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Bates and Olmstead: Court-initiated Strategies to Implement Community Inclusion of Persons with Psychiatric and Other Long-term Disabilities

Theresa A. Laurie

COMMENTARY

Bates *and* Olmstead: *Court-initiated Strategies to Implement Community Inclusion of Persons with Psychiatric and Other Long-term Disabilities*

By Theresa A. Laurie

As Maine reorganizes its health, human services and mental health services into one organization, policymakers need to consider how this new department should implement its programs on behalf of not only persons with severe and persistent mental illness but also those with long-term disabilities of any type.

Historically, and for the most part independently, the two departments have developed community-based services in support of separate disabled populations. However, two court decisions are currently influencing the state's program development: *Olmstead,* a national case, and *Bates* in Maine.

The *Bates* consent order (sometimes referred to as the "AMHI consent decree") derives from a Maine Superior Court class action suit brought in February 1989 on behalf of patients of the Augusta Mental Health Institute (AMHI) against the Commissioner of the Department of Mental Health and Mental Retardation.[1] This suit alleged that treatment was inappropriate and that there were inadequate community support services for persons with severe and persistent mental illness. The class was later extended to others who subsequently have been, or could in the future, be institutionalized at the Augusta Mental Health Institute. In part, this extension is due to the continued lack of access to appropriate housing and needed services in communities where these class members once lived. Currently, the Augusta Mental Health Institute is in receivership. Receivership shifts management of AMHI's court-ordered compliance requirements to reduce hospital patient size and improve community-based care from department commissioner and staff to the Maine Superior Court and Attorney General's office.

Olmstead is a Georgia court decision regarding the rights of the disabled which was upheld by the U.S. Supreme Court in 1999. Mentally disabled clients had brought suit against the Georgia Department of Human Resources, challenging their continued confinement in segregated institutional environments. In the context of the public services portion of the Americans with Disabilities Act (ADA), the patients sought placement in community care residences where they were therapeutically determined to be ready to enter. The U.S. Supreme Court concurred with the lower court's ruling that the state of Georgia was in violation of the "integration mandate" of the ADA. A core objective of the *Olmstead* decision is to secure housing and long-term care for persons with disabilities who need publicly sponsored arrangements in order to reduce their exclusion from society.

Although *Olmstead* and *Bates* both require the state to provide for community inclusion of persons with psychiatric disabilities, the desegregation of long-term disabled populations, and the development of programs with services to support independent living in communities, *Olmstead* is a more far-reaching decision than *Bates*. *Olmstead* recognizes the full diversity of persons who are categorically disabled under the ADA. This decision restates that unnecessary segregation and institutionalization constitute discrimination in violation of the ADA. It emphasizes the need to provide community integration and services for individuals in the most appropriate setting, with a preference for non-institutional living arrangements. Because the *Olmstead* decision influences Medicaid funding, it is an example of how a federal court ruling can compel state action.

Maine has not yet resolved how to implement *Olmstead*'s requirement to offer residential services to persons with disabilities. The process is in the "work group" stage in the Department of Health and Human Services. Currently, the long-term plan to develop comprehensive regional community services throughout Maine gives priority to serving the *Bates* "class members," who represent only a subgroup of the disabled population recognized under *Olmstead*. To move from a court-ordered population to a system marked by inclusion and representative service capacity will be an ongoing challenge of the newly organized Department of Health and Human Services.

Unfortunately, in the short run, trying to develop a broad system of services, while having to anticipate the personal circumstances of others who have not yet

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become clients of the public mental health system (as is dictated by *Bates*), has resulted in temporally incompatible service-development perspectives. They are incompatible because the many possible personal avenues toward independent living require different implementation strategies and involve varying service domains, both state-sponsored and within any of the communities preferred by each client. Complicating service-planning and policy as required under the *Bates* consent order, the Department of Behavioral and Developmental Services also is dealing with the need to rearticulate policy statements and goals in light of concerns emanating from the developing consumer and family movements statewide.

The broader and seemingly absolute objectives articulated in *Olmstead* are based on principles acknowledged by the ADA. The effect is to enlarge the scope of public policy and the field of implementation by supporting a definition of persons with disabilities to include the mentally ill. Maine's *Bates* decision circumscribes the reach of community health services policy and program development only to a more narrowly defined subgroup of the mentally ill in the state.

Moving forward, it is clear that policy adjustments need to be made in order to redefine how Maine conceptualizes the program objectives of both *Bates* and *Olmstead*. Some objectives should be considered immediate, others intermediate and, still others, ultimate. For example, identifying and resolving the circumstances of the people affected by *Bates* are immediate implementation objectives. Developing needed service resources regionally and the recruitment of skilled diagnosticians into clinical practices in Maine are intermediate objectives. Eliminating segregation based on disability—in other words, the fulfillment of *Olmstead*—is ultimate.

Bates and *Olmstead* both suggest we need policies that ensure meaningful participation in decisionmaking, especially when such participation leads to the improvement of wellbeing and supports individual choice in defining home milieus. State action to promote these aims would foster a system that operates on a foundation of client-centered programming. This long-term objective shifts the focus from achievable tasks completed on behalf of individuals (which has been an emphasis under the *Bates* decision) to meeting favorable community goals and furthering societal aspirations more broadly. A comprehensive set of services based on the parallel implementation of *Bates* and *Olmstead* also could enable the development of a flexible system as well as enhanced social inclusion and less segregation of persons with all types of long-term disabilities, including mental illness.

Currently in Maine, *Bates* continues to serve as the primary driver of efforts to establish a comprehensive set of reliable, applicable and affordable services for persons with severe, disabling psychiatric conditions across the state. However, once Maine's policy based on *Olmstead* is established, there will be administrative pressure to meet the residential care needs of all persons with long-term disabilities. This should provide an opportunity to greatly improve upon the continued implementation of *Bates*. In fact, compliance with *Olmstead* allows the mental health division to lift the lid off the *Bates* "petri dish," releasing it from a circumscribed community integration experiment into a larger space bound by the requirements of the ADA. The parallel implementation of the two court decisions permits separate long- and short-term systems goals to be managed, transmuted and completed over time and under leadership as is appropriate to the process for each.

Thus, as the two departments blend their administrative and service development resources, it is imperative that the mutual obligations of each court decision be met through cooperation, rather than through competitive programmatic and policy spheres. Even if the near future includes the successful close of the *Bates* consent order or the end of formal receivership for AMHI, the state will not be absolved from having to use sufficient leverage and available resources to create therapeutically appropriate services in Maine communities. Implementing the best of both *Bates* and *Olmstead* in direct light of one another would greatly advance the state's ability to meet the common independent living needs of persons with severe and persistent mental illness, along with those who suffer with, experience, and recover from other disabilities.

Please turn the page for article references and information about the author.

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Theresa A. Laurie holds a Masters of Law and Social Policy and a Masters of Social Services from Bryn Mawr College, and a Ph.D. from the Bryn Mawr Graduate School of Social Work and Social Research. She did post-doctoral research with the Mental Health and Social Welfare Research Group at the University of California, Berkeley, and has taught at the University of New England and the University of California, Berkeley. She was the principal coordinator in the Maine Department of Behavioral and Developmental Services for the Bates consent decree in its formative years. She is currently recovering from a disabling head injury.

ENDNOTES

1. The Department of Mental Health and Mental Retardation was reorganized and underwent several name changes since the original consent decree, first to Mental Health, Mental Retardation and Substance Abuse Services, and most recently to Behavioral and Developmental Services (BDS). In 2004, it is being incorporated as part of the new Department of Health and Human Services, created through a merger of the Department of Human Services and BDS.

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