

November 2019

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Recommended Citation

Katz, D., Penn, A., & Gillece, J. (2019). The Consent Decree: A Means of Obtaining Mental Health Services for People who are Deaf. *JADARA*, 26(2). Retrieved from <https://repository.wcsu.edu/jadara/vol26/iss2/10>

THE CONSENT DECREE: A MEANS OF OBTAINING MENTAL HEALTH SERVICES FOR PEOPLE WHO ARE DEAF

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Abstract

Consent decrees are a widely used technique to get services for disabled persons, and they can be an effective method to get appropriate state-wide mental health services for persons who are deaf. Many state mental health systems have resolved litigation through the formation of 'consent decree units.' If properly designed and implemented, such units can improve services for patients who are deaf, empower administrators to provide programs not otherwise possible, and result in effective mental health units. The steps involved in using the consent decree approach are given and guidelines for structuring and implementing a consent decree are provided.

decree (Geer, 1985). In brief, a consent decree, as it applies to this paper, is an agreement between a defendant (in this case the mental health system) and a plaintiff (a deaf patient who is being denied his or her legal right to adequate mental health services). The agreement or consent decree states, in essence, that the defendant will provide satisfactory services for deaf patients if the suit is dropped.

Because consent decrees are a widely used litigational approach to obtaining services, a knowledge of the issues involved in them is important for those serving mentally ill persons who are deaf. This is especially true in view of the recent passage of the Americans With Disability Act (McCrone, 1991). This new law will provide attorneys with tremendous leverage in obtaining consent decrees. As a consequence, there will be many more lawsuits filed with consent decrees often being the most satisfactory resolution.

It is the intent of this paper to provide professionals in deafness with suggestions and guidelines for obtaining and designing consent decrees which will result in improved treatment for deaf patients, be effective for mental health administrators, and yield a productive dividend for

Making Consent Decrees Work for Deaf Patients

State mental health systems which do not voluntarily provide equal and appropriate services for deaf mentally ill persons can often be made to meet their obligation through the use of a consent

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the efforts of advocacy attorneys. The authors have participated in the consent decree process and/or worked in a mental hospital ward established by such a decree for patients who are deaf (Geer, 1985). In our case, it was a unit at Springfield Hospital Center in Sykesville, Maryland.

Historical Perspective (Legal Advocates' Position)

In 1983, the Maryland Disability Law Center (MDLC) and the National Association of the Deaf Legal Defense Fund (NADLDF) sued Maryland state officials for failing to provide appropriate mental health services to an involuntarily committed deaf patient (Nancy Doe vs. Charles Buck). The patient who, to preserve her confidentiality, sued under an alias, had been in the state mental hospital system over twenty years prior to the suit (Geer, 1985). The Complaint alleged that during this time period, she had been excluded from treatment programs because of the hospital's failure to provide any means to meet her unique communication and mental health needs, e.g., no sign language interpreters were provided. None of the staff knew sign language nor had they the other requisite expertise needed for adequately treating deaf mental health patients. Furthermore, no outside consultants had been obtained to bridge these huge gaps.

Among other issues, the Complaint alleged that the state's failure to provide equally effective treatment to this deaf patient constituted handicap discrimination in violation of Section 504 of the Rehabilitation Act of 1973, 29 USC 794 (Charmatz, 1986). Section 504 prohibits hospitals and other recipients of Federal funds from discriminating on the basis of handicap. As relief, the Complaint sought \$6,000,000 in compensatory and punitive damages as well as an injunction requiring the state to adopt policies and practices that addressed

the special communication and mental health needs of deaf patients.

After about two years of pretrial legal wrangling and negotiation, the parties settled the case in 1986 with the signing of a broad-ranging Consent Decree. Among other things, the Decree obligated the State of Maryland to establish an inpatient unit "as a model for treating hearing-impaired mentally ill persons using appropriate communication methods." The Decree specified staffing levels for nurses, psychiatrists, psychologists, social workers, occupational therapists, and activity therapists. It required that these staffers be "trained in the mental health needs of hearing-impaired individuals." It stipulated that "either a certified interpreter or another staff member who signs fluently will be on duty in the unit 24 hours a day."

Early Problems

The Unit for Deaf Patients opened with great hopes for success by all the parties involved. However, in less than two years it had deteriorated into little more than a warehouse for deaf patients, largely because of poor leadership and insufficient funds.

During the steady decline of the Unit, plaintiff's attorneys had monitored the situation in several ways. For one, the Decree required the state to submit quarterly reports regarding its compliance efforts. However, because the Decree failed to specify the contents of the reports, they proved to be of little help in identifying problems. Much more valuable data came from numerous on-site visits by Nancy Doe's guardians and by Maryland Disability Law staff attorneys. Perhaps the most important compliance information was derived from the complaints of Unit staff members themselves. Many of these professionals became demoralized and outraged by the state's failure to

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provide care for deaf patients and to respond to their complaints. As a last resort, they sought help from the "other side," i.e., the same legal advocates originally responsible for establishing the Unit.

Armed with mounting evidence of major breaches of the Consent Decree, in June, 1988, Nancy Doe's attorneys threatened to take the State back into court. Only then did high-echelon mental health officials focus on the Deaf Unit and its problems. Since this legal threat, the Unit's fortunes have risen, albeit slowly, haltingly, and never easily.

Lessons Learned

The up-and-down history of this Consent Decree's implementation has taught valuable lessons to all concerned. The parties learned that the problems do not necessarily end with the signing of the Decree; it is only the beginning.

Many of the difficulties we faced could have been avoided if the Consent Decree had required the State to develop a plan of implementation that defined tasks and timetables in specific operationally-stated terms. We learned the importance of strong language in the Decree, language the plaintiff's attorneys could point to whenever the State wavered in its implementation. Only such clear and unequivocal written specifications provide the leverage needed to compel the State to meet its obligations under the Decree to which it had agreed. We also discovered the necessity of sustained vigilance and monitoring to ensure that the Decree is continually and fairly implemented. Oftentimes, government decision-makers operate in a crisis atmosphere, temporarily plugging up one problem and then moving on to the next emergency. Thus, when the decision-makers were no longer focused on the first problem—in this case the Deaf Unit—the

momentum for long-range solutions evaporated. Only constant pressure can sustain that momentum. A properly drafted consent decree can provide and expedite that pressure.

Characteristics of Deaf Patients That Led to the Nancy Doe Consent Decree

Deaf patients, as a group, need sign language in order to communicate (Vernon, 1987). For most, lipreading (or speechreading) is not enough (Sussman, 1990). For example, the best lipreaders grasp only about five percent of what is said, if they depend on lipreading alone (Vernon & Andrews, 1990, p. 100). This is obviously inadequate to enable therapy to occur, nor does it allow deaf patients any meaningful way to interact with their hearing fellow patients (Steinberg, 1991). Even writing has limited value because most deaf patients have great difficulty with reading and writing English, although they are generally fluent in American Sign Language (Brauer, 1990).

Thus, for deaf patients in Maryland and in most other states, prior to the Nancy Doe Decree, hospitalization for mental illness was essentially antitherapeutic custodial isolation. It was more for the benefit of society and for the good of deaf patients.

Ancillary Benefits

In addition to the direct advantages that have accrued to deaf inpatients as an outgrowth of the Nancy Doe Consent Decree, there are many ancillary benefits. For example, once deaf patients were identified and centralized, other service agencies knew where they were and could send in appropriate specialists to serve them. As a result, hospital stays have been shorter and recidivism less frequent. Half-way houses have been

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developed in the community. Hearing screening has been implemented, state-wide, in public hospitals for the mentally ill.

These are but a few of the benefits that occurred when the Deaf Unit was established. Consent decrees have this potential, nationally, if they are carefully developed in ways that enable them to serve their stated purpose, if they are revised as needed, and if given the administrative structure to function effectively.

Issues Faced in Units Created By Consent Decrees

Funding

Usually, Consent Decrees are agreed upon with no clear, well developed procedure for funding. In most cases, the hospital or facility in which the unit is placed is expected to absorb the costs in its general budget.

This creates major problems. The population for which the unit was established is generally difficult to serve. It will usually require specialized staff, longer length of stays, more varied intensive therapies, special physical accommodations, lower patient/staff ratios, et al. These services are costly. As a result, a disproportionate percentage of the host facility's funds are channeled into the unit created by the consent decree. Thus, other units in the hospital suffer a loss of services. This causes resentment. The hospital's administrators are left in a difficult role, often having to give up special projects and interests of their own to support a unit forced upon them by the courts. The "Consent Decree Unit" is then seen as a plague, something that nobody wants because it takes disproportionate resources from all.

Unfortunately, it does not take long for these feelings to develop. Once they do, the special unit is an essentially hopeless position, unless the consent decree has been established in

comprehensive, ironclad terms, dictating the direct lines of management funding.

The problems surrounding the allocations of money should and can be reduced by having the funds for the special unit come from a separate source established at the headquarters level of the State Department of Mental Hygiene solely to support the unit. This should be spelled out in the Consent Decree.

Specialized Staff

As indicated earlier, special populations generally require staff with unique skills (Brauer & Sussman, 1979). Such persons are almost always in short supply, expensive, and may lack some of the credentials demanded of other facility staff (Sussman, 1990). Our deaf unit is an example. To work with deaf patients requires skill in sign language and a strong fund of knowledge about deaf culture. Few nurses, psychiatrists, psychologists, social workers, attendants, or other mental health professionals have this competence. Without it, interpreters must be used (Frishburg, 1986). They are extremely expensive, e.g., we have 24-hour coverage with as many as three interpreters on duty at busy times. The estimated bill for this service is approximately \$300,000 per calendar year (\$25 per hour per interpreter). Such a substantial budgeting item is very difficult for general hospitals to absorb.

Because of the unique requirements of the patients in most "consent decree units," two staffing adjustments are required. First, job descriptions must be altered to face the reality of the supply-and-demand situation relative to personnel. This may create union and civil service problems. For example, in our locale there are many masters-level mental health counselors available who are either deaf themselves and have fluency in sign language or else they are hearing know sign language. By contrast, masters-level

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social workers and psychologists who can sign are in very short supply. Yet the Civil Service rules permit only the hiring of masters-level social workers as therapists, and do not allow those positions to be filled by masters-level mental health counselors or psychologists.

Since consent decree units have unique staff needs, it is imperative that they be given latitude in terms of the job descriptions and hiring procedures. These exceptions need to be specified in the consent decree, then processed through alternative personnel channels.

In addition, provisions need to be made for specialized instruction, related job standards, and pay increments for staff. On the deaf unit, classes in sign language and the culture of deaf people are required. (Competency standards are set for sign language and must be met by specified deadlines.) Salary raises must reflect these additional job criteria. For example, it is unreasonable to expect people to make the sacrifices necessary to master sign language if there is no reward. Other units established by consent decrees will have similar needs for adjustments in job descriptions and salaries.

Periodic Review of the Decree

Regardless of how carefully written, no consent decree can anticipate all the problems that will arise. Thus, a part of the decree should be a provision for a re-evaluation and possible revision every two years. Parties to the original decree (or their representatives) and the director of the special unit should be present and agree on any changes made. If agreements cannot be reached, legal recourse may be necessary.

Persons to Implement Decree

There needs to be two people assigned the responsibility of assuring that the stipulations of the decree are followed. First, an administrator with power in the state's mental health division should have the assignment and the authority to implement the requirements of the decree. Otherwise, the entire process gets lost in the confusion, inertia, and the occasional passive aggressiveness of the bureaucracy. For example, contracts are delayed excessively, job descriptions cannot be changed, admissions are denied, discharges frustrated, supplies cannot be purchased, etc.

Secondly, there needs to be an experienced administrator on the special unit who will be responsible to see that the conditions of the decree are met. When there is a problem, this person should have a direct line of communication with the administrator in the State Department of Mental Health who has the authority and responsibility to see that the decree is followed.

Review Hearings

At least three times a year there should be review hearings to assure that there is conformity with the requirements of the decree. The administrator of the unit, those persons responsible for implementation of the decree, and the legal advocate should be present.

In the absence of such review hearings and administrative structure, the only effective way violations of the decree can be acted upon is for the legal advocate to threaten to file suit. This is usually not in the interest of the administration, the special unit, the legal advocate, or the patients.

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Administrative Viewpoint

Advantages

For administrators, consent decrees are a fact of life which have both pluses and minuses. One major advantage is that a decree empowers. It provides leverage to enable a mental health administrator to meet special needs. In Maryland, this has resulted in major improvements in services to deaf patients.

With a properly conceptualized consent decree, the administrator is in a position to do what needs to be done and what should be done for at least one group of patients. This is a rare luxury in most state mental health systems (Trybus & Edelstein, 1981). For example, in Maryland we were able to hold a national conference focusing on the needs of deaf mental patients. This long neglected population is now being served effectively and humanely in Maryland. The impetus has been laid for such services to generalize nationally.

Opposing Views

The opposition to consent decrees has come primarily from administrators, not from deaf people needing help or from those who want to provide the treatment. Many administrators resent the diversion of staff and resources from their regular program to "consent decree units." Some feel that consent decrees take control away from mental health authorities and leave the courts administering hospitals. A chief counsel for one state mental health department claims his experience with the consent decrees has been so bad he would litigate everything rather than enter into another such arrangement.

Maryland Situation

In Maryland, the mental health administration has established a trusting, positive relationship

with the advocate attorneys who brought about the consent decree. This is far preferable to an adversarial stance which inevitably results in the two parties wasting undue amounts of time and money fighting one another instead of serving patients. By having open communication and trust between the administration and the legal advocates, problems can be resolved in reasonable ways that benefit patients.

Certainly no administrator welcomes a lawsuit or being forced into a consent decree. However, once a decree has been agreed to, it can result in excellent services to certain populations when properly structured and administered.

Summary

One way to obtain appropriate patient mental health services is through a consent decree. The following steps and conditions for gaining and implementing such a decree are suggested:

1. Select a test case, i.e., a hospitalized deaf patient who is not receiving adequate service and who has been hospitalized under these circumstances for at least 10 years.
2. Using local advocacy lawyers along with consultation from the Law Center at Gallaudet, file suit on behalf of the deaf patient.
3. If possible, resolve the suit by a consent decree which contains the following stipulations:
 - a. The decree develops clear procedures for funding. It is especially important that monies for the unit created by the consent decree does not come out of the general hospital budget because

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- this creates bad feelings and envy from other hospital staff and administrators.
- b. Specialized staff will usually be necessary. These staff needs should be carefully described and the union and Civil Service waivers required obtained as part of the decree.
- c. The consent decree should provide for a re-evaluation and possible revision of its structure and implementation every two years. Parties to the decree and the director of the unit created by the decree should agree on any changes made.
- d. Administratively, two key persons are needed to implement a consent decree. One is an administrator in the state's mental health division who has the authority to implement the requirements of the decree. Second, there must be an administrator on the unit created by the decree who is responsible for seeing that its requirements are met.
- e. At least three times a year, a review hearing should be conducted to assure that there is conformity with the decree. The administrator of the unit, the legal advocate, and the two persons responsible for implementation (Item d above) should be present.

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