Memorandum

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DJ 168-72-0

Subject	Date
Recommendations to Investigate Memphis Mental Health Institute Memphis, Tennessee	NOV 2 1990

To: John R. Dunne
Assistant Attorney General
Civil Rights Division

From: Arthur E. Peabody, Jr.
Chief
Special Litigation Section

Introduction

We recommend initiation of an investigation into conditions of confinement at the Memphis Mental Health Institute (MMHI) in Memphis, Tennessee, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. Section 1997. The information we have obtained indicates that conditions at MMHI deprive residents there of their constitutional rights. These conditions include inadequate psychiatric care and treatment, inadequate supervision of patients and neglect caused, at least in part, by an inadequate number of professional and direct care staff. Other allegations suggest general medical care deficiencies, including overuse and misuse of medication, and an unsafe and unsanitary environment. These conditions may be subjecting MMHI residents to undue bodily restraint and undue risks to personal safety as well as denying them of their constitutional rights to adequate medical care and reasonable safety. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982).

Background

The Memphis Mental Health Institute is located in northern Memphis. The facility is approximately 27-30 years old and serves a population of 160-175 patients. There are presently 217 beds at the facility although there are plans to reduce that number by 44 beds. 1/ Although currently certified by the Health Care Financing Administration (HCFA), an October 1989 report following a review of the facility by HCFA surveyors cited major problems. 2/

1/ The Commercial Appeal, July 15, 1990, at p.B1.

2/ Although MMHI is currently HCFA certified, such certification does not conclusively determine whether a facility meets constitutional standards. See Woe v. Cuomo, 729 F.2d 96 (2d Cir. 1984), cert. denied, 105 S.Ct. 339 (1984). The HCFA Survey Report is dated October 30-31, 1989.

Sources of Information

Allegations regarding alleged inadequate conditions at MMHI first came to our attention when attorneys traveled to Memphis to conduct investigatory activities at the Arlington Developmental Center. During the course of the Arlington investigation, numerous allegations of grossly inadequate conditions of confinement at MMHI came to our attention. We obtained further information from a variety of sources including a 1989 HCFA report of MMHI, interviews with present and former members of the staff at MMHI and parents of MMHI patients and former patients, numerous articles from the local newspaper in Memphis, documents from the Alliance for the Mentally Ill (AMI) of Memphis, and documents from the facility itself from present and former employees.

Inadequate Supervision and Unsafe Environment

Our information indicates that there are insufficient numbers of qualified professional and direct care staff to adequately supervise residents. Because of these deficiencies, MMHI appears to be unable to protect its residents from harm. Based on our information, environmental conditions at MMHI also endanger the health of residents.

The failure to have sufficient numbers of staff has resulted in physical harm to patients. A parent of a former patient told us that her daughter was raped and that the facility has been trying to cover up the incident since it occurred. 3/ The patient had been admitted to MMHI only a short time before the incident. A local rape crisis center confirmed that the patient had, in fact, been raped. The patient's mother believes the rape to have resulted directly from the inadequate supervision of patients due to insufficient staff at MMHI. 4/ The facility did not contact the patient's parents until the day after the incident and refused to allow the patient go to a rape crisis center until after the police intervened in the matter. 5/

The sister of another former patient also informed us of a sexual incident at the facility. 6/ The source's sister was

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3/ Telephone interview with Joanne Woodford, mother of a former MMHI patient, August 30, 1990.

4/ Id.

5/ Id.

6/ Telephone interview with Diane Billings, sister of a former patient at MMHI, August 13, 1990.

have been fired due to their own drug abuse and mental illnesses. 15/

The shortage of staff members and the lack of training for the facility personnel continue to be primary concerns of our sources. As one source stated, "MMHI is one of the worst institutions in the South" and also that she believes that "very few patients are actually helped by receiving treatment there." 16/ Many of our sources indicated that the staff seems inadequately trained to handle even minor situations at the facility and is generally ineffective in helping the patients. 17/

Additionally, one former employee of MMHI told us that he was criticized by the MMHI ~~by the~~ administration for being "too involved and overly concerned about his patients." Furthermore, he alleges that often patients are intimidated and threatened by the staff and that the overall attitude of the staff toward patients is "deplorable." 18/ This source stated that many employees are "totally insensitive to patient needs and didn't treat patients as people." 19/ He also notes that staff members often sleep or watch television while on duty and that, at least in one unit, patients allegedly find it very easy to buy drugs from staff members. 20/

Staffing shortages are exacerbated by excessive and unnecessary crowding at MMHI. One source told us that most of the eight units are only able to accommodate 25 patients but often have up to 30 patients at one time. Furthermore, the same source indicated that while some units are overcrowded, often other units have extra room but will not "accept" patients from other units to accommodate the overcrowding, nor will administration move beds to change the cramped conditions on overcrowded units. 21/

15/ Telephone interview with Marianne Finely, Effective Advocacy for Citizens with Handicaps, Inc. (EACH) representative at MMHI, August 14, 1990.

16/ Telephone interview with Dee Green, mother of a former MMHI patient, August 15, 1990.

17/ Green interview, Billings interview, Woodford interview.

18/ Telephone interview with Billy Henderson, former MMHI technician, August 13, 1990.

19/ Id.

20/ Id.

21/ Id.

Our information suggests that the physical environment at MMHI poses health and safety risks to MMHI patients. The most serious allegations involve the failure to maintain sanitary conditions. One source we spoke with indicated that the facility is not cleaned on a regular basis. Also, that source was quite concerned about roach infestation at the facility. She indicated that when she checks patients at night and turns on the lights in patient rooms, she sees roaches "scurry everywhere." 22/ She said that when food is being served, roaches are visible in the rooms and around the tables where patients eat their meals. 23/

In sum, serious allegations meriting investigation have been raised with respect to the adequacy of staff and the safety of the general environment.

Inadequate Psychiatric Treatment

Beyond the problems already noted resulting from MMHI's acute staffing shortages, there is evidence that patients are not receiving adequate psychiatric treatment. Our sources indicated that a primary problem at MMHI is the lack of adequate treatment programs for patients in that the programs are not individualized to meet patient needs. 24/ Further, it is alleged that what treatment programs exist are not monitored to determine whether they are benefitting the patients. 25/ The failure to properly review residents' treatment programs allows patients' drug schedules to go unmonitored. In at least one case, this apparently resulted in brain damage to one MMHI patient when two potent antipsychotic medications were inappropriately used in combination. 26/

One source told us that patients who have an acute need to be seen by a psychiatrist have little or no chance of being seen on a timely basis. 27/ Another source told us patients have extremely limited access to physicians and that, for patients, "it is literally impossible to talk to a doctor at the facility." 28/

22/ Collier interview.

23/ Id.

24/ Id.

25/ Id.

26/ Scott interview. Mrs. Scott's son, Keith, a former patient at MMHI, was prescribed a dangerous mixture of haldol and lithium and his current doctor fears that the brain damage may be irreversible.

27/ Collier interview.

28/ Lee interview.

One patient's mother told us she believes that, because her son did not participate in group therapies, he never received any type of treatment at MMHI. 29/

We were told that there are no adequate schedules of activities for the patients to follow. 30/ Further, we were informed that patients are idle during most of the time and that it is a rare case when patients are afforded any type of scheduled activity. 31/

Improper Use of Medication

Almost all of our sources indicated some concern about the misuse and overuse of psychoactive medications at the facility. 32/ Furthermore, one of our sources indicated that individualized drug treatment was not maintained and that she frequently saw the same medication being prescribed for many different patients with many conditions. 33/ According to our information, there have number patients harmed by improper medication administration. The mother of a former patient at MMHI informed us that her son has possible irreversible brain damage that her son's present doctor has told her is linked to a dangerous mixture of mind-altering drugs used at the facility. 34/ The same source claims that drug schedules are not closely monitored.

We were told that there has been at least one death at MMHI that resulted from the mismanagement of drugs. A current MMHI employee told us that a 15-16 year old patient died in July of 1989, allegedly after a wrong medication was given the patient by an MMHI physician. 35/ Apparently the medication blocked his bowels and led to his death. According to our sources, MMHI staff were told by the administration that if they "talked" they would be fired. 36/

29/ Green interview.

30/ Collier interview.

31/ Id.

32/ Collier interview, Scott interview, Woodford interview, Green interview.

33/ Collier interview.

34/ Scott interview.

35/ Scott interview, and telephone interview with Richard Mark, MMHI employee, August 20, 1990.

36/ Mark interview.

Another source told us that her son's medication had so adversely affected him that he could not sit still, was therefore continuously walking and, as a result, had lost 25 pounds in one month. That same source told us she suspected her son was being over-medicated because prior to her son's recent release hearing, he was talking and walking normally, but at the court hearing the next day, her son could not speak or lift his head. 37/

Another source reported to us that her son was so heavily medicated that he spent 22 or 23 hours a day in bed during his 1989 stay at the facility. 38/ These allegations strongly suggest overuse and misuse of psychotropic medications. Moreover, these allegations indicate that insufficient psychiatric care is available to avoid unreasonable use of chemical restraints.

Conclusion

Our information indicates that conditions at MMHI are depriving patients of their constitutional rights. If the allegations and information we have received are true, patients at MMHI may be being deprived of, inter alia, their right to adequate medical care, including psychiatric treatment a professional would consider reasonable to avoid undue risks to personal safety and unreasonable bodily restraint, reasonably safe conditions of confinement, and freedom from undue bodily restraint. Therefore, we recommend that an investigation of Memphis Mental Health Institute be instituted under our CRIPA authority. Funds are available to conduct this investigation.

Approved: _____

Disapproved: _____

Comments:

37/ Telephone interview with Ann Coffey, mother of former patient at MMHI, August 14, 1990.

38/ Green interview.