning.

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<sup>31</sup> For the purpose of this investigation report, we have referred to the discharging clinician as “Dr. A.”. Her identity is known by DMH, the licensing agency overseeing HPH.

<sup>32</sup> There is no legal designation called “financial guardianship.” The April 4, 2018 order itself, while temporary in nature, was a plenary guardianship.

<sup>33</sup> This information is incorrect, based on all available records. DMH was unable to attend the discharge meeting on the previous day, for reasons not known.

<sup>34</sup> HPH Records. DAP Note, 6/29/18 1:47:17 PM

<sup>35</sup> HPH Records. DAP Note, 6/29/18 1:47:17 PM. This record is electronically signed after CaSonya’s death, on June 29, 2018 1:47 pm.

<sup>36</sup> DMH Investigation Report, p. 12.

<sup>37</sup> ED Report, St. Elizabeth’s Medical Center, #E00053915047 p. 1

<sup>38</sup> Discharge Summary, Carney Hospital, report 0628-0401 p. 2

<sup>39</sup> HPH Records, DAP Note, 6/19/18 6:55:38 PM, Dr. A.,

HPH Records, DAP Note, 6/25/18 5:34:34 PM, Dr. A.,

<sup>40</sup> HPH Records, DAP Note, 6/20/18 11:47:26 PM,

HPH Records, DAP Note, 6/22/18 4:14:44 PM,

<sup>41</sup> HPH Records, Treatment Plan, 6/9/18, Dr. A. and others. See 104 CMR § 27.10(4).

<sup>42</sup> HPH Records, Initial Psychiatric Evaluation, 6/8/18 6:06:32 AM, MD.

HPH Records, Physical Assessment, 6/8/18, , RN.

<sup>43</sup> HPH Records, DAP Note, 6/17/18 11:45:22 PM.

HPH Records, DAP Note, 6/18/18 11:38:43 PM,

HPH Records, DAP Note, 6/19/18 8:28:01 PM,

HPH Records, DAP Note, 6/20/18 11:47:26 PM.

HPH Records, DAP Note, 6/21/18 9:33:44 PM.

<sup>44</sup> DMH Investigation Report, p. 5

<sup>45</sup> HPH Records. DAP Note, 6/27/18 12:50:15 PM, RN. The discharge note by this RN states that CaSonya actually received therapy, but there is little evidence on the records received, detailing the therapy that CaSonya was provided, aside from a handful of groups attended and daily check-in meetings with staff and Dr. A.

<sup>46</sup> See HPH Records DAP Note, 6/13/18 3:01:53 PM; HPH Records. DAP Note, 6/16/18 4:46:46 PM; HPH Records DAP Note, 6/16/18 6:34:05 PM; HPH Records DAP Note, 6/23/18 2:46:43 PM; HPH Records DAP Note, 6/23/18 10:46:58 PM.

<sup>47</sup> Instance from 6/27/18 records observations made on the prior day. These and the other clinical notes referenced in this report were made by RNs, and other clinical staff (LPNs, LICSW, etc.) but also include some entries made by Dr. A.

The summary of records noted here are not intended to argue that there was not some incremental, albeit uneven, progress over the course of CaSonya’s stay. A number of notes in the latter part of her stay at HPH suggest that CaSonya was more able to engage with staff in between episodes of self-dialogue. However, the DMH Investigation report concludes that there was a “noted recurrence” in her symptoms in the last six days of her stay at HPH. DMH Investigation Report at 4.

Regardless, our point, as clarified below, is that her progress, by HPH’s own account, did not appear commensurate with an ability to manage the stress of living on the street or in a homeless shelter. A slower and more carefully coordinated discharge was needed, or a discharge to a more supportive setting, as CaSonya herself requested.



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<sup>48</sup> The words underscored were written by hand onto a blank on the form, which already contained the preceding language for the third prong for commitment. The G.L. c. 123 section 7 & 8 Petition for Commitment also relied upon the first and second prongs as alternative grounds.

<sup>49</sup> 42 CFR § 482.43(a). While revised regulations took effect in November, 2019, this requirement has been in effect since January 12, 1995. See *Medicare and Medicaid Programs; Revisions to Conditions of Participation for Hospitals*, 59 FR 64141-011994 WL 693037 (December 13, 1994).

<sup>50</sup> As noted above, the regulations were enhanced or reorganized in 2019. Unless otherwise indicated, the citations here are to the regulations in effect at the time of CaSonya's discharge. 42 CFR § 482.43(b)(1) (2018). See also 42 CFR § 482.62 (2018 and 2021) (adequate qualified professional and supportive staffing required in engage in discharge planning in psychiatric hospitals).

<sup>51</sup> 42 CFR § 482.43(b)(4) (2018).

<sup>52</sup> 42 CFR § 482.43(b)(5) (2018).

<sup>53</sup> 42 CFR § 482.43(b)(6) (2018).

<sup>54</sup> 42 CFR § 482.43(d) (2018).

<sup>55</sup> 42 CFR § 482.43(c)(5) (2018).

<sup>56</sup> See 130 CMR § 415.419(B)(3).

<sup>57</sup> 104 CMR § 27.01.

<sup>58</sup> 104 CMR § 27.09(1)(a).

<sup>59</sup> 104 CMR § 27.09(1)(b). See also, Watson, *Discharges to the Streets – Hospitals and Homelessness*, 19 St. Louis Pub. L. Rev 357, 377 (2000), quoting JHCO (now Joint Commission) protocols providing for discharges to appropriate housing and services and not to emergency shelters or the street).

<sup>60</sup> See Appendix 1, Order of Temporary Guardianship dated April 4, 2018.

<sup>61</sup> HPH Records, DAP Note, 6/27/2018 12:11:15 PM,

<sup>62</sup> See Appendix 1, Order of Temporary Guardianship dated April 4, 2018.

<sup>63</sup> "DMH Investigation Report" p. 5.

<sup>64</sup> *Id.* at page 6.

<sup>65</sup> According to the DMH Investigation Report, p. 6, Dr. A. indicated that "the client's attorney had requested that the court hearing date be postponed prior to that hearing to allow for more time for the HPH treatment team to compile an aftercare plan. Dr. A. added that if HPH had cancelled the pending court date "we have to discharge her in the moment."

<sup>66</sup> "There was no HPH documentation found of the client having, or having been visited by an attorney, or that attorney having spoken with any HPH team member." DMH Investigation Report, p. 6.

<sup>67</sup> In order for a psychiatric facility to comply with state regulations regarding discharge, planning must take place early into the in-patient stay. See 104 CMR § 27.09 (1).

<sup>68</sup> Dr. A.'s original claim that CaSonya had been "discharged" on June 20, 2018 is untenable given that she remained confined in a facility. MassHealth regulations define "Day of Discharge" as "[t]he day on which a member leaves the hospital". 130 CMR § 425.402. This is true even the facility had been searching unsuccessfully for an alternative placement.



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The basic legal meaning of “discharge” was confirmed most recently by the S.J.C. in *Pembroke Hospital v. D.L.*, 482 Mass. 346 (2019). There, the court considered the matter of a patient that the hospital claimed had been discharged while he was simultaneously being detained and transported involuntarily to another hospital. The court found that a patient could not have been discharged “if his or her liberty had not been restored” and if the patient continued to be confined at the facility. *Id.* at 352-3. Being “released from care” without having one’s liberty restored is insufficient. *Id.* at 353.

Dr. A. also created a “Physician Discharge Summary” dated June 20, 2018 that was later amended by a second Summary dated June 27, 2018, the actual date of CaSonya’s discharge from the hospital. HPH Records. Physician Discharge Summary, 6/20/18 4:15:18 PM, Dr. A.

DLC listened to a voicemail message from early in the morning of June 22 in which the HPH clinical director called Ms. Angela King, stating she was still trying to reach two DMH employees, but “we do have to discharge her today.”

<sup>69</sup> HPH Records. DAP Note, 6/20/18 11:47:26 PM.

HPH Records. DAP Note, 6/22/18 11:43:26 PM.

HPH Records. DAP Note, 6/22/18 4:14:44 PM.

HPH Records. DAP Note, 6/23/18 2:46:43 PM.

HPH Records. DAP Note, 6/24/18 6:47:26 AM.

HPH Records. DAP Note, 6/25/18 4:15:18 PM.

HPH Records. DAP Note, 6/25/18 10:21:13 PM.

HPH Records. DAP Note, 6/26/18 11:04:06 PM.

A June 20 email from Ms. Angela King to DMH reviewed by DLC records her deep concerns over DMH’s inability to reach HPH, and staff from DMH and the respite program not visiting CaSonya. Ms. King describes CaSonya’s current state and her inability to live independently and the need for a discharge meeting to ensure a stable environment with treatment, hopefully a return to the respite program.

<sup>70</sup> The hospital was on notice that CaSonya would not be seeking to remain for an extended period as a conditional voluntary patient. From the records, at no point did CaSonya revoke the 3-day Notice of Intent to Leave the Facility that she signed on June 8, 2018.

<sup>71</sup> HPH Records. DAP Note, 6/22/18 4:14:44 PM.

<sup>72</sup> HPH Records. DAP Note, 6/27/18 12:11:15 PM. Records, DAP Note, 6/27/18 12:11:15 PM.

<sup>73</sup> The DMH investigator report also notes the following:

- “An HPH History and Physical Exam, dated June 9, 2018 was noted as unable to be completed ... [t]here was no record found of another attempt having been made.” p.13
- “An HPH Biopsychosocial Assessment, dated June 9, 2018, was found to be partially completed, and not signed...Treatment Recommendation fields of that form were also found to be blank.” p. 13
- “The HPH Treatment Plan document was also dated as originating on June 9, 2018 ...no entries were evident in the Treatment Plan section. The form included electronic signatures by Dr. A. and Ms. [Name omitted].” p. 13

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- “It may also be noted that the Contact Notes concerning discharge planning efforts for the client (logged as made on June 20 and 21, 2018) were not included in the copy of the full HPH record set requested by and sent to this Investigator. Those notes were provided ... on the date of the interviews with Name of LISCW and Dr. A omitted].” p. 13.

<sup>74</sup> “DMH Investigation Report” p. 8-9. Strictly speaking, the hospital’s version is not literally inconsistent with one treatment note, which states that the mother and respite “are unable to take her at this time.” High Point Hospital DAP Note, ([name omitted]) at 6/29/18 1:47 PM). (This treatment note, begun on June 27, purports to describe a meeting from the day before. However, it appears that it was completed, or at least electronically signed, on day after CaSonya’s death, on June 29.) Another note from the same clinician on June 27, 2018 (11:30 am) states “Respite is unwilling to accept Pt. back into care with her current presentation (self-dialoguing, yelling and pacing around).

<sup>75</sup> HPH Records, DAP Note, 6/27/18 12:11:15 PM.

<sup>76</sup> 104 CMR § 27.10(4).

<sup>77</sup> HPH Records. DAP Note, 6/27/18 12:50:15 PM. At the time of her death, a sealed water-logged envelope was recovered from CaSonya’s person with her discharge instructions.

<sup>78</sup> DMH Investigation Report, p. 14. In addition, The DMH investigator also found that the HPH Treatment Plan was incomplete. Aside from medication to be administered voluntarily or involuntarily, there was no meaningful treatment plan ever created. The two page form for this plan in CaSonya’s file is largely blank and remained incomplete throughout CaSonya’s entire stay. See HPH Records, Treatment Plan, 6/9/18, electronically signed by [Dr. A., LPN. and LICSW].

<sup>79</sup> HPH Records, DAP Note, 6/29/18 1:47:17 PM.

<sup>80</sup> DMH Investigation Report p. 10.

<sup>81</sup> See Clinical Discharge Summary, unsigned at p. 5, and Nursing Discharge Summary at p. 2.

<sup>82</sup> *Id.*

<sup>83</sup> The DMH case manager is quoted as saying, “[a]s soon as staff both in Respite (and myself with DMH) found out she was instead discharged into a shelter, everyone was very active in trying to locate [the client] in the shelter in order to get her back into Milford Respite. I personally put out calls and emails to the managers on the BEST team in Boston who were also helping looking out for [the client].” DMH Investigation Report, p. 10. For more information about the Boston Emergency Services Team (BEST), see <http://northsuffolk.org/services/emergency-services/boston-emergency-services-team/>

<sup>84</sup> It is unclear why HPH brought CaSonya to Boston, and they were unable to tell us. DMH believes that HDP latched onto a Mattapan post office box address found somewhere in her file. The G L c. 123 sec. 10 and 11 form prepared by them uses a Mattapan address, a place where a cousin had lived and CaSonya might have received mail at some point, but the G.L. c. 123 sec 12 form uses a Milford address and her G.L. c 123 sec. 7 and 8 petition for commitment lists her mother as her “nearest relative or guardian” with a 508 area code. Her mother, her brother, her doctors and hospitals and the respite, and her DMH office were all in the vicinity of Milford/Northbridge MA.

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CaSonya's family reports that she had no services or supports in the Boston area at the time of her discharge.

<sup>85</sup> 104 CMR 27.09. Discharge reads in pertinent part:

(1) Discharge Procedures.

(a) A facility shall arrange for necessary post-discharge support and clinical services. Such measures shall be documented in the medical record.

*(b) A facility shall make every effort to avoid discharge to a shelter or the street. The facility shall take steps to identify and offer alternative options to a patient and shall document such measures, including the competent refusal of alternative options by a patient, in the medical record. In the case of such discharge, the facility shall nonetheless arrange for or, in the case of a competent refusal, identify post-discharge support and clinical services. The facility shall keep a record of all discharges to a shelter or the street, in a form approved by the Department, and submit such information to the Department on a quarterly basis.*

(c) When a patient in a facility operated by or under contract to the Department is a client of the Department pursuant to 104 CMR 29.00: Application for DMH Services, Referral, Service Planning and Appeals, the service planning process outlined in 104 CMR 29.00 shall be undertaken prior to discharge.

(d) A facility shall keep a record of all patients discharged therefrom, and shall provide such information to the Department upon request.

(2) Voluntary Admission Status. A patient voluntarily admitted to a facility under 104 CMR 27.06 shall be discharged upon his or her request, or upon the request of the patient's legally authorized representative who applied for the admission of such patient, without a requirement of a three-day notice.

(3) Discharge Initiated by Facility Director. The facility director may discharge any patient admitted as a voluntary or conditional voluntary patient at any time he or she deems such discharge in the best interest of such patient....

(4) Conditional Voluntary Admission Status. A patient admitted to a facility on conditional voluntary status under 104 CMR 27.06 shall be discharged by the facility upon his or her request; provided however, he or she shall give three days written notice of his or her intent to leave the facility to the facility director, and may be retained at the facility for such three-day notice period, during which time the facility director may require an examination of such patient to determine his or her suitability for discharge. Such patients may be retained at the facility beyond the expiration of the three-day notice period if, prior to the expiration of the said three-day notice period, the facility director files with a court of competent jurisdiction, a petition for the commitment of such patient at the s [sic] facility.

(emphasis supplied).

<sup>86</sup> HPH Records. DAP Note, 6/27/18 1:47:17 PM, LICSW.

<sup>87</sup> BHCHP provides "medical respite care", short-term medical and recuperative services, for homeless people who are too sick for life in shelters but not sick enough to occupy a costly acute care hospital bed. The Barbara McInnis House is BHCHP's 104-bed medical respite facility located in Jean Yawkey Place on the campus of Boston Medical Center. In addition, according to its website, BHCHP offers adult primary care and behavioral health clinics in various community locations via clinic hours. See <https://www.bhchp.org/>.

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<sup>88</sup> DMH Investigation Report p. 11.

<sup>89</sup> *Id.*

<sup>90</sup> Boston Police Department #P180325845 Incident Report.

<sup>91</sup> *Id.*

<sup>92</sup> Discharge Summary, Carney Hospital, report 0628-0401 p. 2.

<sup>93</sup> Commonwealth of Massachusetts Registry of Vital Records and Statistics, Division of the City of Boston, Certificate of Death no. 718857, Medical Examiner Maria Del Mar Capo-Martinez, MD, Lic. # 268066. The St. Elizabeth's Medical Center medical records indicate that the patient was found with a 500 count bottle of baby aspirin with about 300 pills missing.

<sup>94</sup> Examples of the common or trade names for the OTC medications are, respectively: Motrin/Advil, Tylenol, aspirin, Benadryl.

<sup>95</sup> See. G.L. c. 123, § 6 (prohibiting retaining a person at a facility except under certain conditions or "except during the pendency of a petition for commitment"); G.L. c. 123, § 11 (providing that "the facility may petition a court for an extended commitment of the person and...he may be held at the facility until the petition is heard by the court."); and 104 CMR § 27.09(4) ("Such patients may be retained at the facility beyond the expiration of the three-day notice period if, prior to the expiration of the said three-day notice period, the facility director files with a court of competent jurisdiction, a petition for the commitment of such patient at the s [sic] facility.")

<sup>96</sup> See *Zinerman v. Burch*, 494 U.S. 113 (1990).

<sup>97</sup> Civil commitment imposes a formidable burden upon the hospital. Here, HPH would need to show:

*a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.*

G. L. c. 123, § 1. The harm must be shown to be imminent, that is, it will materialize "in days or weeks rather than in months." In *Matter of J.P.*, 486 Mass. 117, 118-19 (2020) (citation omitted). There must be no alternative available that is less restrictive than hospitalization. *Id.* at 118 (citation omitted). Each of the statutory requirements must be demonstrated beyond a reasonable doubt. *Id.* at 119 (citations omitted).

In addition, in *Matter of J.P.*, the court noted that while [it] is true that homelessness can mean a lack of safety and stability, but that does not mean that homelessness, in and of itself, is sufficient to support a finding of a very substantial risk of harm to the person himself or herself. If it is to be used at all as part of the involuntary civil commitment analysis, it must be done with extreme caution. ...It is a broad term that may, but need not, be synonymous with living on the streets and being exposed to the attendant dangers that come with it. But even if a person does not have a place to stay and will be in a homeless shelter or on the street, that is not proof that he or she will pose a substantial danger to himself or herself.

*Matter of J.P.*, 486 Mass. 117, 124 (2020).

<sup>98</sup> See definitions in ft. 13, above.

<sup>99</sup> In reaching this conclusion, we acknowledge the values of personal autonomy, independent living, and freedom from coercion and institutional living that inform the disability rights movement. This includes what is sometimes referred to as "dignity of risk," the right of persons both with and without disabilities to make their own decisions autonomously, even those that they or others may eventually regret. With reservations

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and concern, we note that this may even include a decision by some people who are capable of self-protection to reject care from an institution or homeless shelter, and to live on the street. For the similar reasons, DLC opposes outpatient commitment and similar forms of coerced medical treatment.

However, a number of factors set this story apart from another individual's informed consent to reject supports and services:

--There is no indication in the record that CaSonya wished to be discharged on June 27, 2018 to the street, in a large city where she had no known supports. In fact, at the discharge meeting, the treatment notes reflect that she clearly stated "I don't want to go to a shelter. I want to go to the respite" and then she left the office. HPH Records, DAP Note, 6/29/2018 1:47 pm (describing 6/26/18 meeting).

--CaSonya was in a severely compromised state at the time of her discharge. She likely was able to express preference about her discharge, but probably was not capable of appreciating the risks of living on the street without readily available supports and services. Even if she had agreed to do so (and the evidence clearly indicates otherwise), this would not have been informed consent;

--She likely still met the third prong of the definition of a *likelihood of serious harm* to herself, i.e., "a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community." See G.L. c. 123, § 1, 7. If so, she ought not to have been discharged, or not discharged to a location that magnified her need for skills of self-protection.

--Other less restrictive options were readily available to her and HPH in the near term, including respite identified by DMH;

--HPH had an obligation to create a safe and appropriate discharge plan with alternative options, and failed to do so;

--HPH had an obligation under federal regulations involve her guardian in the discharge and failed to do so.

We also acknowledge that both the Commonwealth and the hospital had ADA obligations to offer services in the least restrictive environment appropriate to CaSonya's needs. We express no clinical judgment as to whether continued hospitalization was necessary for CaSonya or not. Assuming not, as noted above, CaSonya could have been offered services and supports in less restrictive environments, that are far safer than discharging an individual who is actively delusional, disoriented and unable to care for herself to the streets of Boston. For example, group living environments and community mental health providers, when adequately staffed may provide effective treatment and/or supports. The model of a peer-run respite program has been an important innovation in provided person-centered supports with help by trained staff with lived experience. Many of these settings offer reasonably high rates of recovery, using holistic trauma-informed care, person-centered planning, peer recovery specialists and other treatment modalities in a more supportive and therapeutic environment than many psychiatric in-patient facilities. Indeed, before bringing a commitment case to hearing, HPH would have been obligated to exhaust

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these alternatives. See G.L. c. 123 section 1 (see definition of likelihood of serious harm, third prong and need to establish no reasonable provision for protection is available in the community); *In the Matter of a Minor*, 484 Mass. 295, 309-310 (2020) (discussing *Com. v. Nassar* and constitutional principles). Many of these less restrictive environments can be made available in the first instance to avoid emergency room admissions and subsequent hospitalizations for mental health reasons. Legislation has been filed this session before the state legislature to divert individuals in crisis from emergency rooms to receive community-based crisis stabilization care wherever possible.

In sum, there is not necessarily a contradiction between ADA obligations to provide effective services or treatment in the most integrated setting and the need to avoid unnecessary discharges to homeless shelters, where such supports are typically not available. Note that in the original *Olmstead* litigation, when plaintiff Elaine Wilson sought community-based treatment from the Georgia state defendants, the hospital tried to discharge Ms. Wilson to a homeless shelter, her advocates intervened by filing a complaint and this proposed discharge was then rescinded. Susan Stefan, *Beyond Residential Segregation: The Application of Olmstead to Segregated Employment Settings*, 26 Ga St. U. L. Rev., 875, 887 (2010) citing *Olmstead v. Zimring*, 527 U.S. 581, 593 (1999).

<sup>100</sup> *Id.* at p. 9. We found this statement, if true, to be both troubling and peculiar. It is troubling insofar as a primary reason for discharging to the street might have been a belief as to the clinician's liability, and not a belief as to the individual's safety. It is peculiar because the hospital could easily have dismissed the case, if it believed an individual no longer met the commitment standard. Even if the clinical staff erred in originally seeking a commitment, mental health professionals are generally immune from civil suits for damages under these circumstances, as provided in G.L. c. 123, § 22.

<sup>101</sup> *Id.* at p. 9, 10. DLC does not know the identity of this "other patient" or whether DMH knows their identity or the outcome of their discharge.

<sup>102</sup> Discharge Summary, Carney Hospital, report 0628-0401 p. 1 and Emergency Department Report, St. Elizabeth's Medical Center #E00053915047, p. 1

<sup>103</sup> "Beacon Health Options (Beacon) is a behavioral health management organization specializing in the development and management of behavioral health services for a wide variety of customers including integrated health care delivery systems, academic medical centers, health maintenance organizations and state and local governments." See Beacon Health Strategies Provider eServices User Manual, available at [https://provider.beaconhealthoptions.com/docs/manual\\_eservices.pdf](https://provider.beaconhealthoptions.com/docs/manual_eservices.pdf), p. 2. See also <https://www.beaconhealthoptions.com/providers/beacon/>.

<sup>104</sup> See 104 CMR 27.03(23)(h)(1) and (2); <https://www.mass.gov/service-details/dmh-licensed-inpatient-facility-incident-notification-forms>.

<sup>105</sup> See Mass. Gen. Laws c. 38 § 3(2).

<sup>106</sup> Department of Mental Health, Investigation Report # 18-HPH-004, dated August 21, 2018 at p. 15.

<sup>107</sup> See Department of Mental Health Decision Letter on Complaint Log #18-HPH-004, dated August 30, 2018.

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<sup>108</sup> 104 CMR 32.00 defines ‘dangerous’ as posing “a danger or the potential of danger to the health or safety of a client.”

<sup>109</sup> Decision Letter, p 3-4.

<sup>110</sup> See Department of Mental Health Decision Letter on Complaint Log #18-HPH-004, dated August 30, 2018. In seven sentences, DMH instructed HPH to do the following:

- Review its policy and practices about involuntary commitment and the right to hearings and counsel;
- Review its policy and practices about discharge readiness and discharges to shelters;
- Review clinical assessment and treatment planning policies and practices and their system for ensuring they are followed (noting there were “significant lapses” in this case; and
- Review medication management policies to ensure that described practices were not accepted practice.

It also told the hospital to inform DMH of changes to policies, practices or training materials and to “provide verification that all hospital staff have been fully educated.” This anemic language suggests that the most penetrating undertaking possible is to ask that hospital staff “*go back and read the manual.*”

<sup>111</sup> Both DMH and HPH records establish that the DMH worker was not present. The HPH treatment note recording the discharge plan states “DMH did not show for meeting....Continue to attempt to reach DMH worker...” HPH Records, DAP Note 6/27/2019 12:11. Ms. Angela King states that she emailed the social worker before the meeting to express the depth of her concern but learned from the respite clinician at the meeting that the DMH social worker had a scheduling conflict. She explains that she was shown a fax sent by the DMH worker to the Riverside respite clinician that morning saying that DMH could not attend. We are unable to draw a clear conclusion as to why a DMH representative was not present. For example, we know that CaSonya’s mother had tried unsuccessfully to reach HPH for a period of two weeks before CaSonya’s discharge meeting. We believe DMH ought to have determined why it was not at this meeting and ought not to allow hospitals to undertake discharge meetings of DMH clients when they are not present, at least in discharges of this type.

<sup>112</sup> It is concerning to us that HPH created a policy addressing discharges to shelters, but not discharges to the street, even though this case concerned the latter and not the former. There is no indication that a policy addressing discharges to the street was already in place or was required to be created by DMH. The shelter policy mentions one important issue raised by CaSonya’s case, the need for the discharge to be located in an area of the individual’s preference or their area of tie (“catchment area”) with known resources. It does not address to other issues raised by CaSonya’s case, such as the need for notice to the guardian, where the individual does not object, and the need for a refusal of alternatives to be a competent, informed refusal.



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<sup>113</sup> This is 20 years. 104 CMR 27.16(3).

<sup>114</sup> The hospital did not furnish us any records on these subjects under our written patient records request, or pursuant to the releases sent directly preceding our discussions. We assume then, that no records of this information were kept, yet we also find this bewildering. DMH regulations require hospitals to keep as part of the patient record, records of all placements, 104 CMR 27.16(2)(o) and discharge information. 104 CMR 27.16(2)(s). HPH officials were unable to even explain what protocol existed for recording or retaining this information. It is particularly disturbing given that the hospital has reporting obligations to DMH which continue for 30 days after discharge. 104 CMR 27.03(h)(1) and (2) (death or any serious incident regardless of location within 30 days of discharge); see also <https://www.mass.gov/doc/30-days-post-discharge-report-for-hospitals-only/download>

<sup>115</sup> As noted above, one licensed clinical social worker told the DMH investigator: “I did not have a safe plan for the discharge of CaSonya] and one other patient that same date. I didn’t like it.” However, there is no indication in the record that the employee took any action to address her fears or concerns.

<sup>116</sup> G.L. c. 19, sec 1. This authority is granted subject to the proviso that it does not usurp other state laws or authority granted to other state agencies or political subdivisions.

<sup>117</sup> *Id.*,

<sup>118</sup> G.L. c. 19, sec. 19; 104 CMR 27.00 and 104 CMR 32.00.

<sup>119</sup> G.L. c. 19, sec. 19. This statute was amended at the beginning of DMH’s death investigation. See also G.L. c. 19 sec 18 (general authority to issue rules and regulations).

<sup>120</sup> *Massachusetts General Hospital v. C.R.*, 484 Mass. 472, 478-79 (2020) (citations omitted). See also 104 CMR 27.03 (licensing requirements), including 104 CMR 27.03(15)(e)(6) (authority to revoke the deemed status of a facility for noncompliance with DMH regulations).

<sup>121</sup> 104 CMR 27.09(1)(b)(2021).

<sup>122</sup> See <https://www.mass.gov/doc/eohhs-state-operated-facility-and-congregate-care-site-data/download> As to the health and safety risks faced by unhoused persons, see Appendix A section 3 to this report, and associated endnotes.

<sup>123</sup> Our comments to the proposed DMH regulations addressed the types of distressing or tragic outcomes we have seen from discharges to the streets and shelters:

#### *DMH Oversight Over Discharge of Patients from Facilities*

*DLC is currently examining a range of discharge planning issues, including the troubling problem of patient dumping, i.e., patients who are discharged to the street or to shelters, often with negative or even tragic outcomes. We were very pleased then, to see the proposed change to 27.03(23)(h) which empowers the Department to the examine death or serious injury of patients served in DMH licensed facilities that occur within 30 days following discharge. We appreciate the Department's initiative in making this proposed regulatory change and believe that it is critical to adequate enforcement of the other discharge planning*

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*protections in the regulations.*

*However, we believe that DMH licensed facilities should rarely discharge a patient to the street or to a homeless shelter, unless there is informed consent given either by a competent patient and/or a legally authorized representative who has refused alternative options presented to them. We recognize, of course, the interest in moving discharge-ready persons served out of the more restrictive environments, and the issues of personal autonomy at stake. Nonetheless, we also believe that there have been too many examples of discharge to the street or shelters and that these scenarios should be followed carefully by the central office.*

See May 1, 2019 Comments of the Disability Law Center regarding proposed regulatory changes to 104 CMR § 27.00, filed with DMH Office of General Counsel. Our comments then recommended that the last sentence in 104 CMR § 27.09(1)(b) be changed to add the language underlined in bold font below:

*The facility shall keep a record of all discharges to a shelter or the street, **including documentation as to why the individual does not meet the definition of subsection(3) of the definition of likelihood of serious harm as found in G.L. c. 123 section 1, [ ]** in a form approved by the Department, and submit such information to the Department on a quarterly basis.*

In a footnote attached to our proposed language, DLC observed:

*In some cases, the challenges of living on the street or in a homeless shelter will tip the scales of the third prong of the definition of "likelihood of serious harm" in G.L. c. 123, section 1. This provision refers to "a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community." In those situations, the risks and difficulties of living on the street or in a shelter, with their own informed consent, or the consent of their guardian, will mean the individual is no longer discharge ready.*

Note however, if the individual is discharge ready and the only alternatives are the shelter or street, the facility should not re-commit, but rather should identify alternative options. See *Pembroke Hospital v. D.L.*, 482 Mass. 346, 353-354, n.10, 11 (2019).

DMH declined to adopt our proposed changes, or any change at all, to its regulation governing discharges to the street or to a shelter. It is true that other language in the existing regulation strongly discourages such discharges. (See 104 CMR § 27.09(1)(b), requiring "every effort to avoid such discharges and requiring alternatives be offered.") However, this regulation was insufficient to protect CaSonya, and moreover, it is weaker than DMH's own long standing sub-regulatory policy. (See DMH Policy #83, "Homeless Individuals" (Commissioner Mark J. Mills, February 22, 1983) (available at

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<https://www.mass.gov/doc/policy-83pdf/download>) at 1 (“In no instance should a person be discharged from an in-patient facility with directions to seek housing or shelter in an emergency shelter.”).

There were other aspects of the 2019 amendments to the DMH regulations governing licensing and operational standards for DMH facilities that were positive steps intended to protect patients from these types of tragic outcome. One such change (referenced in our comment quoted above) was a modification to 104 CMR § 27.03(23)(h) that allows the Department to examine deaths or serious injuries of patients that occur within 30 days following discharge. Another change, also to 104 CMR § 27.03, strengthened the ability of DMH to impose civil fines and sanctions of non-compliance. We commend DMH for proposing and adopting both of these changes.

<sup>124</sup> See <https://www.mass.gov/doc/30-days-post-discharge-report-for-hospitals-only/download>

<sup>125</sup> Theoretically, this information would be revealed if quarterly reporting under 104 CMR 27.09(b) were later matched with incident reports recording deaths or serious bodily harm sent to DMH within 30 days of discharge. However, this requires harm to first befall the individual. DMH should explicitly require the hospital to flag on the quarterly DMH notification form the reasons for discharges to the street and to homeless shelters.

<sup>126</sup> We believe that this is a relatively low threshold. Most people who are moderately oriented as to time and place are capable of expressing a preference as to where they choose to live. Our primary concern is that hospitals avoid discharging persons to the street or to shelters against their will, as happened to CaSonya, and that meaningful alternatives be offered by the hospital, working in collaboration with DMH and community resources.

<sup>127</sup> ACCS, or Adult Community Clinical Services, is DMH’s primary program for serving adults in the community with significant mental health issues. As we understand it, in recent years, DMH has tried to make more ACCS placements available by helping ACCS clients to move out of that program into more independent settings.

<sup>128</sup> DMH states that it ordered corrective action in policy and training. However, it would be more accurate to say that it directed the hospital to review its own policies, revise them if needed and train its employees. See discussion on p. 33 and endnote 33.

DMH states that the closing of HPH’s in-patient mental health programs changed the scope of the Department’s enforcement and monitoring work, which DLC found to be inadequate. However, the DMH’s corrective action was set forth in a decision letter dated August 30, 2018, and was responded to by DPH on September 20, 2018. HPH did not decide to end in-patient mental health hospitalizations until almost a year later, approximately August 19, 2019.

DMH also states that “patient dumping” is a term best reserved for discharges from emergency departments, and the federal EMTALA statute, which does not apply here. We agree that the term is most commonly used in that legal context. However the difference is one without a distinction, at least for those discharged from in-patient mental health hospitals onto urban streets, away from their home communities, against their will.

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- <sup>129</sup> Andrew Blankstein and Richard Winton, *Los Angeles Times*, available at <http://articles.latimes.com/2007/feb/09/local/me-dumping9>.
- <sup>130</sup> *Id.*
- <sup>131</sup> *Id.*
- <sup>132</sup> *Id.*
- <sup>133</sup> See <https://www.latimes.com/archives/la-xpm-2009-apr-09-me-homeless-dumping9-story.html>.
- <sup>134</sup> Richard Winton, *Los Angeles Times*, available at <https://www.latimes.com/local/lanow/la-me-ln-patient-dumping-20160421-story.html>.
- <sup>135</sup> *Id.*
- <sup>136</sup> Andrea K. McDaniels, *The Baltimore Sun*, available at <https://www.latimes.com/bs-hs-what-is-patient-dumping-20180111-story.html>; David McFadden, The Associated Press, available at <https://www.seattletimes.com/nation-world/mother-of-patient-left-in-cold-says-she-was-denied-care/>.
- <sup>137</sup> Andrea K. McDaniels, *The Baltimore Sun*, available at <https://www.latimes.com/bs-hs-what-is-patient-dumping-20180111-story.html>.
- <sup>138</sup> April M. Short, AlterNet, available at [https://www.salon.com/2018/01/18/hospital-staff-dumped-a-mentally-ill-patient-in-freezing-weather-wearing-only-a-hospital-gown\\_partner/](https://www.salon.com/2018/01/18/hospital-staff-dumped-a-mentally-ill-patient-in-freezing-weather-wearing-only-a-hospital-gown_partner/).
- <sup>139</sup> *Id.* See also, video footage, “Hospital Outrage,” NBS News, January 12, 2018, available at <https://www.nbcnews.com/nightly-news/video/video-shows-baltimore-hospital-s-patient-dumping-1135974467981>
- <sup>140</sup> Alejandra Reyes-Velarde, *Los Angeles Times*, available at <https://www.latimes.com/business/la-me-patient-dumping-20180702-story.html>
- <sup>141</sup> *Id.*
- <sup>142</sup> *Id.*
- <sup>143</sup> Cynthia Hubert, *The Sacramento Bee*, available at <https://www.sacbee.com/news/local/article220994870.html>.
- <sup>144</sup> *Id.*
- <sup>145</sup> *Id.*
- <sup>146</sup> *Id.*
- <sup>147</sup> See Respondent’s Answering Brief in *Southern Nevada Adult Mental Health Services v Brown*, 2020 WL 3270265. The named plaintiff, a Las Vegas resident, was wheeled out of a Nevada psychiatric hospital, put into a taxicab and sent to the Greyhound station with a one-way ticket to Sacramento, CA “to remove the burden of treatment from the State of Nevada.” *Id.* at 9.
- <sup>148</sup> Rebekah L. Sanders, *Arizona Republic*, available at <https://www.azcentral.com/story/news/local/phoenix/2019/01/08/phoenix-hospitals-dumping-homeless-patients-martin-amputated-foot-health-care-medicare-medicaid/1861487002/>.
- <sup>149</sup> *Id.*
- <sup>150</sup> *Id.*
- <sup>151</sup> *Id.*
- <sup>152</sup> *Id.*
- <sup>153</sup> Associated Press, available at <https://www.apnews.com/59eb421d799f4c3db54f9deda1728d4a>.

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<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.*

<sup>157</sup> Adams, Kali, International Development, Community and Environment, “HEALTHCARE AND HOMELESSNESS: How can we better service the health needs of homeless individuals? A Case Study of the City of Worcester MA” (2017) at 25, available at [https://commons.clarku.edu/idce\\_masters\\_papers/117/](https://commons.clarku.edu/idce_masters_papers/117/).

<sup>158</sup> *Id.*

<sup>159</sup> 42 CFR 482.43(b)(4).

<sup>160</sup> Adams, Kali, International Development, Community and Environment, “HEALTHCARE AND HOMELESSNESS: How can we better service the health needs of homeless individuals? A Case Study of the City of Worcester MA (2017)” at 71, Appendix F. available at [https://commons.clarku.edu/idce\\_masters\\_papers/117/](https://commons.clarku.edu/idce_masters_papers/117/)

<sup>161</sup> *Id.*

<sup>162</sup> *Id.*

<sup>163</sup> For current data on the composition of the homeless community in Massachusetts, approximately 18,471 people, see <https://www.usich.gov/homelessness-statistics/ma/>; <https://www.mahomeless.org/about-us/basic-facts>; <https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/massachusetts/>; and <https://endhomelessness.org/wp-content/uploads/2019/08/MA-fact-sheet-2019.pdf>.

<sup>164</sup> See <https://www.mhsa.net/about-us/discharge-planning>.

<sup>165</sup> Averyt et. al., “Impact of Continuity of Care in Recurrence of Homelessness Following an Acute Psychiatric Episode,” *Bepress*, 1997, at 204-205, available at [https://works.bepress.com/dennis\\_culhane/53/](https://works.bepress.com/dennis_culhane/53/).

Data issued by SAMHSA in 2011 indicates that 26% of all sheltered persons who were homeless were considered to have a severe mental illness, and for about 30% of chronically homeless persons, a mental health condition. See [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/homelessness\\_programs\\_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf).

As one commentator noted, discharge to the street “is a prescription for relapse, readmission or worse” and discharge to a shelter may be equally as bad. Sidney Watson, “Discharges to the Streets: Hospitals and Homelessness” 19 St. Louis Pub. L. Rev. 357, 363 (2000)

<sup>166</sup> *Id.* at 206.

<sup>167</sup> A large segment of the general population does not understand what it takes to find and maintain temporary shelter, including the need to wait in line on a daily basis and/or comply with other procedures. See Brown et. al., “Waiting for Shelter: Perspectives on a Homeless Shelter’s Procedures,” *J. Community Psychol.* 2017; 45:846-858, available at <https://deepblue.lib.umich.edu/bitstream/handle/2027.42/138221/jcop21896.pdf?isAllowed=y&sequence=2>. Nor does the public at large understand that on any given night in Massachusetts, the approximately 3,000 shelter beds for individuals are full or beyond capacity. See Massachusetts Coalition for the Homeless. <https://mahomeless.org/basic-facts>.

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People who are unhoused face a lack of food, water and protection from the elements; a lack of transportation needed for necessary daily tasks (picking up medication etc.); challenges in communicating with others (notwithstanding some programs providing cell phones); barriers related to inadequate funds for small incidental expenses; and above all else, stigma and discrimination. See Balasuriya. “The Never Ending Loop: Homelessness, Psychiatric Disorder and Morality,” *Psychiatric Times*, (May 20, 2020). The best solutions for these individuals may be not in creating more shelter beds, but in Housing First and rapid rehousing programs to return these individuals to permanent housing with available supports. The longer a person is homeless, the more difficult it becomes for them to be rehoused. See *Housing and Shelter*, SAMHSA, <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/housing-shelter>

<sup>168</sup> According to a Massachusetts-based study of 445 homeless adults, mortality rates were 3 times greater for the unsheltered cohort (i.e., those who were unhoused and not living in a shelter) compared to all adult homeless persons) and almost 10 times greater than the general Massachusetts population. Overall the mean age of death for the entire survey sample of homeless persons was 53 years. Jill S. Roncarati et. al., “Mortality Among Unsheltered Homeless Adults in Boston, Massachusetts, 2000-2009,” *JAMA Intern Med.*, Sept. 2018.

<sup>169</sup> See discussion of medical research in Kushel, M., “Things Fall Apart: Preventing High Readmission Rates Among Homeless Adults,” *J General Internal Medicine* 31, 985–986 (2016). <https://doi.org/10.1007/s11606-016-3744-9>. Kushel quotes Matthew Desmond, who wrote in *Evicted: Poverty and Profit in the American City*, “Without stable shelter, everything else falls apart.”

<sup>170</sup> To point to a current illustration, consider COVID-19 risks associated with homelessness. See <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html>.

National data shows disturbingly high rates of mortality among unhoused people, with one prominent resource estimating between 17,500 and 46,500 deaths in 2018. “Homeless Mortality Data Toolkit: Understanding and Tracking Deaths of People Experiencing Homelessness,” National Health Care for the Homeless Council, January 2021.

<sup>171</sup> See, “Housing Not Handcuffs, 2019” National Law Center on Homelessness and Poverty, December 2019, at 66, available at <http://nlchp.org/wp-content/uploads/2019/12/HOUSING-NOT-HANDCUFFS-2019-FINAL.pdf> (reporting estimates of 13,000 unhoused people who die each year as a result of violence); Ellsworth, J.T., “Street Crime Victimization Among Homeless Adults: A Review of the Literature,” *Journal of Victims and Offenders: An International Journal of Evidence-based Research, Policy and Practice*, vol 14., issue 1 (2019) , available at <https://www.tandfonline.com/doi/abs/10.1080/15564886.2018.1547997>, (abstract reviewing 33 studies; findings indicating homeless people are subject to victimization at disproportionate rates for assault, robbery and theft).

<sup>172</sup> See, e.g., Stannard, E., “Suicidal Man Kills Himself After Hospital Discharges Him” *New Haven Register*, October 21, 2018. The Massachusetts Housing and Shelter Alliance states that “Discharges into the shelter system are a costly and ineffective way to address the unique needs of mentally ill and other persons in the community and



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contributes to, rather than prevents, homelessness.” <https://www.mhsa.net/about-us/discharge-planning>

<sup>173</sup> “...[R]ecovery may be jeopardized and projected cost-savings lost if the discharge ultimately results in ongoing and more intensive use of healthcare resources including ED or nursing facility visits.” Pirkey, “*A Shameful Practice*” 39 L.A. Law 20 (2016) at 3 (footnote omitted).

<sup>174</sup> *Id.* (footnote omitted).

<sup>175</sup> See Moore, “*Chapter 794: A Qualified ‘No’ to the Practice of Homeless Dumping*,” 38 McGeorge Law Review 195, 200 (2007)