AUGUSTA MENTAL HEALTH CONSENT DECREE
BATES V. GLOVER AND IVES
SUPERIOR COURT CIVIL ACTION DOCKET 89-88

# OVERVIEW OF THE "AMHI CONSENT DECREE"

Prepared by NAMI Maine, August 2011

## Introduction

*Paragraph 109* of the AMHI/Riverview Consent Decree requires the state to: educate families about the terms of the Decree, available services, treatment, medications and diagnoses, and how to cope, and to fund group counseling, respite care, and psychoeducational programs for families. Licensing regulations require all mental health service providers to refer families to family supports (NAMI, GEAR, and other places where they can receive support). NAMI Maine, via a contract with the state, is required to help families understand the decree and their rights under the decree. This document is developed to provide that education. For more information, please call 1-800-464-5767.

## History

Riverview Psychiatric Center, formerly the Augusta Mental Health Institute (AMHI), opened in October of 1840. It was called the Maine Insane Asylum and it housed 133 patients. Ten years later, the facility had doubled in size (253 patients), had lost most of the main building to fire, and was refusing applications for lack of space. By 1901, the facility housed 1,020 patients and Maine's only forensic unit for "the criminally insane". Thirty years later, the hospital held 1,555 patients and in the 1940s 1,837 patients. Shock and insulin treatments were introduced and the hospital also served as a farm. By 1960, the facility held 1,747 patients, but deinstitutionalization was underway. Boarding and foster homes were constructed to move people into the community. Lithium therapy was introduced in 1969 and patients were first eligible for Medicaid and SSI. As deinstitutionalization progressed, the daily census at AMHI dropped from 1,500 to 350 within a five year period. The first patient bill of rights and patients' advocate programs began.

In the summer of 1989, overcrowding, shortcomings in the community mental health system, and poor conditions in the facility contributed to the deaths of 10 residents. Multiple legislative hearings resulted in the suspension of voluntary admissions and a class action suit was filed by Maine Advocacy Services (now called the Maine Disability Rights Center).

That class action suit resulted in what is now called the AMHI Consent Decree – an agreement between the plaintiffs (specific residents of the facility whose circumstances were cited as the cause of the complaint) and the defendants (the Commissioner of the Department of Mental Health, the Superintendent of AMHI, and the Commissioner of the Maine Department of Human Services). That agreement spelled out what corrections would be made.

## The Basic Principles of the Decree

**All people who have entered the facility since January 1, 1988 are considered "class members**" and entitled to the rights of the decree. The decree itself requires the defendants to *"develop and maintain a comprehensive mental health system to meet the actual, individualized needs of all class members and must operate with the following principles*:

1. All class members must be treated with respect for their individuality and recognition that their personalities, needs and aspirations are not determinable on the basis of a psychiatric label;
2. Class members have individualized needs;
3. All services within the system will be oriented to supporting class members to live in the community;
4. When hospitalization is necessary, it should be available in facilities nearest the class members homes;
5. Class members have the right to live in the communities of their choice;
6. Services are voluntary (with the exception of forensic services, involuntary commitment and some emergency services in a hospital setting);
7. In developing the system, defendants shall prepare an overall plan, detailing the models of service to be used, the costs, the means whereby the quality of services shall be assured, the capacity of each service component and the timelines for development, proof that the development plan is based on consideration of class members actual needs;
8. The system shall require that the size of AMHI and admissions to AMHI will be significantly reduced and community alternatives to hospitalization and discharge plans must be developed to assure a safe transition;
9. The plans for class members leaving the hospital must reflect their special needs and the supports they will need to live successfully in the community;
10. All class members are entitled to receive an individualized support plan, which specifies the services they will receive and which to be carried out and monitored by a community support worker. This individualized plan (ISP) must be fluid so that it can move with the person should they be hospitalized; hospital and community personnel are required to communicate with each other if authorized to do so by the class member;
11. All services are to be provided in the least restrictive setting appropriate and must be delivered by the least restrictive means;
12. Service, treatment, and discharge plans must focus on individual strengths and capacities and not on symptoms, labels or diagnoses;
13. Maximum independence is to be reinforced, as not all class members will want a plan; in those cases, defendants re required to develop alternative systems of care so that all members of the class may have their mental health needs met.
14. Defendants are required to develop, fund, recruit, and support the following community services: housing, residential support services, crisis intervention and resolution services, vocational opportunities and training, treatment options, recreational/social/avocational opportunities, transportation, and family support services.

In addition, defendants are required to develop a resource planning and development system that takes class members actual needs into consideration, to develop a variety of mechanisms for monitoring and assuring the quality of service, and to develop and enforce standards, including a process for class member grievances. The agreement is overseen by a court appointed special master. The first court master was Gerald Rodman; the current court master is former Chief Justice, Daniel Wathen. He can be contacted at: 207-791-1115 or dwathen@pierceatwood.com.

A full copy of the decree is available from the Disability Rights Center, P.O. Box 2007, Augusta, Maine 04338. 1-800-452-1948.

## Terms of the Decree

The decree has 350 paragraphs, summarized below. Each describes a standard that must be met to assure quality treatment either within the hospital or in the community.

1-14 are general matters, agreements by the parties, and stipulations regarding the allegations, settlement, and terms.

15 includes definitions of the terms that will be used in the remainder of the decree.

16-30 define client/class member rights.

31-34 describe the principles that guide the development of a comprehensive community mental health system.

35-48 require the state to develop plans of action that will meet the terms of the decree.

49-74 describe the community system of care; including the requirement to develop individualized service plans and sets guidelines for how services shall be delivered by community providers.

75-83 describe hospital based treatment and discharge planning, including what assessments must include and how soon community support workers must become involved.

84-111 describe the array of services that should be available in the community service system including hospitalization, housing, residential support, crisis intervention, vocational, treatment, recreational opportunities, transportation and family support. **Family support services are described in paragraphs 109-111** and detailed in Appendix A.

112-132 set standards for community mental health organizations (many of these are now the body of state licensing standards for these organizations).

133-223 describe the standards for treatment, staffing, and safety at the Augusta Mental Health Institute.

224-249 describe the standards for operating the now closed nursing home and adolescent units.

250-251 describe standards for the forensic unit.

252 describes the requirement for the defendants to provide public education to reduce stigma and educate people and their families about mental illness.

253–267 outline the standards for caring for those class members who are under public guardianship.

268-273 cover some miscellaneous issues such as payment of legal fees, budgets, and determinations of capacity

274-303 describe compliance and monitoring of the decree, including the role of the special court master.

## Status of the Decree

As of January of 2009, the State of Maine has been under class action for 19 years. A new facility, Riverview Psychiatric Center, has replaced the old AMHI building. A "court master", an attorney appointed by the Superior Court, currently former Chief Justice Daniel Wathen, oversees compliance and reports to the court about it. Multiple and significant efforts have been undertaken to comply with the decree and to reach "substantial compliance." In fact, many of the paragraphs in the decree are now considered to have been met. Ongoing court reviews gauge compliance with the remaining paragraphs. Consent decree managers are employed by the state and available to all class members to assist them with unmet needs. They can be reached through the Office of Adult Mental Health Services: 207-287-4243 or 287-4250 or TTY 1-800-606-0215. The state's routine filings with the court regarding their compliance can be seen on the Department of Health and Human Services website www.maine.gov/dhhs. (You must click on adult mental health, and on the left hand of their screen is a drop down for the consent decree. Scrolling down that page, you will see the reports to the court.)

Many lengthy court decisions have come forward about the case. A December 2004 law court decision in the AMHI case provides a good overview of efforts to comply and is quoted extensively here. "Shortly after the consent decree was approved, Maine entered a prolonged period of fiscal crisis that required the executive and the legislative branches to institute difficult reductions in many State programs, including programs serving individuals with mental illness. In 1994, when the State was still experiencing

fiscal shortfalls, the plaintiffs filed a motion for contempt and enforcement of the consent decree. After a five-day hearing, the trial court (***Chandler, J.***) essentially ruled against the State. The court found the State in contempt[3] in the following areas: (1) failing to properly plan for the downsizing of AMHI and a commensurate increase in community-based facilities; (2) failing to properly plan for and hire staff to support delivery of services to class members on an individualized basis; (3) failing to properly plan to meet the housing and residential needs of class members; (4) proceeding with plans and programs without prior approval of the court master; (5) instituting major changes in funding methods to the detriment of the class members without consultation with or prior approval of the court; (6) failing to meet deadlines for approval of plans and programs without seeking court approval for deadline extensions; (7) failing to institute a coordinated system for monitoring and evaluating progress toward substantial compliance; and (8) failing to recognize that class members "are a distinct class governed by the Settlement Agreement whose needs must be given priority when funding levels mandate that services be prioritized."

The Court of jurisdiction (Maine Superior Court) ordered the State to ‘‘come into compliance by achieving certain objectives by certain dates, and specifically instructed the State on how to come into compliance. For example, the State was ordered to submit all outstanding plans required by the consent decree to the court master by December 1, 1994. If the master did not approve the plans, the master was to hire an outside consultant to assist with bringing the proposed plans into compliance.

In August 1995, plaintiffs filed a motion for imposition of sanctions and for contempt of the consent decree and the September 1994 order. After a five-day hearing, by order dated March 8, 1996, the Superior Court (***Mills, J.***) determined that the State was in contempt of the 1994 order, and proposed to appoint a receiver ‘to take over from the defendants all responsibility for compliance with the terms of the Settlement Agreement, the Consent Decree and the order dated 9/7/94.’[4] The trial court then stayed appointment of the receiver to give the State a final opportunity to comply with specific instructions by specific dates. From 1996 to January 2002, the parties filed various plans for compliance and reports with the court master, and the court master reported to the court. The State did not file a notice of substantial compliance during that time, nor did the State file any motions to amend the consent decree and settlement agreement or to extend its time limits. The plaintiffs filed no additional motions for contempt.

In March 2001, the State informed the court that it intended to file a notice of substantial compliance by the end of that year. When no notice was filed by January 15, 2002, the court, on its own initiative, moved to determine whether the State was in substantial compliance with the consent decree as of that date. Thereafter, on January 25, 2002, the State filed a "Notice of Substantial Compliance" pursuant to the consent decree, claiming to ‘have attained substantial compliance with all requirements of the Settlement Agreement that is incorporated into the Decree.’ Plaintiffs filed objections and supporting factual material addressing most of the paragraphs of the settlement agreement.

After additional court proceedings where evidence was collected to determine if substantial compliance had been reached, the court issued a finding of contempt. Justice Nancy Mills found that 'the defendants, if left on their own, will not achieve substantial compliance in the near future.' She appointed a receiver.

Other important rulings contained in the court's order are that (1) "defendants have developed a system that relegates non-class members with mental illness to second-class status. . . . Such a two-tiered system has not achieved substantial compliance by any standard; that system has failed"; (2) forensic patients are merely warehoused at AMHI without treatment and discharge plans; (3) despite commitments in the settlement agreement to the contrary, patients who need hospitalization at AMHI are refused admission because it does not have the staff or beds to accept patients, and patients who are ready for discharge remain at AMHI because the workers and resources needed to support their living in the community are not available; (4) people who live in the community are not getting the services they need because the State has not identified their needs or developed resources to meet the needs; (5) crisis intervention services are inadequate; and (6) the State was not in substantial compliance with the agreement to develop a comprehensive plan for provision of mental health services."

The trial court further found that '[t]his is not a failure of funding. The evidence made clear that until recent budgetary problems, money for Consent Decree purposes was consistently provided by the Legislature. The court appointed a receiver to operate AMHI and indicated that it would consider appointing a receiver to operate the community mental health system. The receiver for AMHI was given all powers and authority usually vested in the Superintendent as they relate to the duties and obligations under the consent decree. Those powers included, among other things, authority to oversee all financial, contractual, legal, administrative, and personnel functions at AMHI and to restructure AMHI into an organization that will achieve compliance; to retain consultants, experts, or others to provide training to the AMHI staff or to assist in achieving compliance; to negotiate new contracts, including contracts with labor unions; to restructure management; and establish the budget. The receiver was required to report to the court on a monthly basis and to prepare a work plan for submission to the court on how compliance will be achieved. After a motion for stay of the appointment of the AMHI receiver was denied, the State filed an appeal with the Law Court. While the appeal was underway, Elizabeth Jones was appointed receiver of the Augusta Mental Health Institute and was responsible for implementing, along with the Superintendent of the facility, multiple changes which brought the hospital into substantial compliance with the sections of the decree that govern it. In December of 2004, the Law Court made a decision about receivership – upholding some of the earlier findings and dismissing others. Specifically, the higher Court found that the lower court had not met the burden necessary for receivership and the receiver was dismissed.

In July of 2008, following significant reductions in spending for community mental health services as part of the state's budget crisis, Justice Mills again issued an order for an outside monitor to inform the court about the impact of those cuts on the state's ability to comply with the decree. Her order stated: "the court has no mechanism

at this time to obtain detailed and accurate information about the funding of the adult mental health system and the impact of that funding on the defendant's ability to achieve substantial compliance with the terms of the Consent Agreement… It is estimated that at this time, 12,000 people are covered by that Agreement." She called for an independent assessment and Elizabeth Jones, the earlier receiver at AMHI (now Riverview Psychiatric Institute), was hired to carry out that assessment. Her report is due in February of 2009.

In December of 2008, the court master concluded that the Department is not in compliance with the decree with respect to the level of support provided for the Bridging Rental Assistance program (BRAP, a subsidy for people's rent payments and with mental health services including community integration (case management/community support), medication management, assertive community treatment, and individual counseling. More specifically, he sited the obligation to fund and support sufficient housing and treatment to meet the needs of class members who are hospitalized or at imminent risk of hospitalization. Further, he stated that the decree acknowledges that these obligations extend to all people with serious and persistent mental illness (i.e., are not limited only to the class that has been hospitalized at AMHI since January 1, 1988). He recommended that on or before April 10, 2009, the Department increases its funding for BRAP by $421,723 and funding for treatment services by $517,500. He also requested that he be provided with: (l) any and all budget proposals related to the funding, support, or provision of mental health services for FY 09, 10, and 1l, (2) all proposals that affect mental health services, including funding reductions, (3) an impact statement and supporting data for each service for class and non-class members and the affect on the department's ability to comply with the consent decree, and (4) a similar assessment of budget proposals that affect mental health services that originate outside of the Department of Health and Human Services (i.e., the Department of Corrections). All of the above should be provided with sufficient time to permit review, inquiry, and advance comment.

In June of 2009, the court master issued a report indicating that reductions and shifts in funding have negatively impacted the delivery of community mental health services, are inconsistent with the decree, and preclude attainment of substantial compliance. He concluded that the court intends to show cause by determining if the Department has complied and consider the "imposition of appropriate relief in the event there is a finding of non-compliance or contempt."

In August of 2011, the court master issued a report calling for Riverview itself to be released from direct supervision by the court, although continued quarterly reporting will continue to be required. The master makes it clear that though withdrawal of active supervision is recommended, the operation of Riverview will continue to fall under the jurisdiction of the Court and the Consent Decree will remain enforceable. This decision recognizes 20 years of effort to change how the hospital houses, treats, and discharges patients and evidence that the Legislature and Administration have maintained needed funding and staffing levels at the hospital. In addition, the court master indicates that other protections are in place, notably the ADA, the newly established Consumer Council

System of Maine, and CRIPA. He indicates that the Department has made great strides in meeting goals established in 2006, which include:

- Consumer-centered, innovative, recovery-focused hospital-based care appropriately integrated with community-based care.
- High quality mental health care within the least restrictive and most appropriate setting.
- Professional administration that ensures delivery of appropriate care within available fiscal resources.
- Rights, dignity, and respect.
- Community integration/community support services/individualized support planning.
- Community resources and treatment services.
- System outcomes: supporting the recovery of adults with mental illness.

The court master's concerns, and the reason he leaves the community mental health system under active supervision is the need for careful attention to the discharge needs of patients and on-going deficiencies in the availability of mental health services in the community, particularly for people who do not have Medicaid. Although funding ($5,659,250) was appropriated for services and housing in 2012, that amount drops to $995,000 in 2013, even though the unmet needs of people with serious and persistent mental illness living in the community are not fully documented. The master's report indicates that the Department will "have to arrive at a reasonable estimate of needs, allocate the additional funds to meet those needs, and distribute those funds in an efficient manner to achieve maximum benefit."

## Decree Relevance for Families of and People with Mental Illness

The implementation of the requirements of the AMHI Consent Decree (now Riverview Consent Decree) is ongoing and fluid. The court continues to hold the state accountable for the establishment and support of a mental health system that meets the needs of adults with serious and persistent mental illness living in Maine. The Department continues to submit compliance reports; the court continues to issue findings about that compliance.

Families of and people with mental illness can look to the decree to guide them in knowing their rights and understanding what services should be available to them. It should guide their assessment of how services are provided to them by Maine's independent community service providers. Families of and people with mental illness should see their Individual Service Plans (ISPs) as documentation of what has been deemed necessary to meet their needs and as a mechanism to pursue change if their ISPs do not reflect their needs or what is described there cannot be obtained. For class members who do not want case managers and ISPs, the decree specifies that the state must also assure that services that meet their needs are available.

Questions about the Decree can be directed to:

The Maine Disability Rights Center 1-800-452-1948

NAMI Maine 1-800-464-5767

*Update July 2013*
There are no longer Consent Decree Coordinators. The Maine Office of Substance Abuse Mental Health Services contacts for questions regarding rights under the Consent Decree and assistance and information are:

- For Mental Health Region 1(York and Cumberland County)
  - Paul Coleman at 822-0470 or
  - Linda Santeramo at 822-0166
- For Mental Health Regions II and III
  - Juanita Page 287-7217 or
  - Cecilia Leland 287-9165
  - Brian Gallagher at 2874235
  - Maynard Jalbert 356-2153

# Appendix A

Below is the exact language regarding Family Support

I. Family Support

109 Defendants shall fund, develop, recruit and support an array of family support services to include:

a. Education on the terms of this Agreement;
b. Education on available services, and on mental illness from the perspectives of professionals, other families, and mental health service recipients;
c. Direct support of family groups through the provision of a facilitator at meetings, if requested;
d. Education on treatment, medications, diagnoses, prognoses, and how to care for persons with mental illness;
e. Group counseling;
f. Psychoeducational programs; and
g. Respite services for families who provide class members with intense supervision and assistance. These services shall be made available on a planned basis and shall be delivered according to models which cause the least disruption to plaintiffs and their families

110. Defendants shall also require agencies which provide mental health services to include among their services the referral of family members with whom the providers have contact to area family support groups. When referring a family member to a family support group, agencies shall provide information regarding the group and shall additionally offer to call the support group to vive the family member's name and the means whereby he or she may be contacted by the support group.

111. To comply with this sub-section on family support, defendants shall meet the applicable terms and timetables of their plans required by Section V. of this Agreement.