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CHALLENGES 1977

A report from the Texas Department of Mental Health and Mental Retardation

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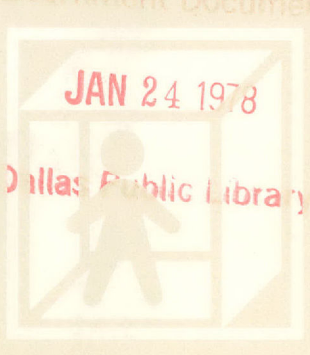


chal·lenge *n* 1 : anything, as a demanding task, that calls for special effort or dedication 2 : a summons that is often provocative or stimulating

Chal·len·ges 1977 *n cap* : a report for the fiscal year Sept. 1, 1976 through Aug. 31, 1977 published by the Texas Department of Mental Health and Mental Retardation on ways 52 facilities coped with difficult situations in their mission to help the mentally disabled of the state; *syn* see MENTAL HEALTH SERVICES (p. 3), MENTAL RETARDATION SERVICES (p. 11), SPECIAL UNITS (p. 21) and COMMUNITY SERVICES (p. 27).

Challenge?

In the face of changing times, complex rules, conflicting standards, court decisions and interpretations, the challenge this year was to keep the facility in one piece and keep it running.

Challenge? Did you ever try to take a million square feet of open floor space and renovate it into four-bed bedroom units without transferring a resident or missing a meal, program, training session or activity?

Challenge? Miraculously convert the tired timbers of a 30-year-old facility into a structure meeting Life Safety Codes without significantly affecting the routine of operation.

Challenge? Try to unravel the 1977-78 Medicaid standards developed originally for nursing homes, written to apply to geriatrics, force-fed into the retarded mold, amended regularly and confused and complicated by broad and conflicting interpretation from review teams and surveyors alike.

Challenge? Take note of the audit teams, review teams, survey teams, inspection teams, investigative teams, citizen groups, media groups, legislative groups and parent groups who chose this year to take the institution's pulse. This was the year there was nearly one audit, survey or investigation for every week in the year! And the school had to pass them all.

Challenge? This was the year that the transition away from isolationism was complete. No longer alone in the backwater of anonymity, the facility was open to the full scrutiny and active involvement of parents, public, courts and news media.

Challenge? Six hundred persons were newly employed in one year, adequately trained and melded into an employee population of 2,000, but accomplished with federal requirements and restrictions so tight that virtually any action (or lack thereof) could and did bring down the wrath of complaints to the Equal Employment Opportunity Commission, grievance hearings, U.S. Dept. of Health, Education and Welfare investigations and adverse workers' compensation rulings.

Challenge? The advent and clarification of resident's rights, employee's rights, applicant's rights and parent's rights have by definition eroded the previous concept of management authority. Hence, a greater and more complex assignment results, with fewer management latitudes and tools available to perform the job.

Challenge? Try, if you will, to accept a sizable part of your total budget in the form of federal dollars (with accompanying restrictions) and dare to resist becoming a bureaucracy. Operations reached $12,000 cost per resident per year with more employees than residents by 25 per cent. We sometimes felt there were as many people keeping records as were providing a service to the residents.

Challenge? The challenge of not forgetting that every resident is special, that every one represented a degree of success during the year and that through our response to challenges, we caused the school to experience some of the greatest improvement in its 30-year history---a challenge throughout a tough year, but a challenge well met.

Many of the challenges described above by Mexia State School staff members are familiar to the 28,000 employees of department facilities and community MHMR centers represented here. Throughout this report, which details how employees coped with those challenges, clients' full names are used when possible. Use of a first name only indicates the need for a fictitious identity to preserve confidentiality.

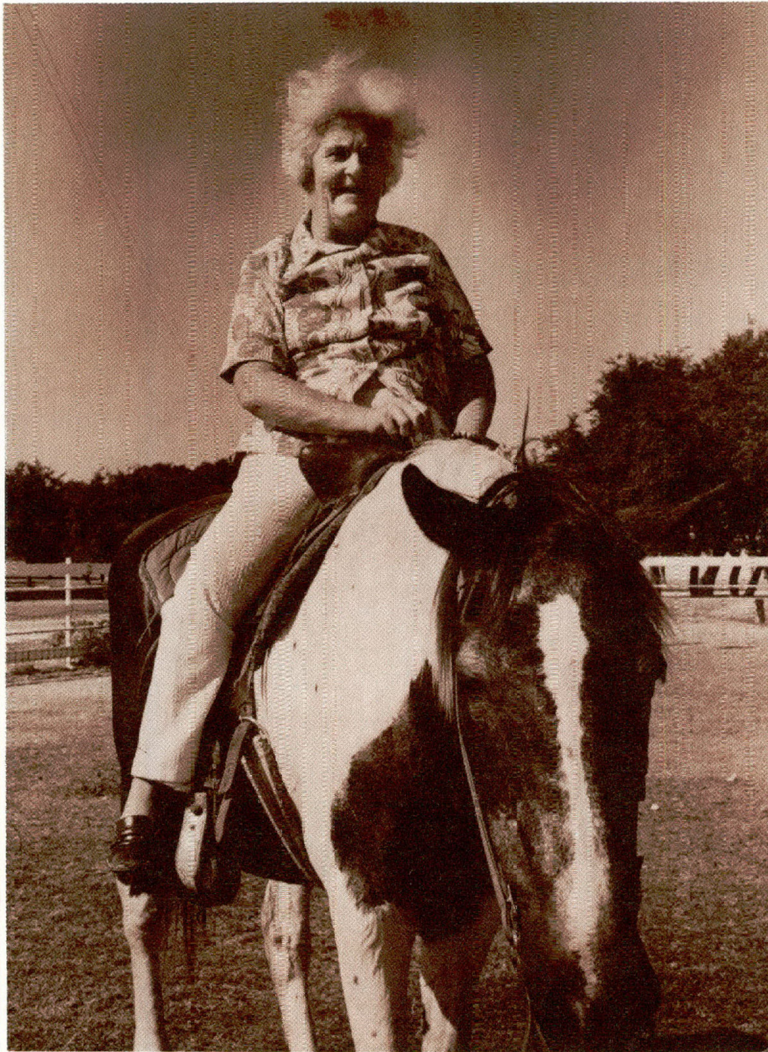
men·tal *adj* 1 : relating to the mind 2 : relating to the total emotional and intellectual response of an individual to his environment

men·tal health *n* 1 : a state of emotional well-being 2 : satisfaction with oneself and one's relationships, coupled with the ability to cope with life

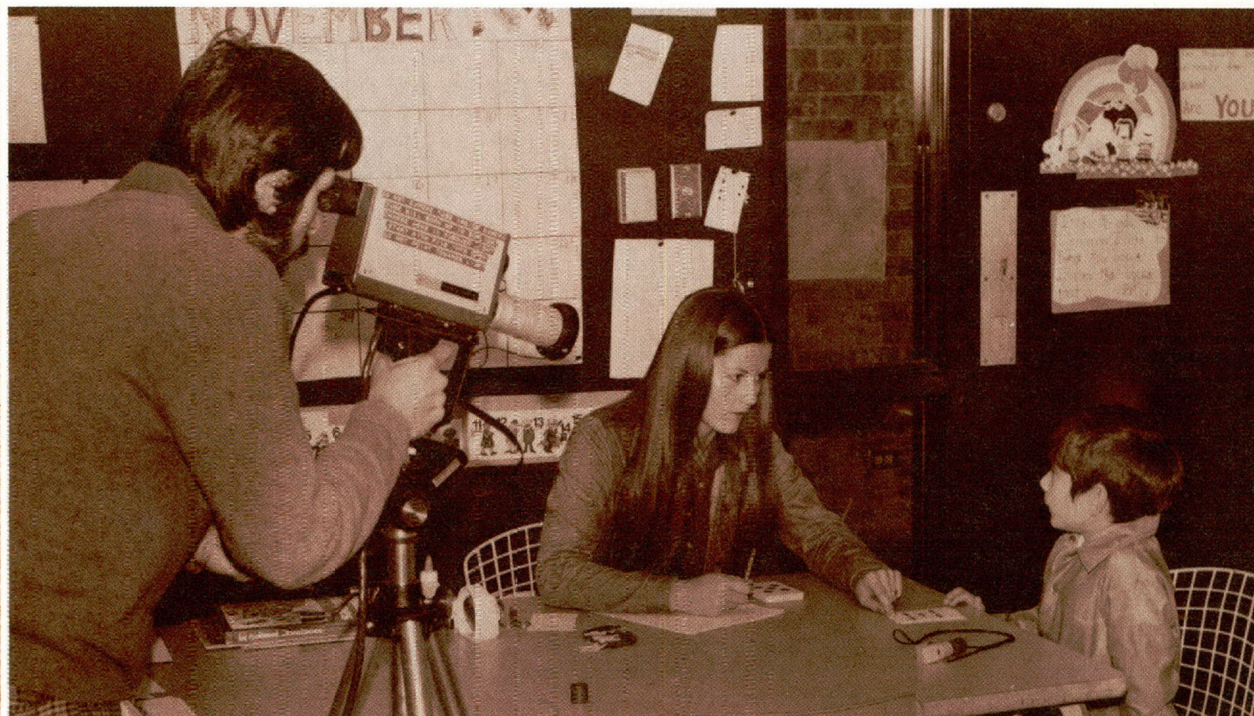
men·tal health ser·vi·ces *n* 1 : assistance to people with emotional problems 2 : provisions of residential and outreach services to those with emotional problems; *syn* see HOSPITALS

men·tal ill·ness *n* 1 : disturbances of thought, emotion and behavior which are irrational, unrealistic or inappropriate to the situation; sometimes accompanied by alcohol or drug abuse 2 : a failure to adapt mentally to external conditions; may be short-lived or persistent, and may be due to physical or mental causes

Mental Health Services



What are mental health services?
—(left) recreation for patients of all ages,
—(below) new techniques to help in treatment and to document progress,
—(opposite page) and academic classes to make job placement easier after discharge.



Two years ago the first priority of the Mental Health Services division was reduction of hospital populations in order to improve treatment for those remaining. That effort resulted in a 17 per cent decrease in the number of patients during fiscal year 1976. As the population stabilized, the decline slowed to a rate of 6.4 per cent in 1977.

Consequently, the top priority during this year was development and expansion of specialty programs for hard-to-treat patient groups. This meant modifying the geographic unit concept instituted in 1968 to help speed discharge and improve aftercare for the enormous hospital populations of the time. Fewer patients are now assigned to units based on their county of residence; instead, they join patients with similar disabilities, such as alcoholism, emotional disturbance combined with mental retardation or chronic schizophrenia.

The chronic patient often is one who sought help too late after the onset of symptoms, or perhaps was admitted to a mental hospital too long ago---before drug therapy was introduced, before staff-to-patient ratios reached a manageable level, before many effective treatment techniques were developed. But the result after years of hospitalization was usually the same: dulled responses, impairment of intellectual abilities, lack of motivation. For those patients, entry to a mental hospital was a trip through a one-way door.

Working with these unresponsive people can be frustrating for even the most dedicated staff members. But today, many staffs and patients are overcoming the hurdles to discharge which may include lack of job skills, social relationships and community resources.

One hospital uses an on-campus transitional facility, donated by volunteers, as a last stop before community re-entry. Another has made maximum use of halfway houses, group homes in the community which ease the route from life in an institution to some stage of independence. Three hospitals are cooperating with community MHMR centers in pilot programs to form a family of friends among chronic patients. In the hospital, selected patients live together as they sharpen self-help and social abilities and learn a marketable group skill, such as janitorial work. In the community, center staff support them in their group home and job situations. A fourth pair of facilities soon will undertake a similar project.

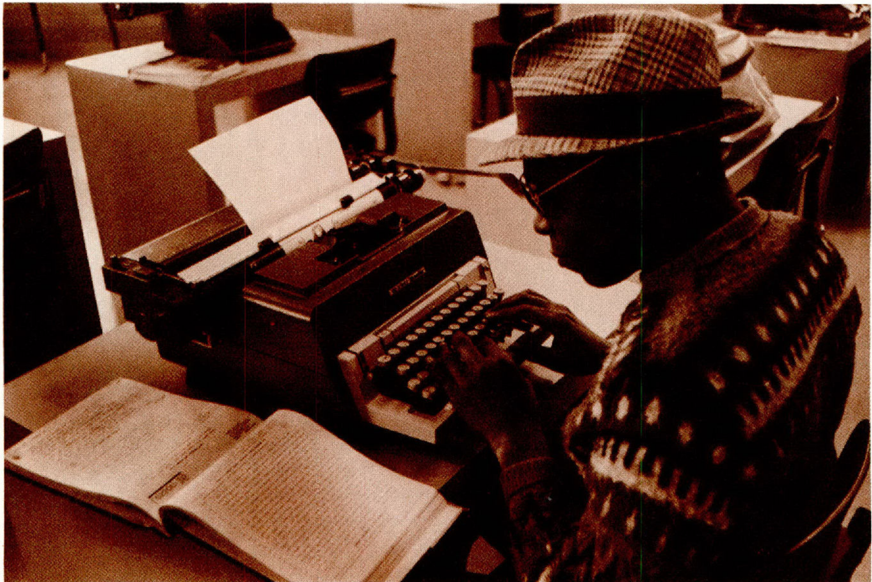
Another hospital confronted the problem of patients who preferred to sit or sleep rather than leave the dormitory for an activity. Ingenious staff members sought a contract for a job activity that could be performed on the residential units. Supervision of the work led to better staff-patient rapport, paychecks for the workers and the surfacing of undiscovered potential among the participating patients.

Other hospital programs were designed for groups with specialized needs---a community activity center for the elderly, for example, and behavior therapy modification for patients with severe problem behaviors. Because more than one-third of admissions continue to carry a diagnosis of chemical abuse, caregivers at one hospital are trying to keep discharged alcoholics from returning by encouraging them to sign contracts certifying their intent to seek aftercare services. And it's working.

Other innovative techniques were developed--a "take-down" procedure to calm an uncontrolled patient, a routine farewell procedure to soothe a compulsive teenage runaway, a child care worker to stay in the home of a discharged youngster to ease the transition from hospital to family. One hospital bought a van to deliver outpatient services to isolated rural areas.

Efforts continued to improve living conditions and to meet life safety codes at the facilities. Each hospital maintained its accreditation under Joint Commission on Accreditation of Hospitals (JCAH) standards, and quality assurance sections were developed to evaluate quality of care and monitor compliance with department rules.

This concern for accountability coupled with creative ways of dealing with human problems are characteristic of department employees who care about the lives entrusted to them. No challenge is great enough to deter their efforts, for they are learning that even the hardest to treat can be reached.



Home Again

How do parents and teachers learn new ways to relate to a disturbed child? **Austin State Hospital** (ASH) Community Resources Development team members have used the personal touch and videotaped sessions to answer that question.

Parents often feel unsure of themselves when their children return home from the hospital. To ease the transition from ASH's Children's Psychiatric Unit (CPU) back to home, parents attend monthly family workshops on the unit. This process teaches them therapeutic techniques in dealing with their children's behavior.

As a child attempts the readjustment to the home environment, and the family faces pressures in having such a child at home, the situation produces a different set of responses from each of them. When Mary Sue returned home, she was unable to adjust to the home environment after living in the structured setting at CPU. She began screaming at inappropriate times and walking throughout the house at night. This so disrupted the family that the parents sought guidance from CPU.

A skilled child care worker was sent to live in the home. After observing the worker relating to Mary Sue for 36 hours, the parents were reassured that they were, indeed, capable of continuing the techniques learned in the family workshops.

Teachers also may be hesitant to accept a child whose behavior has created past disturbances. Jimmy, who was hospitalized as a childhood schizophrenic, had thrown temper tantrums, had bitten and kicked others without provocation and had threatened other children.

Jimmy's hometown teachers were reluctant to believe his progress at CPU in spite of the verbal and written reports. But when the Community Resources Development team showed them videotapes of Jimmy's actions in the CPU program, his teachers were able to witness his new classroom behavior and see exactly how to communicate with him long before his discharge. When Jimmy returned, his teachers were prepared to receive him and continue the progress begun at CPU Day School.

These innovations permit staff to meet the challenge of providing more personalized follow-up care to families living throughout the 33 counties served by Austin State Hospital.

Dare to Hope

Together, 43 former **Big Spring State Hospital** patients now living in community homes had been hospitalized a total of 292 years. The transition began last year when it became apparent to hospital staff members that many patients had long since achieved maximum benefit from hospitalization. But without families, community resources or jobs, their future outside the hospital looked dismal.

The answer came through further utilization of existing halfway houses which agreed to experiment by adding five or six placements funded by Big Spring State Hospital. The monthly cost would be approximately $220 per person, far below the $1,400 now required for hospital care. More important, the plan would provide a way back into the mainstream of life for these men and women who had given up their dreams of living independent and productive lives.

Once settled in their respective community facilities, the patients became involved in the everyday tasks of helping with chores and becoming familiar with their new neighborhoods. Next came day care activity programs, sheltered workshops and even independent jobs.

Over a year old now, the program continues to be extremely successful with many of the participants now discharged and employed full time. Some have moved into apartments of their own. Others have married and are living a life which is much different from hospitalization.

As these clients move out, there are others waiting to take their places. What began as an experiment has turned into a many-faceted service by the halfway house staffs who have met the challenge with innovative programs.

This experiment has paved the way to a new life for those who dared to hope there was another way.

For this couple, acquaintanceship during their hospital recovery led to marriage after their discharge to the halfway house. Soon they'll be ready to move to a home of their own.

Growing Older Better

For millions of Americans the natural phenomenon of growing old---even in the world's richest nation---is the hardest part of their lives, too often marked by emotional disturbances, mental illness, poverty, isolation and fear of the future. The threat of nursing homes and mental institutions looms large in their minds.

In Kerr County, 35.7 per cent of the population is age 60 or older. There are more than 6,000 persons experiencing the physical and/or psychological changes that come with senility.

The function of the Dietert Claim for Senior Citizens, an outreach project of the **Kerrville State Hospital** (KSH) sponsored by the hospital's Volunteer Services Council, is to bring people, agencies and dollars together to develop more effective programs for the aging throughout the area.

Programs designed for patients at KSH are supported by the Dietert Claim (DC). Transportation is furnished by the DC station wagons for patients employed in the city and for weekly shopping trips. Sewing groups make gowns, aprons and other items for the hospital.

The DC Senior Citizens softball team plays the KSH patients on a regular schedule. DC volunteers share fishing trips, picnics, bowling and attendance at community functions with the patients. Many long-term friendships are formed through a one-to-one volunteer visitation program.

DC staff and volunteers work together to assist discharged patients in readjusting to the community. Discharged patients often become involved in activities at the center.

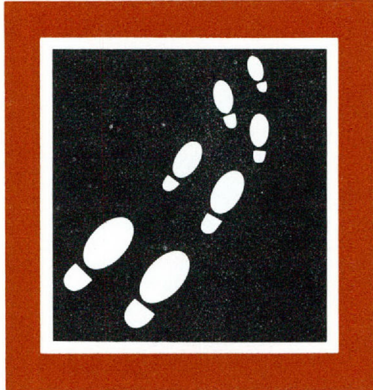
The Dietert Claim is a beehive of activity ranging from a club made up of persons who have suffered strokes and their families, monthly blood pressure clinics, annual glaucoma clinics, mental health seminars and physical fitness classes. A counseling service is available to those age 55 and over.

In addition to support by KSH, Dietert Claim funding is through the Alamo Area Council of Governments, revenue sharing funds from the City of Kerrville, The United Way, civic and social clubs, churches and individuals. Staff support and consultants are offered by other agencies throughout the area.

Age---even when it's more than 90 years---doesn't deter senior citizen volunteers from sewing items for the hospital.

No Longer on the Run

An unusual treatment approach by staff members of **Rusk State Hospital** has brought some relief to the problem behavior of a teenage runaway.



Betty's second admission to Rusk State Hospital last April followed five previous admissions to other hospitals. During the first few months of her stay, she frequently attempted to leave, fought without provocation and became verbally abusive to staff members and other patients.

Following consultation with the superintendent, Mary Gray, M.D., child psychiatrist on the Child-Adolescent Unit, developed a program for Betty: there would be no attempts to stop Betty from running. Staff members would see that she had enough money to make a telephone call and purchase food. She was dressed appropriately before she was allowed to leave, and the staff assured her they would call the Rusk State Hospital Security Department as soon as she left the Adolescent Building.

When she left, security officers kept a close surveillance to assure her safety. After a period of time, she was picked up and returned to the Child-Adolescent Unit. Upon her return, all staff members would assure her they were happy to see her again. Soon Betty learned the staff loved her.

An intensive observation room was used only when Betty became physically combative. Whenever she became verbally abusive, staff members talked with her until she became calm enough to listen and converse.

Gradually her running subsided and she became less verbally abusive. Now when she becomes upset or angry with someone, she will talk about how she feels. And instead of completely losing control, she requests a job to help work off her anger.

It is now rare for Betty to run away. It is most likely to happen on an off-campus trip when the staff members believe she becomes afraid that she will miss the bus or be forgotten and left behind. In her panic, she runs in an attempt to return to the hospital.

Betty now is affectionate toward staff members and has become a good worker. A halfway house placement is planned.

Hospitals

Three Winners

In a year of successful programs at **San Antonio State Hospital** (SASH), three are stand-outs:

1. The opening of the transitional living facility
2. A fresh approach in treating patients with multiple disabilities
3. The aftercare program for alcohol/drug abusers.

All are making an impact in the community and the state.

The Patric Sexton Dennis Memorial Center for Mental Health is the first of its kind in the state system to offer homelike living for about-to-be-released clients.

The cottages, housing 38, opened in December 1976. They were built with funds left in the will of the late Patric Sexton Dennis and money collected by SASH's Volunteer Services Council. The transitional living facility fosters independence and living skills for survival outside the hospital.

On the multiple disabilities unit, the "take down" procedure of behavior therapy, developed by Larry Aniol, Ph.D., director, is teaching the difficult-to-handle patient more normal ways of behavior. If talking doesn't work with violent patients, the staff turns to the "take down," or lowering of the patient gently to the floor.

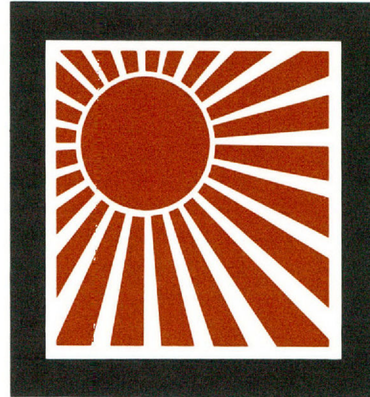
On the alcohol/drug unit, patients are signing on the dotted line.

Before leaving the hospital, the patient agrees in writing to continue treatment in the community. Appointments to participate in area programs are made for patients while they are being treated. Follow-up reports are made to the SASH aftercare program about the patients' sobriety progress.

According to Sean Moore, unit director, patients who continue to receive aftercare have a 50 to 60 per cent success rate.

So impressive are the results of the new concept, other state facilities are emulating the contract idea.

Fairweather Friends



Having a home and job in the community is not a likely prospect for the person who is frequently in and out of mental hospitals, has no work skills or job history and can't rely on family or friends for support. But that picture has changed for a group of **Terrell State Hospital** patients.

The Fairweather Program was implemented there in June 1977. The program is designed to prepare groups of chronic patients for community living by teaching work, living and communication skills, as well as acceptable behavior patterns. The major focus is on development of self-management and self-support abilities, but the key to the program's success is training patients who learn, live and work together as a mutually supportive group.

In addition to living skills, patients are taught work skills and how to function as a team. Janitorial work is the most feasible job skill for the patients because of its simplicity, its projected need by the Texas Employment Commission through 1980 and its enabling patients to work as a crew.

After the group is well-established, they will move to a lodge in Dallas that is sponsored by the Dallas County MHMR Center (DCMHMRC). All members will live together in a homelike setting called Hideaway House and work as a team on job contracts under the supervision of a DCMHMRC employee. They will live independently, enforcing their own house rules. With help from their friends, they will begin new lives.

A family of friends who live and work together can support each other in the transition from hospital to community.

Work for the Uninvolved

No known job skills, little or no motivation to participate in treatment programs, failure to function in the sheltered workshop setting or the patient worker program, refusal to try: all are characteristics indicating a low potential for development.

To the **Vernon Center** staff, the prime problem in dealing with patients with these characteristics was involving them in an activity taking place away from their residence unit. The patients preferred to a) sit, b) sleep, c) rock, d) pace or e) all of these rather than leave the unit for an activity.

To counter this problem, sheltered workshop supervisor Denzil Hollars sought a contract for a job activity that could be performed on the residential units. The contract, obtained from an area bait company, consists of folding small boxes used to package fishing lures. Work supervision is conducted by the unit staff after initial training provided by the sheltered workshop supervisor.

One patient, a 47-year-old profoundly retarded man, was accorded unanimous skepticism when his name was mentioned for referral to the work group. His performance during the first 10 work sessions reinforced staff doubts, but when he began to catch on, he really went to work. He now is being considered for graduation to the sheltered workshop.

The program has created better rapport between patients and staff. In addition, the patients involved generally exhibit increased manual dexterity, improved self-concept, better conception of time and space, more dependability and improved socialization skills. Many patients have drawn their first paycheck as a result of this program and this seems to add to their involvement. Yet, the additional cost to the state of this highly beneficial program is nothing.

The analysis of this program is best summed up by Don Robertson, Maples Unit caseworker: "As we have observed unknown potential surface in these most difficult personalities, we have become aware of the possibility of reaching even those more disabled, if we can come up with the appropriate, innovative approach." Amen.

For additional information contact Larry Wooldridge, Rehabilitation Therapies Supervisor, Vernon Center, Box 2231, Vernon, TX 76384.

A Cluster of Needs

A coordinated approach to individualized behavior therapy modification (BTM) was started at **Wichita Falls State Hospital** (WFSH) to reach and help patients not responding to customary mental health treatment plans. Some impressive improvements have been noted.

A. Om Prakash, Ph.D., director of behavior therapy modification, consults with ward staff members and develops an individual BTM plan, using rewards to change problem behaviors that inhibit a patient's further progress in treatment. A budget of approximately $1,000 per month was approved to purchase items such as coffee, cigarettes, candy and soft drinks that are used as rewards.

One of the first patients referred to the BTM program was Betty, a 22-year-old girl retarded since birth. Betty was admitted to the Multiple Disabilities Unit in July 1976. She had frequent temper outbursts, screamed and beat on objects around her and scratched other patients. She was difficult to motivate and wanted to sleep during the day. Her parents would only take her home to visit for one or two nights.

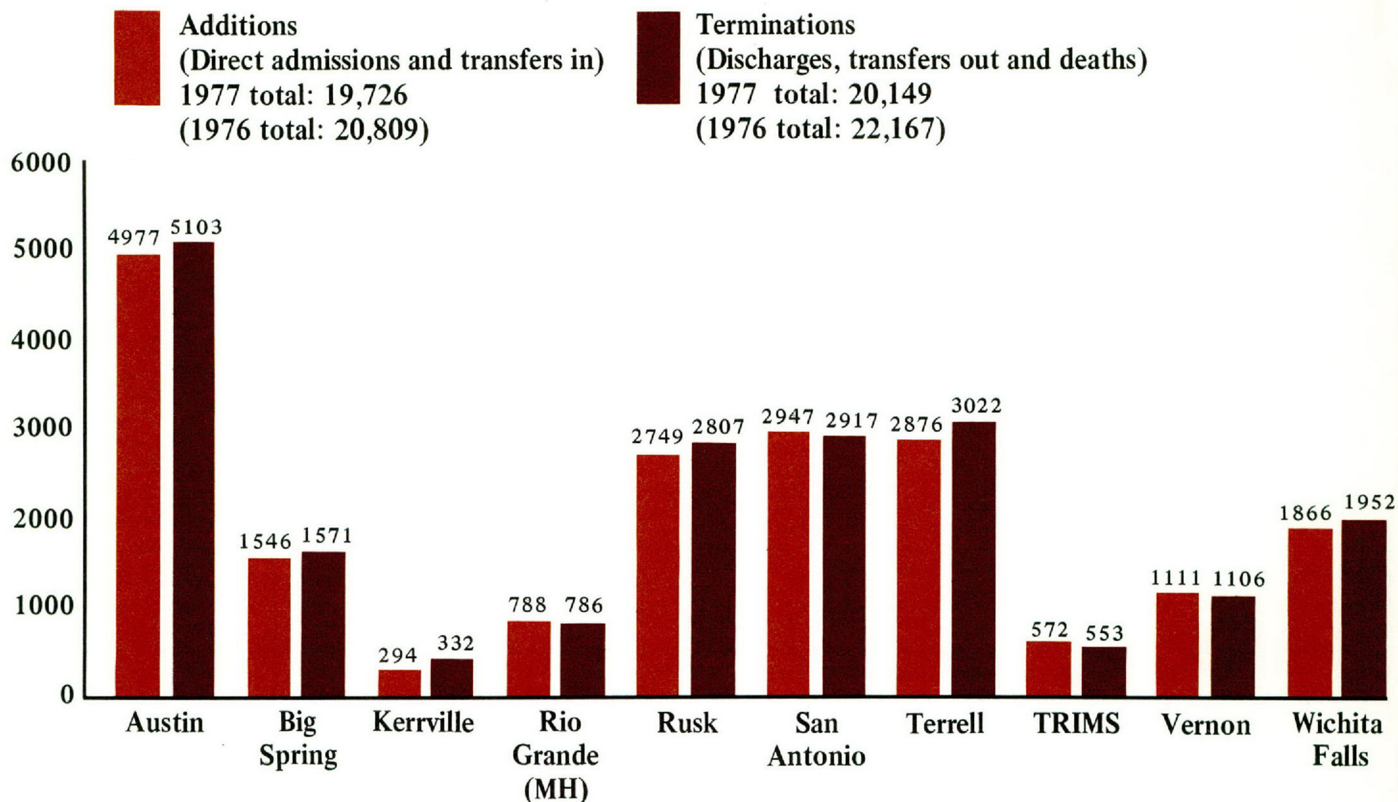
The BTM program designed for Betty in March 1977 focused on her temper tantrum behavior. Before BTM was begun, she was placed in the time-out room 26 times for combative behavior from the time of her admission on the unit. In the months that followed, Betty had only three seclusions for combative behavior. Her parents are proud of the improvements she has shown and now take her home for two or three weeks at a time.

Staff members feel optimistic about Betty's future. They see the possibility of placement in an extended living facility, something unlikely only a short time before.

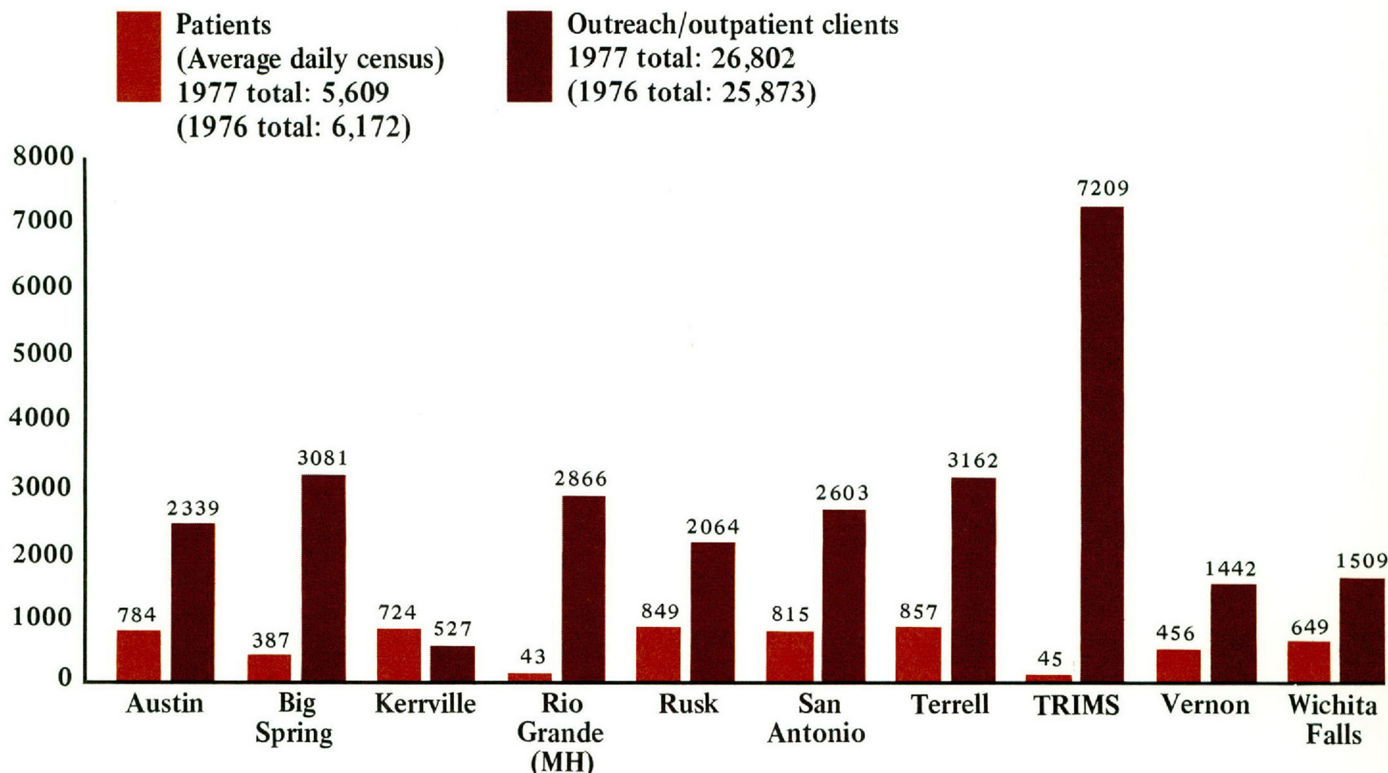
Individual BTM is working, although not all patients have made such rapid improvements. One problem is staff consistency in applying the program. But additional training materials have arrived from Research Media, Inc., (Dr. Charles Atkinson, publisher, 96 Mount Auburn St., Cambridge, MA 02138) to prepare the paraprofessional staff better for working with BTM. These materials will supplement those standard in department facilities and allow all WFSH aide-level staff members to have some degree of BTM training. Because of the success of the individual programs, plans call for the establishment of a BTM unit at WFSH to meet the needs and the challenge of the difficult patient.

Mental Health Services

Additions and terminations



Patients and outreach clients



men·tal re·tar·da·tion *n* : intellectual functioning that is significantly below average, accompanied by limited personal independence and social responsibility and originating during the developmental period

men·tal re·tar·da·tion ser·vi·ces *n* : assistance to mentally retarded persons which may include diagnosis and evaluation, education, special training, supervision, care, treatment, rehabilitation, residential care and counseling; *syn* see SCHOOLS

men·tal·ly re·tar·ded per·son *n* : one determined by a comprehensive diagnosis and evaluation to have below average intellectual functioning and limited personal independence and social responsibility

Mental Retardation Services

What are mental retardation services?
—(top) recreation designed for the multi-handicapped,
—(below left) training in job skills,
—(below right) personal attention for individual needs,
—(opposite page) and music for pleasure and learning.

Mental retardation is a handicap. Add to that blindness or deafness or both, an ambulation problem requiring use of a wheelchair or restriction to bed, perhaps accompanied by cerebral palsy---and that is a multiple handicap, the plight of many state school residents. A group of people once passed over with a sigh of "What's the use?", they now have captured the attention of caregivers who won't back down from a challenge.

Encouraged by progress beyond expectation made by the less profoundly retarded and less physically handicapped, these providers have stretched their budgets, their imaginations and their efforts to offer new opportunities to the multihandicapped. They have designed custom wheelchairs and playgrounds. They have assigned a team of specialists to evaluate each resident so that expertise from many disciplines can contribute to a comprehensive plan of treatment. They have maintained behavior therapy programs to reward desirable behavior and developed ways to monitor changes in physical deformities.

Staff members found innovative answers for other problems, too. They saw elderly residents bored with programs suited for younger residents, so they opened adult day care programs. They helped unmotivated residents learn new skills by offering activities that could earn them extra pocket-change; and they found a local bank to cosponsor a money concepts program for working residents with newly-acquired paychecks. They initiated respite care for local families in need of temporary placement of a mentally retarded family member. And they designed new record systems that provide more useful information and lead to better resident care.

At Central Office, the Mental Retardation Services division found its major challenge was in providing assistance to the 65th session of the Texas Legislature for appropriations and special legislation affecting the operation of state schools. Division staff, for example, worked to obtain funding equity between the programs of the state schools, resulting in notable gains in the appropriations for several of them.

Division leadership also contributed to legislation which affects state schools and mental retardation programs in general. The most important piece of legislation was the Mentally Retarded Persons Act of 1977, effective Jan. 1, 1978. This act provides for the rights of all mentally retarded citizens of Texas with additional rights guaranteed to those in treatment and training programs of TDMHMR and the community MHMR centers. It calls for due process procedures for admission and discharge of residents to and from state schools, more active parent participation in the state school programs and greater concern for the mentally retarded person not being served by the state schools or community MHMR centers.

Another piece of legislation was the Limited Guardianship Act. This permits parents of an adult mentally retarded person to obtain guardianship in limited areas for their son or daughter without the necessity of having a court declare the person incompetent.

A third important legislative item provided funds for a 40-bed unit at Rusk State Hospital for mentally retarded juvenile offenders (opening date: October 1977). TDMHMR can now serve a limited number of those challenging clients, preventing the need for placement in correctional facilities.

One objective met during the year was the development of a curriculum guide to help state school program personnel teach residents the behaviors they lack, as assessed on the Behavioral Characteristics Progression scale. This guide should increase the effectiveness of the trainers.

Efforts continued to help state schools comply with requirements of ICF-MR (Intermediate Care Facilities-Mentally Retarded), a federally-sponsored program reimbursing states whose state schools guarantee a minimum level of care and training to residents. Participation in this program substantially improved the quality of the school programs, enhanced the residents' living environment and upgraded safety conditions of the buildings.

Schools

Best Seat in the House

At **Abilene State School**, as well as at other residential facilities for the mentally retarded, there are large numbers of multihandicapped, nonambulatory individuals for whom it has not been possible or financially feasible to obtain customized wheelchairs. The frequent result is that many are forced to spend most of their lifetimes lying in beds. Yet, a significant number of these residents have sufficient head and neck control to allow them to sit up if individualized wheelchair modifications were available.

For many years, medical personnel and administrators of Abilene State School have wanted to provide cerebral palsied and other physically handicapped persons with this equipment which would allow them comfort in seated or elevated positions. Through the guidance and efforts of the school's medical director, Milton C. Bessire, M.D., a grant was obtained in 1976 from the Developmental Disabilities Council (DDC) of Texas to purchase a vacuum forming press and related equipment, a truck and supplies, and to fund needed personnel and consultant services.

When funding lapsed after one year, the project was continued and expanded with state-appropriated funds. Services are available for Abilene State School residents and for other handicapped in state facilities on a cost reimbursement basis.

School craftsmen make customized seats and backs for clients' chairs and also fabricate prescriptive footrests, chair arms, chair trays, urine holders, food bowls, leg braces and "scooters." The items are tough, not absorbent, easily cleaned and attractive.

The Abilene State School challenge is reaping benefits statewide.

Not too Old to Change

Mary May, a resident of **Austin State School**, believes people can change their ways of living. She should know: she is 68 years old and recently did just that.

For years May spent her days just sitting in the dormitory. She seldom talked with others, and when she did speak, it was usually to tell people to leave her alone. She refused to attend most of the classes or activities available to her "because those classes are for babies." Exercise was not enjoyable because she could not compete successfully with younger people in games or sports. May did not enjoy doing anything and did not know how to have fun. She just sat, day after day.

The school's Adult Living Unit evaluated May's needs and those of others like her. As a result, the Adult Day Care Program began operation Oct. 19, 1976, to meet many of the needs of older, inactive persons. The Shettles Memorial United Methodist Church donated use of its facilities, and is reimbursed by Austin State School for utilities used.

Howard Gruetzner directs the program and Scottie Ivory, Bruce McKee and Pat Schmidt provide training in such activities as social skills, exercise, games, chapel classes, arts and crafts and relaxation therapy. Adult Day Care also produces a feeling of belonging for its 30 elderly clients 16 hours each week. It's fun, and people like May have a better than 80 per cent attendance record.

May no longer spends her days just sitting in the dormitory. She attends all her classes and is a lively, talkative, busy lady. She visits friends on other dormitories and helps organize group games. She is also involved with other ladies in making quilts for sale to the public.

May sums it up well for all the people who participate in the Adult Day Care Program when she says, "They treat us like adults over there. It just makes me feel good."

Appealing to the interests of older, inactive state school residents is the challenge met by an adult day care program.

Forming Better Ways

A problem-oriented record system (PORS) destined for use throughout the department was field-tested by **Brenham State School** beginning Dec. 1, 1976. The project involved training staff in the use of new forms, replacing almost all forms in the original client record system and recommending changes in the proposed forms. This stage followed origination of the forms and initial testing at Fort Worth State School.

The primary divisions of the PORS include Data Base (assessments and evaluations such as social history and growth record), Care/Training/Treatment (the direct services provided to clients, including a plan developed by a team of staff members from several disciplines, all program objectives and progress notes) and Other Administrative Records (such as consent forms and clothing inventory).

The criteria for the forms were derived from standards for ICF-MR (Intermediate Care Facilities-Mentally Retarded), standards set by the Joint Commission on Accreditation of Hospitals/Accreditation Council for the Mentally Retarded and Other Developmentally Disabled, rules of the department commissioner regarding client care and practical implications from actual use. Recommended changes were approved by a Central Office committee which included staff from state schools. Two other state schools will field test the forms during fiscal year 1978 before their adoption.

One innovative feature of the PORS is the use of specific program objectives (SPO). An SPO is a client performance objective expressed in detectable and measurable language, such as "can sort items in the prevocational workshop" or "can dress self." Records are organized according to goals and chronological progress toward specific objectives for each goal. This contrasts with the former method of source-oriented records composed of separate sections representing individual disciplines. With PORS, only medical progress is reported on a different format. Otherwise, all client program information is reported under the Care/Training/Treatment section.

Staff members at Brenham State School felt that organizational changes made as a result of adopting the PORS improved the quality of care to residents. Monitoring client behavior became important, so direct care workers learned new duties to become program monitors. Other realignments of staff duties also contributed to closer attention to residents' progress.

The field testing called for extensive staff effort from all professional disciplines and many support service areas. The result of their contribution is a client record system which provides information that is clearer and more useful. The school's success in converting to the PORS will support future adoption of this record system by other state facilities for the mentally retarded.

Lessons They Can Bank On

They arrive, like clockwork, every Friday afternoon a little after 4:00.

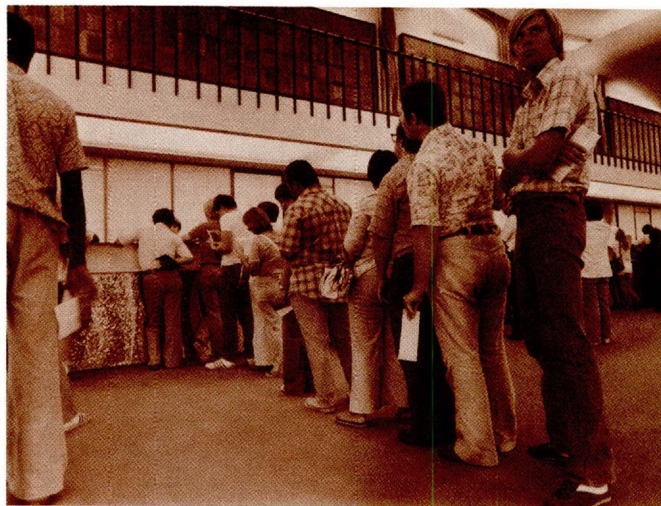
There are always 20 to 30 of them, lining up at the far west tellers' stations at Mercantile National Bank in Corpus Christi. They stay 30 minutes at the most, cashing payroll checks, putting some money in savings accounts and keeping some for spending. Their beaming faces are full of pride as they carefully count the coins and greenbacks.

The small weekly troupe of banking customers are students in a money management class at **Corpus Christi State School** (CCSS). They are learning one of life's most important lessons, that of handling money. It is a step up from another equally vital lesson: learning to hold a job that will produce such earnings. They also are slowly becoming more involved, like any citizen, in the community where they hope someday to live, free from institutional dependence.

The savings program started in October 1975 when one CCSS resident landed a job as a cook outside the school. He was paid by check but had trouble cashing it.

Roy Allee, now director of rehabilitation services at the school, arranged for nearby Mercantile Bank, which handled some of the school's other funds, to cosponsor the money concepts program for more able job-holding residents.

It has proved to be a successful rehabilitation tool, practically problem-free. The program now involves 42 residents, ranging in age from 18 to 37. And their combined savings totals a thrifty $24,080.85.



Money management---it's a problem for some, but a welcome challenge for state school residents who see it as their reward for holding a paying job.

Schools

A Special Playground

A few years ago, Lisa, who is multihandicapped and spastic, spent most of her time in bed at **Denton State School**'s (DSS) nursing service dormitory. She began daily outings with therapists in the last couple of years, but still lacked the amount of vestibular stimulation (circular motion involving the inner ear to develop balance) that normal children receive through swinging and other play.

Because movement experiences are important to the overall development of children, recreation therapist Linda LaBar designed a special playground for multihandicapped residents to increase their sensory integration.

With funding from the Bell Helicopter Employees' Humanity Fund and the DSS Volunteer Services Council, the recreation staff installed a merry-go-round designed by LaBar to hold all sizes of wheelchairs. The residents' safety is ensured with padding, seat belts and chain locks to fasten wheelchairs securely in place.

Specially adapted swings and seesaws allow residents with contractures (deformities caused by shortened muscles or tendons) to enjoy safely playground activities in Gunnel, or bucket, chairs. A shower pool offering additional stimulation brings smiles to residents' faces, especially to those who are deaf and blind. Shuffleboard, bowling and other games are available with the construction of a cement lane. A drinking fountain adapted for wheelchairs and picnic tables make the playground ideal for residents' pleasure while visiting parents, houseparents and foster grandparents, as well as with occupational, physical and recreation therapists. Future plans include a hillside slide resting directly on the ground so residents will land softly.

Respite Means Relief

"We're going fishing. What you do with John is your problem." That was the first time the challenge for respite care was issued to **Fort Worth State School**. It came from parents who had not had a vacation since the birth of their mentally retarded son more than 30 years ago.

Since that time, the challenge to provide respite care has come in many forms. A couple having marital problems sees respite care for their child as a chance to restore the family situation. A single parent entering the hospital for surgery finds relief through the respite program. And in less critical situations, such as a routine vacation, respite care provides assistance, also.

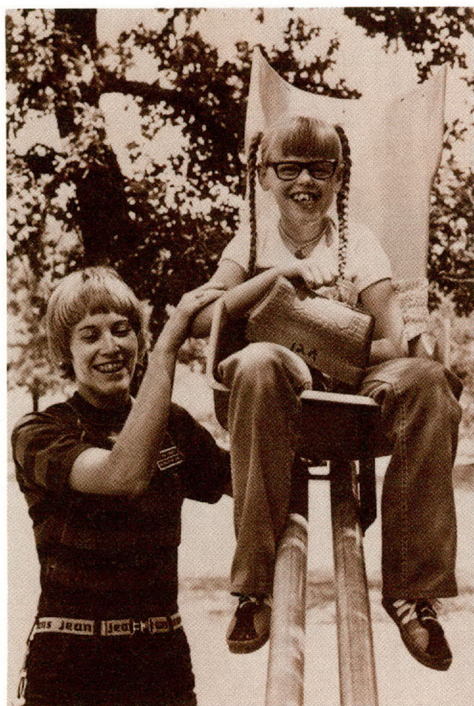
In the past year alone, the call for respite care has been answered 220 times for 155 clients. Each situation is different, but each offers similar challenges---to delay institutionalization or even to prevent it by providing back-up services that permit the family to stabilize.

Furthermore, the respite program itself can be a positive experience for the client. Both the campus residential facility and community-based living programs maintain respite beds. This makes it possible for the individual to spend the respite stay in a setting appropriate to his or her level of functioning.

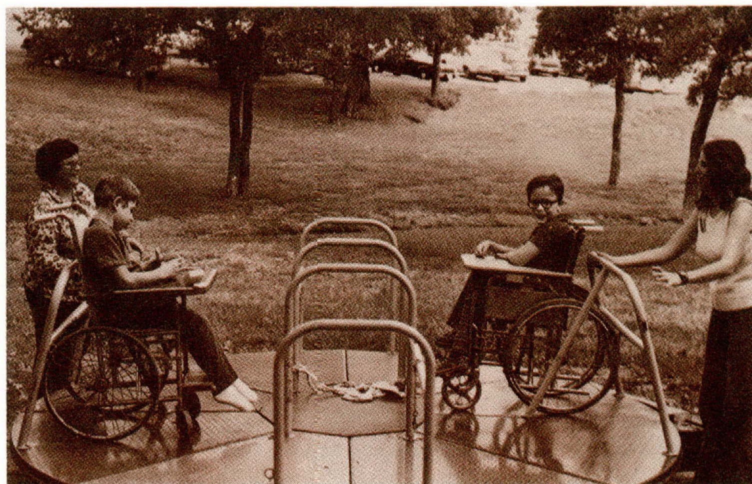
How effectively is respite care meeting the challenge? An excerpt from a parent's letter best answers that: "This was tremendous relief and help for us due to my wife's breaking her leg.... Our daughter was home this weekend. We were amazed. Her attitude and overall countenance is better than in over a year.

"We feel the experiences that she is exposed to are of tremendous benefit to her learning to cope with her life at home and in workshop situations.

"Thanks for helping us out in our emergency."



Bucket seat seesaws and wheelchair locks on the merry-go-round open playground pleasure to the multihandicapped.



Learning to Earn

One of the great challenges facing staff members at the **Lubbock State School** was trying to provide meaningful services to profoundly and severely retarded adult residents who exercised their right to reject available programs and remain on the dormitory all day. The challenge was met by developing an activity that could lead to a much-desired paycheck.

Under the direction of one staff member, a program which became known as Pre-Skills was started on one dormitory. This program was designed to teach tasks that would enable the resident to progress to the workshop where he could earn money performing similar but more complicated tasks. Several of the graduates of Pre-Skills have gone into the workshop program, demonstrating the effectiveness of Pre-Skills.

Initially housed in a day room and later expanding into borrowed classrooms and finally utilizing part of the academic school building, the Pre-Skills training grew from 13 to 60 clients and has a capacity for 120.

The philosophy of Pre-Skills changed from a training ground to a program which met the needs of a broader segment of the adult resident population. Two dormitories participated in a program of Pre-Skills aimed at increased capacities for task completion, work tolerance, appropriate peer interaction and social awareness. Staff members from other dormitories recognized the successes occurring within the program and sought similar activity for their dormitories. Pre-Skills training now includes clients from other units, including some who are nonambulatory.

Due to lack of funds, extra staff could not be hired for each participating dorm, so aides were trained to provide necessary supervision. The staff member who piloted the Pre-Skills program functions as a program coordinator.

The Pre-Skills program has proven a tremendous source of life-enriching experience for many adult residents, permitting the development of skills and a sense of dignity they otherwise may not have come to know.

The challenge of reaching unmotivated residents was met by offering work activities that enable them to progress to the school's sheltered workshop where they can earn money performing more complicated tasks.

Many Strikes Against Her

Barbara is one of 46 mentally retarded residents in the multihandicapped training program at **Lufkin State School.** She is nonverbal and has limited spastic use of both arms and hands. Providing personalized programming for her and the other residents who have a wide range of sensory and motor impairments is a challenge.

A curriculum was designed to enable these residents to develop enough proficiency in self-help, motor, cognitive, communication and social skills to qualify them for higher level programs on campus and a greater degree of personal freedom.

A multidisciplinary team meeting (one involving personnel from all specialties on campus) was scheduled as soon as the residents had been assessed in skill areas included in the curriculum.

In setting up specific training goals for Barbara, several of her deficiencies were noted. First, Barbara had poor grasping ability in both hands and, therefore, was not able to manipulate toys or training materials easily. Professionals from the physical therapy/occupational therapy section suggested programs to increase her ability to grasp and manipulate objects as well as improve her sitting balance.

Representatives from education and psychology designed programs to increase Barbara's cognitive skills. Activities included making discriminations of size, shape and color. The communication skills staff members, who recommended that Barbara be taught some simple way to make known her basic needs, chose a communication board as the most appropriate means, due to her disabilities. Recommendations from professional staff, training personnel and direct care workers were combined to build a thorough and comprehensive training program for Barbara.

Barbara has completed all of the goals set for her in the multihandicapped program and is now enrolled in a higher level training program. The interdisciplinary team, through the curriculum committee, continues to serve the residents in the multihandicapped training program through monthly meetings where individual training programs such as Barbara's are reviewed and recommendations are made to further enhance each resident's progress.

Schools

Pathway to Progress

Tony's diagnosis is severe mental retardation. But in spite of his short attention span and poor vocabulary, he has considerable educational potential. Unfortunately, his self-abuse and destructive behavior have made him unmanageable in his training class.

Tony is just one of approximately 300 emotionally disturbed, hyperactive, hyperaggressive or self-mutilating clients at **Mexia State School** who possess definite educational potential, but are prevented from achieving that potential because of their crippling problems.

In an effort to help Tony and the others, Mexia State School began a pilot program in behavior therapy in summer, 1976. Staffed with six psychologists, each with special training in behavior therapy techniques, the program placed psychologists with residents on a one-to-one basis. Progress was so significant that in April 1977 the program was expanded to 16 behavior therapists and 11 data technicians. The data technicians record baseline data and progress information and observe the client during all waking hours.

Of 50 clients who have entered the program, about 70 per cent have their problems under control. Tony is one of these. Today he is back in class, his attention span has increased markedly, he uses short sentences and complex phrases and his behavior presents no problem in class.

The behavior therapy program is just one example of how Mexia State School has met the challenge of meeting a special need of its clients.

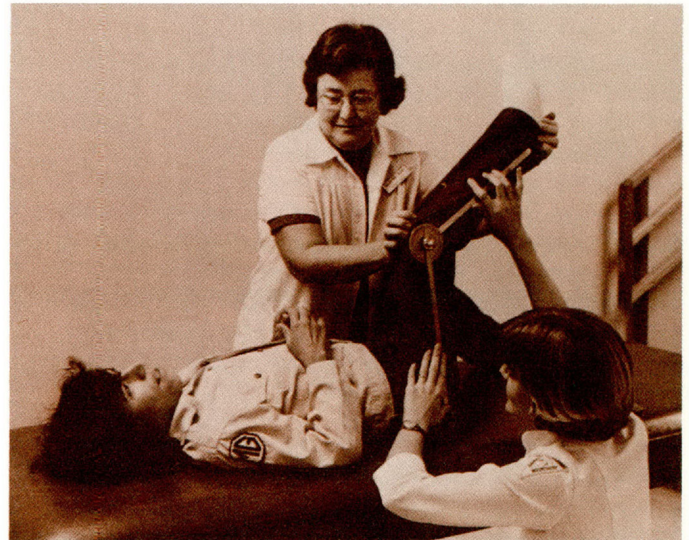
The Right Angle

Preventing increased deformities in the physically handicapped who often are non- or semiambulatory is a challenge met by teamwork at **Richmond State School**. Through coordinated staff efforts, residents' motor development is maintained, comfort assured and surgery and bracing prevented when possible.

It was believed a total team approach could improve on conventional treatments for progressive contractures. The first step was to develop an evaluation system. First, two nonprofessional personnel were taught the technique of goniometry (the measurement of joint angles with a protractor-like instrument). Then an evaluation form was developed for each client, noting the frequency of measurements needed. The form is filed with others due for evaluations at the same time. This way, measurements are made as frequently as needed, and the forms give an excellent picture of client status and results of care.

The few cases of progressive deformities uncovered have been related to skeletal problems that could not have been treated with therapy. The credit for success goes to many staff members from different disciplines working together. Clients receive direct physical therapy, and many are in an occupational therapy positioning program. The unit staff incorporates handling techniques into daily care activities. Finally, the education department in conjunction with physical therapy developed a "therapeutic handling" program to decrease abnormal muscle tone and facilitate normal movement patterns.

An example of the rewards this system has yielded is Robert. He is 13 and well aware of his progressive muscular dystrophy. When he first came to physical therapy, he could walk; now he can only sit with assistance. One of the few abilities he has not lost is range of motion, and he is exceedingly proud of that. He is eager to be measured and brags about the results. The staff has learned to be thankful for *no* loss or *any* gain and to be proud of a challenge accepted.



Frequent measurement of joint angles helps staff members provide better care for progressive deformities.

Teamwork

"The interdisciplinary team process" isn't a meaningless phrase or idle concept at **San Angelo Center** (SAC); it is a working tool not only to identify client needs, but also to promote client desire for self-improvement. The team process, with members from several specialties working cooperatively on a daily basis, provides the thread that enables programs to help clients reach their potential.

Emma's case history is an example of a genuine challenge that the team process is meeting. Emma's behavior problems were of a chronic nature, including arguing, cursing, refusal to follow directions, hostility, anxiety, low frustration tolerance and negligible performance of basic self-help tasks.

Last year Emma was recommended for Social Speech-Interpersonal Relations (SS-IPR) classes, but she refused to return after the first class. An instructor decided before re-enrolling Emma in class she would gain her confidence and rapport by regular visits. The relationship grew until Emma began seeking out the instructor to talk over her problems. Finally, Emma decided she wanted to attend class. Her psychologist reinforced the idea that she could change her life if she tried, and a way to try was by attending classes designed to teach her better ways of coping.

Emma started attending the various programs offered to her. Dormitory staff took every opportunity to reinforce her newly demonstrated skills. Emma's inappropriate behaviors have decreased substantially. She displays her desire for change by improved housekeeping habits, concern for her general appearance, assisting the SS-IPR instructor to draw other students into class interaction and making sound decisions on her own.

At this year's staff meeting to evaluate Emma, the team recommended that she transfer from the behavior modification dormitory designed to treat problem behavior; that decision itself is reinforcing Emma for her progress. Emma has changed her own behavior as a result of individual team members cooperatively working to help her help herself.

New Horizons

Walter Shamard was only 11 when he was admitted to Austin's **Travis State School** in 1961. For years, he lay on his back alongside other residents with severe ambulation problems and spent most of the day looking at the ceiling. He was subject to such severe spastic motions that he could not sit in a wheelchair except for short periods and only with a lot of effort on the staff's part to place him in the chair.

In his bed, Shamard had to have his hands and feet restrained to keep from injuring himself because of involuntary jerking. He functioned intellectually at a high level, but with his inability to move around, Shamard was quite bored, lonely and had much of a defeatist attitude.

With the successful performance of a cervical nerve root operation four years ago, Shamard achieved limited mobility. This small improvement helped the staff see potential and they began an effort to tap it.

First, Shamard learned to sit in a lounge-type wheelchair. Then, with an increasing amount of physical therapy which often hurt both him and the onlooking staff, he eventually graduated to more upright chairs until he could sit in one with a straight back.

Staff members who have worked at Travis State School for several years indicated that Shamard would have loved to stop trying. They admit that it took a long, hard, concentrated fight to convince him to continue physical therapy and to adjust to different chairs designed for him.

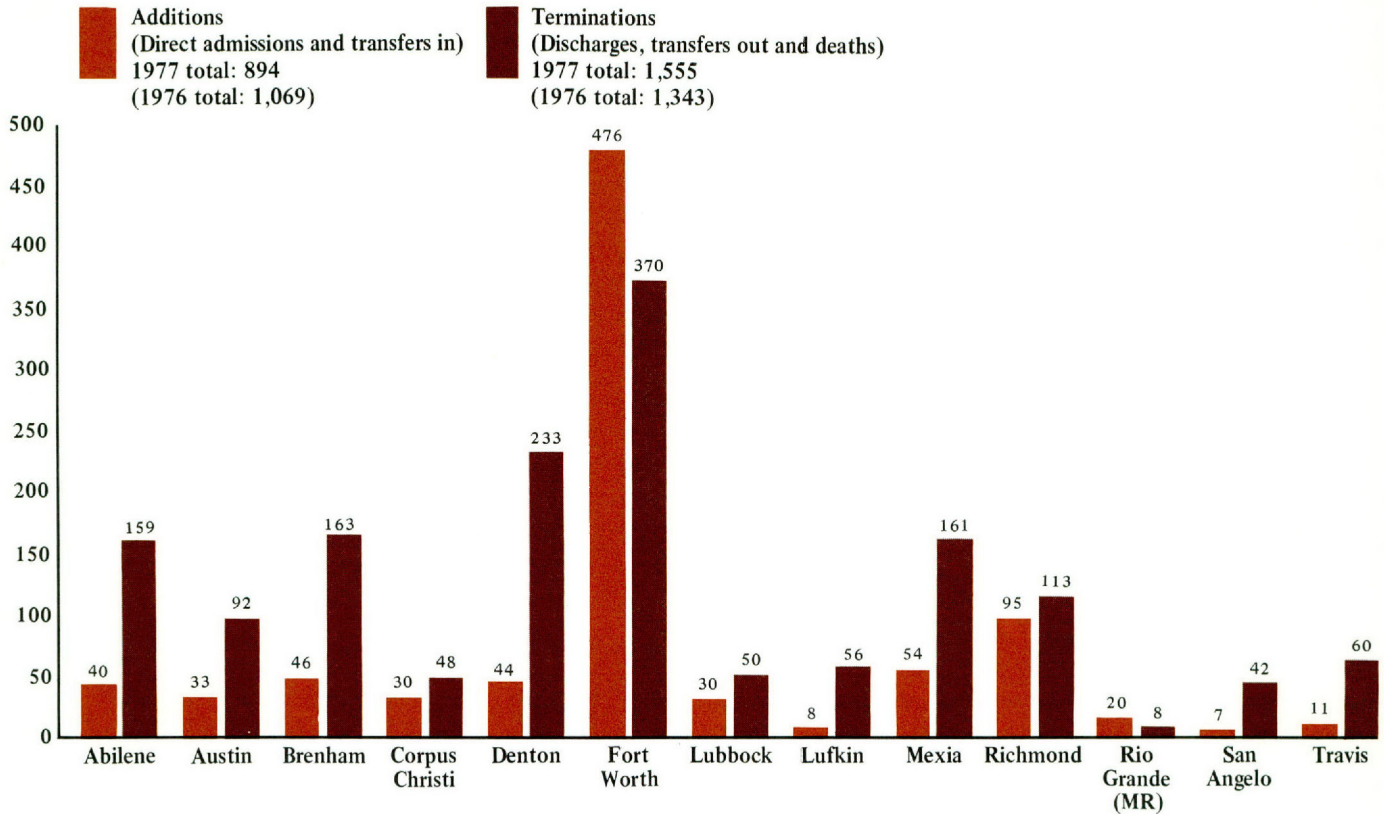
Staff members from other disciplines also saw an opportunity to help Shamard grow. The speech and hearing department determined that he could use a hearing aid and obtained one for him. This aid helped him in all areas of development, especially in listening and speaking. Presently, Shamard is learning to read, and he has asked for an electric typewriter to assist with writing.

From an attitude of defeatism, Shamard has developed feelings of adequacy and independence and a sense of reality about his physical limitations. It's true that he is still considerably handicapped by his body, but he has made considerable strides with the help of concerned and dedicated staff members.

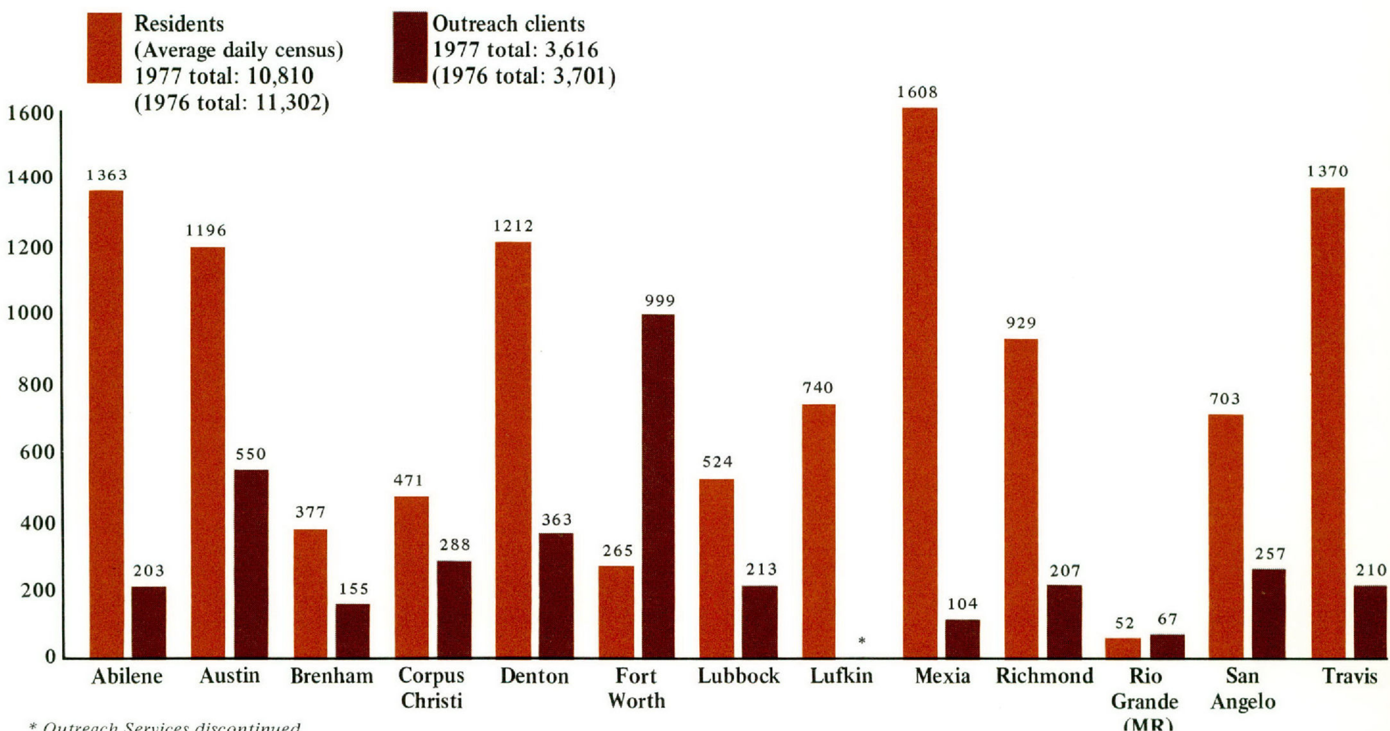
Rigorous physical therapy released this resident from years of confinement to bed.

Mental Retardation Services

Additions and terminations



Residents and outreach clients

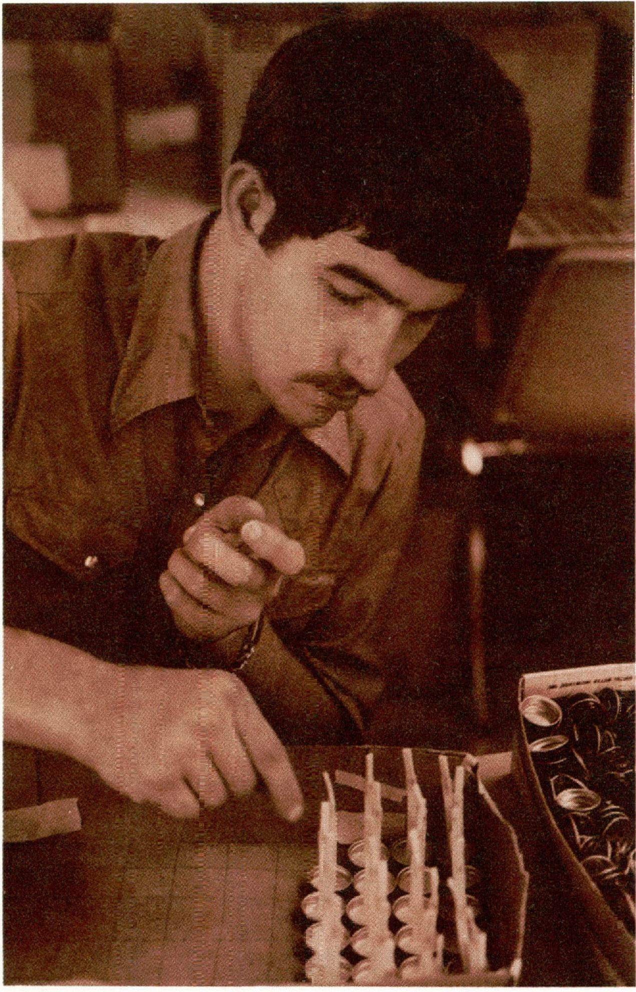


** Outreach Services discontinued*

spe·cial needs *n* 1 : accessibility of mental retardation and mental health services 2 : answers to questions about mental disorders 3 : trained mental health workers

spe·cial u·nits *n* : facilities that meet special needs; *syn* see STATE CENTERS and RESEARCH INSTITUTE

Special Units



What are special units?
—(left) accessible work evaluation and training centers for the mentally retarded,
—(below) recreation for a children's mental health program,
—(opposite page) and laboratory research into the causes of mental disorders.

Fathers of disturbed children can be attracted to and maintained in therapy by persistent and energetic social workers who respect the parents' problems.

Although it may be true that cocaine is not addicting to human beings, that statement is not as clear as it once was. In animals the drug causes abnormal brain waves and behavior that still need to be investigated.

A public agency that offers treatment to virtually every person who calls for an appointment should and can train psychiatrists for public service.

Plucked out of a year of work at the Texas Research Institute of Mental Sciences (TRIMS), these developments illustrate the Houston institute's main reason for existence: a hand-in-hand effort of researchers and therapists to study mental disorders, train workers for the mental health professions and demonstrate new and better methods of treatment.

The year saw new numbers given for national need. The President's Commission on Mental Health in its preliminary report said that nearly 15 per cent of the population---20 to 30 million Americans---need mental health services. The old estimate was 10 per cent. Thirty per cent of all hospital beds are occupied by patients with mental problems. The old figure was 50 per cent.

It is clear that hospital admissions dropped because of successful research with psychiatric drugs, which in turn made community care possible. But the soaring figures of need for services show that, to prevent mental disorders and to cure them when they occur, much more research is needed on the origins of mental disease.

At TRIMS some preventive efforts were directed to early intervention with children of high-risk families in the therapeutic nursery. In the basic research sections, scientists studied drugs and their effects on behavior, brain waves and brain chemistry of animals. One major interest is the effect of the psychiatric drugs on the aging brain. The clinical research ward completed its first year, offering treatment for 70 patients backed by extensive laboratory work on drug blood levels.

The four-year psychiatric residency program accepted its first three physicians in training for administrative and public health positions, and the family psychiatry section became part of a research and training consortium with Children's Mental Health Services and Baylor College of Medicine.

The department's continuing education program, headquartered at TRIMS, offered 38 workshops and seminars for professional staff from all TDMHMR facilities and many community MHMR centers. Programs included psychiatry, pharmacology, law, psychology, dentistry and collaboration in the first binational conference with Mexico on alcoholism and drug abuse. The 4,189 professionals participated in 56,493 accredited continuing education hours, a 250 per cent rise in attendance and a 430 per cent increase in education hours over last year.

With their contributions adding up to $59,055 (33 per cent more than last year), 166 volunteers gave 17,092 hours in staffing clinics, providing recreation for hospital patients and ensuring that the rights of patients involved in research are protected. Even one volunteer is worth her weight in pills.

The three state centers for human development---in Amarillo, Beaumont and El Paso---originated during the last decade to provide day care programs for the mentally retarded. Because they are located on the periphery of the school and hospital service areas, they have added another function---accessible residential treatment.

The Beaumont and El Paso facilities provide short-term residential care for the mentally ill, and all three offer respite care for the mentally retarded. With the addition of new cottages at the El Paso unit, that facility now has a number of beds available for long-term residence by the mentally retarded.

One center for human development, faced for the first time with discharging mental health clients from its new inpatient unit, contracted with the local mental health association for professional follow-up and a volunteer program to ensure smooth transition of the clients to the community MHMR center. Another center for human development found its alternate living program the subject of great controversy when the first group homes opened in the community. Months of debate over zoning ordinances followed before the residents felt secure in their new homes.

These centers for human development are administered by the Community Services division of Central Office as a means to coordinate their activities with those of their local community MHMR centers. The state center for mental health and mental retardation in Harlingen, on the other hand, has always emphasized residential care and is administered by the Mental Retardation Services division. All of the centers provide outreach programs throughout their regions.

State Centers

Zoned for Controversy

When the **Amarillo State Center for Human Development** eased into an alternate living program for the mentally disabled, the community took note.

The first problem arose when a three-bedroom home was selected for eight adult clients and their resident supervisor. When nearby property owners objected to the venture, the city became involved in a question of zoning ordinances. It was soon established that placement of only four clients would eliminate the need for hearings to obtain a specific-use permit. With that question resolved, four men moved to the Woodward Project to begin their adjustment to semi-independent living.

There was James, whose mother had died recently and whose dad was making plans for James' future . . . David, whose return home from a state school had been unsatisfactory...Bud, whose elderly aunt and uncle were planning for his future because his parents were dead . . . and Juan, whose home near the Oklahoma state line had no programs or opportunity for training or employment.

The next step for the alternative living program was an apartment complex in a residential area where 20 mildly retarded adults could strike out on their own with staff guidance and support.

In June 1976, the city confirmed that the complex on Wisdom Street was an appropriate location since it was zoned for multiple family dwellings and "since the people to occupy the apartments are only mildly retarded adults who presently are employed and only have staff available for minimum supervision."

Clients were settled in their new homes when the city later determined that the Wisdom Project "more nearly fit the classification of a mental health center or a home for alcoholic, narcotic or psychiatric patients." With this conclusion, the option the center chose was to establish a new classification in the zoning ordinances of the city for living arrangements for the mentally retarded.

The next step was to seek a specific-use permit which would allow the clients to remain at Wisdom Project. At public hearings, spokesmen from the center staff as well as volunteers and opponents of the project were allowed to speak out. The outcome was a victory for Wisdom Project.

The Amarillo State Center for Human Development now has a well-seasoned staff who are grateful to community leaders, parents and friends for their support of a new venture. And the subjects of the controversy found pride in their community and in themselves.

Caring All the Way

For the first time in its history, the **Beaumont State Center for Human Development** was faced during fiscal year 1977 with the challenge of providing a residential treatment program for the mentally ill.

Of major program importance was assurance of continued consistent care for the clients following discharge. This concern was compounded since the Beaumont State Center (BSC) initiated treatment for the client, but responsibility for follow-up care was in the hands of MHMR of Southeast Texas. How could BSC be sure that the client would keep the appointment made for him or her with the MHMR center's outpatient clinic?

To meet this challenge, BSC, with the approval of MHMR of Southeast Texas, contracted with the Mental Health Association in Jefferson County for professional follow-up and a volunteer program to help the client to readjust to his community.

The Mental Health Association employs a professional client services coordinator who meets the client upon admission to BSC's mental health unit and follows progress until after discharge, making sure appointments are kept with MHMR of Southeast Texas outpatient clinics and helping ensure therapy continues. The client services coordinator continues involvement for up to three months, helping the client in acquiring other needed services in the community.

A volunteer coordinator from the Mental Health Association "Operation Friend" program also becomes involved early. The volunteer coordinator recruits, trains, assigns and supervises more than 70 volunteers from the community to supplement and take over the services of the client services coordinator. Following a 15-hour training program, volunteers are asked to give two to four hours per week on a one-to-one basis being a friend to an assigned client.

Two results of the program illustrate its success. First, approximately 50 per cent of those clients discharged from BSC's mental health unit did not contact the MHMR of Southeast Texas outpatient clinic until a visit was made from the Mental Health Association's client services coordinator. Second, 75 to 80 per cent of all clients discharged from the BSC have been able to readjust to the community without returning to the mental health unit, and only about one per cent have had to enter a state hospital.

She Tries Harder

Peggy Hamilton is a competent, responsible volunteer at the **El Paso State Center for Human Development** (EPSCHD). Hamilton also is mentally retarded.

She says, "I know that I am not like others. I am a slow thinker. I have to try harder."

Hamilton was referred to the center by a Texas Rehabilitation Commission counselor who believed that she would benefit from being able to help others at the center. Much of her success as a volunteer can be attributed to the interest and concern shown by EPSCHD staff.

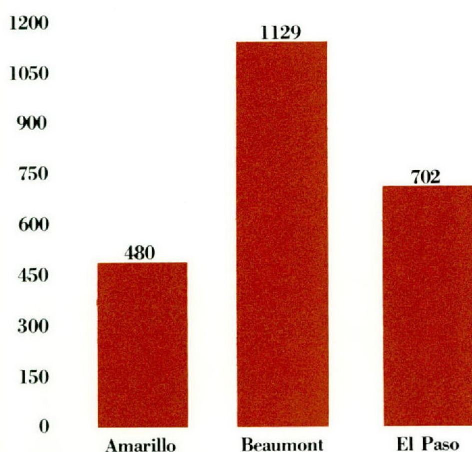
Transportation is provided by a EPSCHD bus which carries clients to and from the center. Hamilton assumes full responsibility for boarding the bus at the proper time and assists with the clients while on the bus.

She was assigned to a cooperative and supportive staff member who explains patiently and clearly what she wants Hamilton to do. Her duties include typing, filing, answering the phone and running errands. The positive reinforcement from her supervisor and knowledge of a job well-done build her self-esteem.

Staff members now are exploring means of providing part-time employment for Hamilton so that she may become even more self-sufficient.

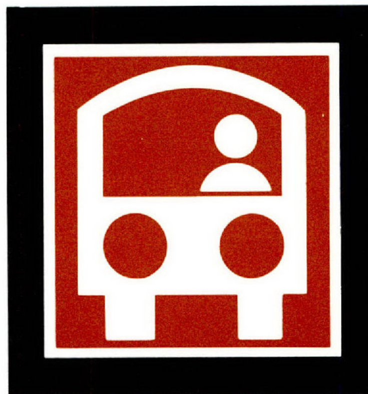
"I enjoy working at the center because all of the people are so helpful," says Hamilton. She is proof-positive of what a retarded person can accomplish when treated with respect and understanding.

(Hamilton's hard work, dependability and training paid off in October after the fiscal year ended when she became a part-time employee of the center. She continues her volunteer work.)



Disaster Alert

Caring for clients is a responsibility that must be met regardless of complicating circumstances. At the **Rio Grande State Center for MHMR** in Harlingen, where tropical storms are not uncommon, disaster planning is essential to ensure safety and continuity of care for the facility's mentally ill and mentally retarded residents.



When Hurricane Anita approached the lower Texas coast last August, staff members of the center were ready. They moved the center lock, stock and barrel to San Antonio for the duration of the threat.

Residential clients who were able to go home were either furloughed or discharged. The rest, approximately 80, were moved to the San Antonio State Hospital (SASH) for two days where a complete residential center was set up.

Dozens of support personnel went along to care for the needs of the center's clients. This included food service, supply, maintenance and nursing service.

Clients were transported to San Antonio in a caravan of center vehicles which included three buses, four station wagons, three trucks and numerous private vehicles belonging to the staff. Due to the size of the caravan and the circuitous routing by way of Laredo necessary to avoid the storm, it took more than 13 hours to reach the destination. Upon arriving, the group was welcomed by Robert Inglis, M.D., SASH superintendent.

While at the San Antonio facility, clients were treated as regular SASH patients, taking part in the hospital occupational and recreational therapy.

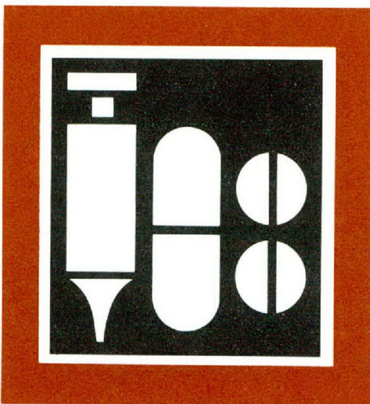
Medical records of the clients went with them to insure uninterrupted care, and the center pharmacy prepared a two-week supply of medications for each client in case it was needed. Food and other supplies such as linens went with the clients to San Antonio. The center staff was prepared to function as an independent unit, if necessary.

Meanwhile, in the Gulf, Hurricane Anita struck the Mexican coast instead of Texas. With the threat of the storm over, the word went out from Harlingen to return the clients.

Perhaps the most important thing to be learned by this evacuation is should another disaster threaten the Rio Grande State Center, clients can be safely moved with minimum advance notice.

(Statistics are on pages 10 and 20.)

Best Drug, Best Dose



Doctors can "crack" the chest and re-route the small vessels of the heart, they can palpate the liver, but if something goes wrong in the brain, they cannot open up the skull and look for short-circuits.

For this reason, researchers at Houston's **Texas Research Institute of Mental Sciences** (TRIMS), like those of scientific centers elsewhere, are trying to find accurate, noninvasive measures to tailor treatment with psychiatric drugs to individual patients.

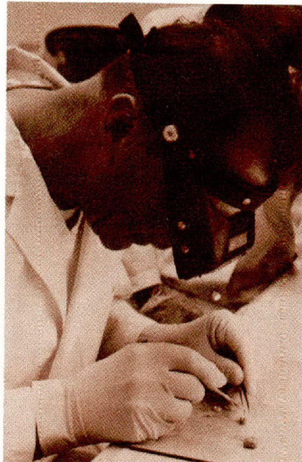
There are two ways to do this: observing changes in the patient's behavior in response to a drug, and measuring blood levels of the drug from samples taken from the patient. If patient A, for example, improves when 200 nanograms (a nanogram is one-billionth of a gram) of chlorpromazine are present in one milliliter of his blood, that is one kind of correlation. Patient B may need less or more, or he may need another drug. Each patient is different, and the wide variability in absorption, metabolism and excretion has left chemotherapy of mental illness an inexact science.

Researchers in TRIMS laboratories have developed several techniques for detecting minute amounts of a drug in blood. What remains to be done is to simplify these methods so they can be used routinely for all drugs, and with less equipment than is available at TRIMS. Before standards of treatment may be said to be reliable and precise, studies of large groups of patients taking the many different drugs are needed.

During the last year, the institute's clinical research ward has been selecting its patients and establishing an environment that is comfortable and steady, in which patients' emotional and physical needs are well met and which is conducive to research.

This is a major focus of interest at TRIMS and was the topic of the institute's 11th annual symposium in November 1977, "The Kinetics of Psychiatric Drugs." Now that the clinical research ward is in operation and the research protocols have been designed and approved, the job is to move pharmacological knowledge from laboratories to patients---to ensure that each patient receives the best drug in the best dosage for his or her disorder.

(Statistics are on page 10.)



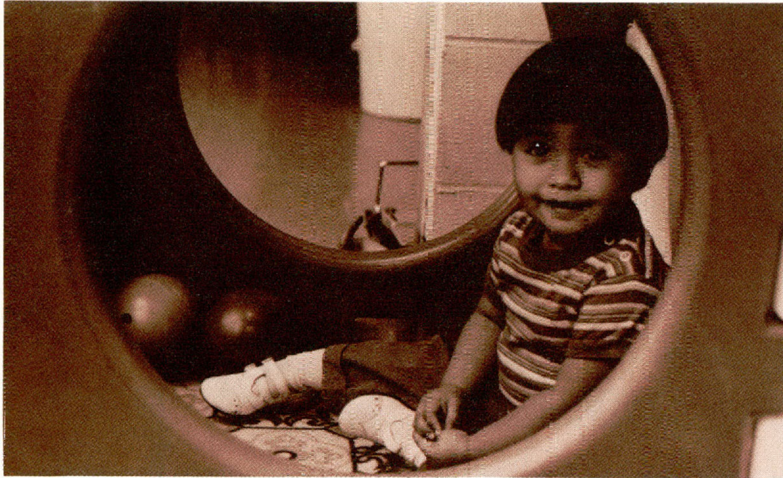
Research in the laboratory is leading to better client care, including new ways to tailor treatment with psychiatric drugs to individual patients.

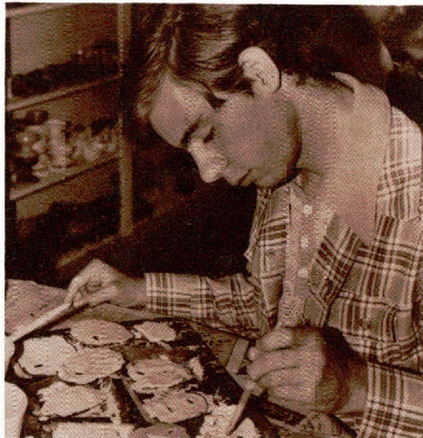
com·mu·ni·ty *n* : a group of people living in a particular area

com·mu·ni·ty men·tal health and men·tal re·tar·da·tion cen·ter *n* : an accessible system of services within a defined geographic area for persons who are disabled by mental retardation, mental illness or alcohol or drug abuse; also called *community MHMR center, community center* or *center*

com·mu·ni·ty ser·vi·ces *n* : assistance close to home for people who are mentally disabled; may include inpatient, outpatient and day treatment; programs for alcoholics, drug abusers, children and the elderly; emergency, follow-up and transitional services; consultation, education and screening; *syn* see COMMUNITY CENTERS

Community Services





What are community services?
–(top) playrooms to stimulate toddlers who are developing slowly,
–(center left) activity programs for the elderly in nursing homes,
–(center right) workshops for mentally retarded teenagers,
–(below) development programs for children,
–(opposite page) and classes in basic living skills for young adults.

This year there were increasing costs for service delivery, demands for innovative programs and needs to expand the geographic areas served. Above it all was the call for a means of accountability that could maintain public confidence in this community MHMR center system.

To meet these challenges, some center workers focused new attention on special populations---the elderly, the children of alcoholics, the mentally retarded juvenile offenders, infants developing slowly, teenagers with both school and personal problems, new parents learning their baby is mentally retarded.

These persistent staff members also responded to silent pleas for help from individuals whose lives had been so empty of meaning, so tangled in problems that restoration seemed an impossible dream. But they dared to dream and were not deterred by such obstacles as one client's 40 years of deafness and 20 years of residence in a state school. The challenge he presented was matched with a hearing aid, speech therapy, job placement and a home of his own.

Another center provided aftercare, therapy, medical treatment and a workshop position for a man who had been a mental hospital patient for decades. Still another corps of caregivers accepted the call to help someone nobody wanted and offered the means to an independent life for a mentally retarded man turned away by an abusing family, an ill-equipped school, a rejecting community and an institution unable to reach him. Others searched for, and found, the right placement for someone whose diagnosis had been changed from "mentally retarded" to "mentally ill."

Many of these efforts required coordination between the centers and the state facilities. Some state schools and centers, for example, jointly started community residential programs for the mentally retarded. A similar effort was initiated between three state hospitals and three centers to develop pilot community residential programs for patients in long-term care.

Abusers of drugs and alcohol found more community alternatives to treatment than ever before. Liaison workers were on hand in the courtroom as defendants faced the judge's bench to link them with community chemical abuse services they so desperately needed. Cities, counties, local agencies and individuals joined in providing land and buildings for community detoxification facilities. Halfway houses encouraged long periods of sobriety for alcoholics, and other agencies chose to handle detoxification, intermediate care and follow-up under one roof. Drug treatment agencies began coordinating their efforts.

The wise use of money was not neglected as a way to help clients. One center took a small grant to initiate a volunteer program that, it was hoped, would merit continued funding. Another center began collecting its sliding scale client fees as a means to indicate fiscal responsibility and help clients realize their investment in treatment.

Teams of staff members across the state struggled with (and overcame) difficult problems---adding programs without extra funding, for example, and making those services accessible to an isolated or scattered population. They learned ways to involve citizens in planning efforts and formed committees of staff members to monitor the quality of care delivered. This improved accountability to the public was a challenge faced by every center as a prerequisite for seeking review of its programs by the Joint Commission on Accreditation of Hospitals. New department rules mandating Peer Review Committees and Professional Advisory Committees further increased the level of accountability.

Although exasperated by voluminous and often conflicting standards required by other agencies, the centers responded with good intentions and ended the year with many new programs underway and many old ones certified. Sixteen centers received ICF-MR (Intermediate Care Facilities-Mentally Retarded) certification for community-based residential services for the mentally retarded.

The TDMHMR Community Services division's management audit section, which assisted the centers in upgrading their accountability, completed 13 management audits of center programs. These audits, focusing on economy and efficiency of each center's administrative program, produced reports which were shared with the Governor's Budget Office, Legislative Budget Board and the respective centers' boards of trustees. The reports analyzed administrative practices and made recommendations where deviations from the standards of good management were found. A follow-up program monitored remediation efforts of each center.

A planning grant awarded during the year helped develop the state's 28th center, Pecan Valley MHMR Region, to serve Erath, Hood, Palo Pinto, Parker and Somervell Counties. With its addition effective Sept. 1, 1977, community MHMR services were made available to 125 counties, representing 82 per cent of the state's population.

Centers

A Second Chance

Imagine the year is 1928 and you are born to working class parents. Your development is normal until at age seven a bout with meningitis and high fever results in brain damage. You are suddenly unable to hear, unable to speak. Epileptic seizures and indications of cerebral palsy follow.

Your development is slowed, and in a few years mental retardation is suspected. To add to your burdens, you are black and you reside in a small south Texas community. You live in a society afraid, ignorant and intolerant of human differences.

This was Hiram Bearden's early history. At age 27, he entered Abilene State School in 1955. After years of training and despite his many handicaps, school staff members agreed in 1976 that Bearden might be able to live in the community.

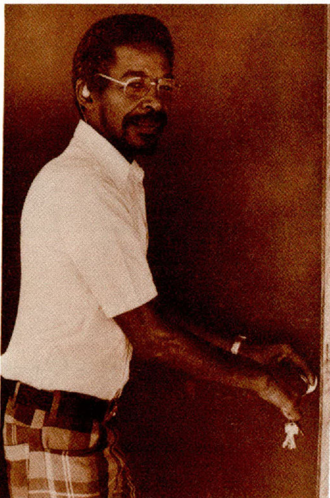
He was referred on a trial admission to the **Abilene Regional MHMR Center** for training in community orientation, independent living and vocational adjustment. After a short period of adapting to the center's group home, Bearden was sent to the audiologist at the Abilene State School for his severe hearing loss. On a hunch, the audiologist ordered a complete hearing aid system for Bearden. Later tests revealed Bearden could respond to his name. His silent world of 40 years finally had been pierced.

The next referral was to the West Texas Rehabilitation Center in Abilene for speech evaluation. There, Bearden's progress has been remarkable, and he continues to work on pronunciation of the alphabet and basic words.

Further success followed for Bearden after his job placement at a community hospital. Within four weeks he had earned two pay raises and the admiration and respect of his co-workers.

Plans are being made for Bearden's transfer to independent community living. He will continue to receive necessary follow-up and speech therapy.

Despite many difficult years and severe sensory handicaps, Bearden, now at age 49, maintains a positive attitude and an admirable zest for living.



Keys to the door of his own home represent a second chance for independence after a lifetime of handicaps and obstacles.

Wide Open Spaces

Amarillo, the Panhandle's largest city, was one of Texas' pioneers in community mental health care for the region during the 1960's. From that time forward, it has been the **Amarillo MHMR Regional Center**'s philosophy that every man, woman and child in the area is entitled to community-based mental health care. In 1973, the center's board of trustees expanded its 21-county service area to provide such care to 500,000 people dispersed over an area of some 20,790 square miles.

The first step was providing a means by which local citizens could influence regional developments. Six district committees were appointed by county judges and mayors throughout the region. These committees were responsible for assessing local needs, developing local resources and planning for what would eventually become six family service centers.

A learning experience took place when the first center was established in Hereford. Overcoming problems such as community acceptance of the services, the isolation from Amarillo's support service, the need for adequate supervision of staff and the level of expertise needed by that staff were all building blocks for future centers.

Today, there are family services centers in Hereford, Dumas, Borger, Perryton, Pampa and Wellington. Dalhart and Canadian are visited by staff members weekly. Each center provides services varying from intake and evaluation to psychological testing, individual and group psychotherapy, marital and family therapy, play therapy, medication checks, aftercare, screening for state hospital admissions and consultation and education. Back-up services are provided by the 100-bed Psychiatric Pavilion in Amarillo and nine private psychiatrists under contract to the board of trustees.

The active caseload of each center now varies from 30 to 70 clients per month. Almost 70 per cent of the admissions to Vernon State Center in fiscal year 1977 were screened by components of the Amarillo MHMR Regional Center.

Believing that each Panhandle resident has the right to community-based mental health care motivated the Amarillo MHMR Regional Center to meet the challenge of providing it.

Rx: Oatmeal Mornings

A prescription for oatmeal rather than pills is possible for a new client of **Austin-Travis County MHMR Center**'s services for the elderly.

"With older people, there is often difficulty identifying the real problem," says Vickie Strader, community coordinator for services for the elderly. "Confusion can be caused by a stroke so mild as to be unnoticed. Confusion also can be caused by constipation, among other things, so a prescription for oatmeal is not out of order. We start with simple possibilities rather than making assumptions."

Providing mental health services to the elderly as mandated by Public Law 94-63 has been a challenge that has brought growth. Among the many agencies that serve the elderly, the Austin-Travis County MHMR Center deals specifically with the mental health problems of aging persons, of whom an estimated 25 per cent are clinically depressed. But depression cannot be treated without attending to some of the other problems of aging that may seem only indirectly related to depression.

"The accumulation of losses that occur as people age makes them vulnerable to depression," explains Jim Brooks, the program's director. "Losses such as the inability to get around, decline of vision or hearing, loss of job or family to serve, and, of course, deaths of friends and family often build to the point of depression."

Brooks is clear that MHMR's program cannot answer all the needs of the elderly. His goal is to use as fully as possible the resources that already exist in the community.

Treating the mental health needs of the elderly frequently requires attention to other problems of aging.

An Assurance of Quality

Bexar County MHMR Center is a large and complex organization which served more than 16,000 clients in 1977 at 22 locations in the San Antonio area. The staff provided more than 251,000 client-hours of outpatient and day care services alone.

Public Law 94-63 requires that community MHMR centers, to qualify for continued federal funding, have a system for assuring the quality of care that is rendered. In order to monitor the quality assurance system, a Clinical Services Review Council was established.

The council is composed of 15 persons representing the center's clinical and administrative components. Six subcommittees composed of other employees monitor and review the quality of service provided by the center:

1. A Medical and Drug Committee reviews medical practices and medical management problems, maintains an up-to-date drug formulary, evaluates proposals for policies relating to medical responsibility and studies physician time utilization.

2. A Utilization Review Committee assures an appropriate use of center facilities, staff and services.

3. Establishing standards of care is a task assigned to the Client Care Committee. This committee also responds to questions concerning the quality of care administered to clients of center programs.

4. The major task facing the Clinical Records Committee is to develop a unified client record system as well as develop a mechanism for forms control.

5. A Staff Development Committee has responsibility for developing a continuing education program for staff and for monitoring an effective orientation program.

6. The Human Rights Committee studies grievances pertaining to clients' human rights and recommends policies on clinical research, consent and confidentiality for participation in proposed studies which involve center clients.

The Clinical Services Review Council is an integral part of the clinical practices of Bexar County MHMR Center. The number of hours spent in direct service to patients has increased significantly, and there has been an increase in understanding on the part of clinicians and administrators for one another's problems and concerns.

Proper utilization of staff, adequate patient data and the development of quality standards of care are now issues at the staff level. The Clinical Services Review Council has brought to the direct care staff a means to monitor quality, effectiveness and efficiency to help them better serve the clients.

Centers

How to Stretch a Budget

A major challenge for **Brazos Valley MHMR Center** in Bryan has been the need to expand services into each of the seven counties in the region without additional funding for personnel or facilities. To accomplish this, the center has acquired donated office space, organized mobile service delivery teams and provided resource books for officials and caregivers.

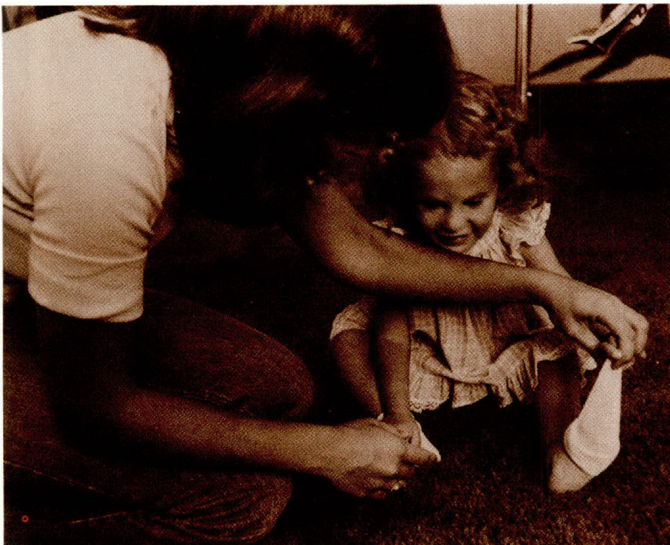
Last June, Central Administration began seeking donations of space and utilities. As a result, office space was obtained in four of the six outlying counties in the region by the end of the fiscal year. Staff from both the Mental Retardation and the Alcohol and Drug Abuse Programs use the space to deliver services on a weekly, biweekly or as-needed basis.

Mobile service delivery is used when possible. For example, the Mental Retardation Program staff offers its infant stimulation program in clients' homes in all seven counties, and assessments are performed by a mobile diagnostic team.

The Drug and Alcohol Prevention Program's staffs have provided in-service training for nurses and teachers in three counties. In addition, DWI classes are being offered on a continuing basis in each county. Volunteers have been trained in six counties and are working with youth referred by county officials.

An important component of this effort is the development of an information and referral data base for each county. Working under a Developmental Disabilities Advisory Council grant, the center collected information during the summer and plans to distribute more than 250 resource books during 1978 to elected officials and caregivers in the counties. Potential clients should be identified and referred more readily as a result of this project.

Although the plan is new, results are already visible. Region residents show greater awareness of the center's programs, referrals have increased and key community members have shown a readiness to work with center staff.



Mobile infant stimulation workers make center services accessible by visiting the homes of families who need their help.

Students in Trouble

With the opening of the new Copperas Cove office of the **Central Counties Center for MHMR Services** in 1977 came a new program: an adolescent day treatment unit. The idea for such a program resulted after community and school leaders in Copperas Cove asked for help from the Central Counties Center in Temple. Their problem was finding a way to deal with young people experiencing personal/emotional problems and school-related difficulties.

The school system and the community wanted some way to continue the student's educational training while he or she received therapy or treatment. So, an adolescent day treatment center, classified somewhere between outpatient and residential in intensity, was developed for young people in need of therapy.

The students attend school for three class periods in the morning plus lunch, and then the school furnishes transportation to the center by 12:30 p.m. Parents now pick up their children at 5:00 p.m., but the center will provide transportation home as soon as a van can be purchased.

The adolescent program presently has eight clients five days a week for a session correlated with the school's quarter---12 weeks in length. These young people are between the ages of 13 and 18 and are nonpsychotic. They typically are under-achievers in school, discipline problems, truant or experimenting with drugs. Others may be on juvenile probation.

Kay Hibbs is the unit coordinator. Her program has activities ranging from group and individual therapy to arts and crafts and recreation. The program is structured on three levels. Each student progresses toward the next highest level as treatment continues and the needed skills are acquired. Parents of the youngsters are required to participate in the parent group on a weekly basis.

Thus, the adolescent day treatment program has found a way to serve the student in trouble, his or her family and the school system.

Journey Home

Edwin has been in a psychiatric hospital for more than 30 of his 49 years. He grew up physically healthy and mentally alert in a small northwest Texas community. But when he failed a high school Spanish course, he became discouraged and refused to return to school for his senior year. He later earned his G.E.D. and began occupational education, yet he complained that he could not concentrate and felt that he did not have enough intelligence to continue. On each of several jobs, Edwin had problems with employers and fellow workers. He lost interest in life and would not leave the house unless coaxed by his family.

Finally, Edwin was sent to a private hospital and later to a state mental hospital, but he remained withdrawn and apathetic. Although he was well-oriented at first, there was a certain amount of deterioration that occurred over the next 30 years. Recent therapy, however, helped Edwin progress to a point of likely rehabilitation. Last winter the hospital staff contacted the follow-up and aftercare team of the **Central Plains Comprehensive Community MHMR Center** in Plainview for his discharge to his home area.

Edwin did return and was visited by a caseworker from the center who had located a place for him to live. Edwin continued medical treatment with the staff psychiatrist of the center and was assigned outpatient group and individual psychotherapy.

While he participated in the center's day treatment program, the caseworker secured for Edwin a position at the vocational workshop operated by the center. There Edwin can work and, in fact, make a small salary, which is something he had not experienced for 30 years.

Edwin has progressed enough that he is now in charge of certain assigned work activities. He is making friends and coping with a world that has changed drastically since his boyhood.

The Central Plains MHMR Center will be able to accept more Edwins with the opening of two new 12-client residential living/treatment homes early in 1978. The homes will serve as an alternative to hospitalization by providing follow-up and aftercare services.

Through the efforts of a community-based center, Edwin is experiencing acceptance by society. Soon, he will be able fully to experience living in the way that people in the Panhandle of Texas enjoy life.

A Dark Beginning

It was just another morning for Pam Stockman and Helen Ferguson, aides in the infant stimulation program for the **MHMR Center for Central Texas** in Brownwood. They were busy helping children learn various basic skills when they were approached by their supervisor and told of a four-month-old girl who was to be admitted to the program.

The child, Cathy, weighed nine pounds, seven ounces at birth and had appeared to be a normal, active infant. Unfortunately, leaving the hospital began an odyssey for Cathy which included enough trauma to wilt the spirit of any adult.

Cathy was a neglected child. At two-and-a-half months of age she weighed one pound, four ounces less than she did at birth. It wasn't that her parents didn't care. They just didn't have the parenting skills to provide properly for her. As a result, she almost died from malnutrition and had to be placed in the custody of child welfare.

A foster family helped Cathy regain her physical health, but they could see that she was not developing normally. Because of this, the child welfare worker contacted MHMR and Cathy was admitted to the infant stimulation program.

Stockman and Ferguson worked with Cathy but little progress was shown. Finally, a Brownwood physician indicated that Cathy might be suffering from a premature closure of the bones in her skull. At age seven months, Cathy had surgery to reopen her "soft spot" so that her skull could develop. After recovery she returned to the program. During the next month, Cathy caught up in every area except language, and in many areas she has progressed beyond the normal levels for her age.

For a 16-month-old child, Cathy has been through a lot. Cathy is now ready to be adopted and to begin a new life. Cooperation among interested people allowed some light to enter into a life that began so dark.

Centers

Children of Alcoholics

Ralph is a slightly-built, doe-eyed nine-year-old boy. His smile would win the heart of any adult. However, Ralph seldom smiled.

His response to adults fluctuated between avoidance and dependency. He had low self-esteem and poor impulse control which caused many problems in school. He also felt isolated due to his father's insistance that he not bring home friends or talk about his mother's alcoholism.

Ralph's parents, because of their focus on the problem of alcoholism, had unrealistic expectations of him which kept him in a state of great anxiety. The ineffectiveness of such parents as appropriate role models is reflected statistically in the increased probability of their children themselves becoming alcoholics.

When an alcoholism program expands its role as therapeutic agent to include the children of clients, family life can be greatly enriched. The alcoholism services program of the **Dallas County MHMR Center** has done just that. The staff members found the Montessori approach ideal for treating the children of alcoholics because there are many ways in which parents may be involved. As a system based on an ordered environment, self-paced instruction, development of inner discipline and liberty within limits, the Montessori method is suited especially to the needs of these children.

The center's alcoholism services location has a Montessori room available for child care on evenings when the unit is open. Since the Montessori materials are adaptable to different ages, children quickly engage in chosen activities.

Here, Ralph learned to liberate himself from physical dependence. The attainment of manual dexterity and self-confidence came in Ralph's learning to care for his own physical needs. At home, his parents were thrilled to see his eagerness to help. This reinforced their need to know that they were *not* failures as parents. Because there were positive changes in Ralph's behavior as well as that of his parents, conflicts which often arise as alcohol abuse is abated were avoided.

For more information, contact Celynn McDonald-Jay, Coordinator of Alcoholism Services, Dallas County MHMR Center, 3949 Maple Ave., Dallas, TX 75219.

The ordered environment of the Montessori classroom is especially suited to the needs of children of alcoholic parents.

Success Is Staying Sober

Tom, who began drinking when he was 19, is 37. Until a few months ago, the longest time Tom had been sober was 20 days.

He had been unable to hold a job and had been in and out of jails most of his adult life. His wife and children, after years of hoping, finally gave up on him and left.

Last March, Tom, who was in jail for drunkenness, was referred by the probation department to the Shelby County Halfway House located in Center. During his three-month stay at the halfway house, Tom went through comprehensive counseling, social-personal adjustment training, vocational guidance and an Alcoholics Anonymous program. On June 23, Tom was discharged from the halfway house. He had a full-time job and his family was waiting for him. He also began G.E.D. classes.

Tom has been sober four months, his longest sobriety in 18 years. Tom, who was born and grew up in the rural piney woods of East Texas, now has the confidence he can make a success of his life. The Shelby County Halfway House and the other programs of the **Deep East Texas Regional MHMR Services**, headquartered in Lufkin, will continue to provide support for Tom in his effort to lead a more successful life.

Deep East Texas Regional MHMR Services provides a comprehensive network of mental health, mental retardation, alcohol, drug and public education programs strategically located in the 13-county area for which the agency is responsible. The services have provided treatment to approximately 3,500 clients during fiscal year 1977 and reached another 5,000 through public education.

The 37 community-based programs, like Shelby County Halfway House, have experienced a productive and successful year through the efforts of the clients served, the support of the local community and the dedication of more than 130 staff members.

Partners in Justice

When Julie was remanded by Van Zandt County Court Judge Richard Ray to the chemical abuse program of the **MHMR Regional Center of East Texas** (MHMRRCET) in April, she was a disheartened chronic drinker whose family had disowned her.

With no job or home, Julie had drunk up the money people loaned her and faced charges of driving while intoxicated in two East Texas counties. She was also a drug abuser.

After a period of participation in the chemical abuse program, Julie entered a Tyler halfway house through cooperative efforts of the Texas Rehabilitation Commission and MHMRRCET.

Today, a halfway house resident, Julie is in therapy at MHMRRCET, is employed and has withdrawn from drugs.

Her success owes much to the efforts of Glen Gray and Michael Wohl, who fill two chemical abuse liaison worker positions created by a grant from the Texas Department of Human Resources. Gray and Wohl have been described as the "warm hearts" among a myriad of agencies, the "missing links" meeting the challenge of providing a needed connection between the courts and clients seeking community services.

Julie is one of 1,230 contacts made by liaison workers since the program's inception in January 1977. Contacts include state hospital clients, former hospital clients needing aftercare, family members, referrals to the Department of Human Resources and MHMRRCET clients.

During evaluations Gray and Wohl become aware of the client's personal, social and economic situation and often refer the client and family to various programs of the Department of Human Resources.

Judge Ray said Glen Gray is called upon at least 15 times a week. "In seven months," he said, "the program has prevented approximately 40 persons from being committed to a state hospital."

Gray is present at each county criminal docket call and counsels immediately with each defendant placed on probation because of drug or alcohol-related offenses. In many cases, a defendant will be instructed to attend drug or alcohol abuse classes provided by MHMRRCET as a condition of probation.

The liaison workers are meeting head-on a second challenge---that of providing preventive maintenance to high school students. By informing students about the effects of alcohol and drug abuse, Gray and Wohl believe the lives of future Julies can be guided in other directions.

Reach for Hope

"I was lying in the recovery room, tired and in pain, when a group of doctors came in and stood over me and asked me if I knew what a mongoloid child was. I said I did, and then they told me that they thought my daughter was a mongoloid. Then they left."

That is how Sherrie, a 19-year-old woman whose husband was thousands of miles away in Korea, was given the news that her second child was mentally retarded.

"I was scared and lonely, angry and then guilty. But I was lucky. It only took me three months to find out that I needed help for my baby and where to find it. And now I want to help others."

Sherrie *is* helping other parents to cope with the trauma and the despair they experience when they first receive the diagnosis of mental retardation in their children---particularly if this diagnosis is made at birth. Sherrie is one of five trained volunteers, all parents of mentally retarded children, who serve as peer counselors with Reach for Hope at the Child Development Services of the **El Paso Center for MHMR Services.**

Reach for Hope, initiated with funds from the Texas Education Agency under Public Law 89-313, is a crisis intervention program. It offers immediate, informed support through hospital visits to parents receiving newborn diagnoses of Down's syndrome or other mental and physical handicaps, plus assistance in finding services for developmental stimulation.

Realizing that the obstetric nurse is the first source of contact and information for the parents of most mentally retarded infants, close ties were sought with the nursing staff of all the major hospitals. These contacts apparently are bearing fruit, for in the first six weeks of the program, six calls were received for Reach for Hope volunteers.

All of the children entered the service delivery system before the critical eighth month, when stimulation is most effective.

Volunteers make daily visits while the mother is still in the hospital. These are followed by home visits on a weekly and then monthly basis until the infant enters the service delivery system.

"I wish I had had someone to talk to," Sherrie reported, as have countless others in the three-year history of the Child Development Services. That is what El Paso parents of mentally retarded children are now receiving from Reach for Hope---someone to talk to, someone who has been down that road before them.

Big Buddies

Volunteers who help children and youths ages 4 to 16 are known as Big Buddies at the **MHMR Center for Greater West Texas** in San Angelo. Big Buddies offer friendship and help to mentally re tarded youngsters who are trainable or educable, students with language learning disabilities, and juveniles who are emotionally disturbed, predelinquent or delinquent. Two new programs in the last year have added to Big Buddies' effectiveness.

The program known as NYPUM (National Youth Project Using Minibikes) is a coordinated effort of the Big Buddies program, the San Angelo YMCA and Tom Green County Juvenile Probation Department. It is designed to serve predelinquent and delinquent youths from ages 10 to 15.

Members of the group are assigned a minibike when they enter the program. After classes in riding safety and maintenance, they are responsible for proper upkeep of their bikes. Activities include dirt track riding, figure riding and parade riding. Members also participate in non-minibike activities such as swimming and camping.

The objectives are to increase diversion from the juvenile justice system, to decrease arrests and to promote community agency cooperation in the delivery of needed services to troubled youth. Considerable progress has been noted. School grades have improved and truancy, vandalism and arrests have decreased. Program participants have developed more responsibility, improved communication skills and more positive interpersonal relationships.

Of prime concern to the program is the development of positive self-concepts within the adolescents served. The minibikes are used as tools to stimulate the development of positive, responsible behaviors by becoming a common denominator between the program directors and the alienated youth. The program was made possible by Honda Motor Company, which donated 10,000 minibikes across the nation, including 22 to San Angelo.

The second program, PRIDE (the Program of Recreation Incorporated with Developmental Education), engages 20 trainable and educable mentally retarded children in recreation not usually accessible to them. As a result, many are now able to communicate better with both peers and staff and are showing great improvement in coordination and agility. This program is filling a previous void for the children participating by allowing them an opportunity to explore and develop their physical capabilities.

The Revolving Door Stops Here

Rejection was the hallmark of George's history and, worse, his expectations of the future. He was 27 years old, mentally retarded, with parents unmotivated and unskilled to teach him the rules of the game, much less how to win on his own terms.

As a community-designated reject, he had found the public schools had "nothing to offer." At the age of 12, with minor legal infractions already on his record, George entered a state school for the mentally retarded, but made little progress. A rehabilitation agency tried placement on a large commercial farm, but support services and his own motivation were not sufficient to keep him functional.

A return home resulted in fights with an alcoholic father, and the community again labeled him undesirable. Institutional commitment resulted in even poorer adjustment and diminished self-esteem. A return to the community offered George the bleak hope that the revolving door of "placement somewhere," was possible.

The challenge became helping someone nobody wanted, someone with whom many had already failed in their attempts.

Then in September 1976, the Calhoun County Work Activity Center opened its doors under the sponsorship of **Gulf Bend MHMR Center** in Victoria. George was one of the initial clients.

Here he receives academic and social skills instruction. His competence making fishing lures for a local business firm led to other small jobs. Not yet settled, George is being helped in his search for an apartment by cooperating social welfare agencies.

The guided steps to functional independent living offered by the Calhoun County Work Activity Center are meeting a challenge of terminating the go-nowhere track of the revolving door.

Minibikes are the keys which open closed doors between troubled young boys and the volunteers who want to help them.

Learning to Work

Vocational training and sheltered workshop opportunities are essential if mentally handicapped individuals are to be successfully integrated into the community.

"A productive job is often the first step toward elimination of many other social and personal problems," according to John P. Billings, executive director of the **Gulf Coast Regional MHMR Center** in Galveston.

Until fiscal year 1977, the Gulf Coast Center had little in the way of vocational services because other, more pressing needs such as residential facilities, human development and community service centers took priority in budgeting.

Without a great increase in available money, the Gulf Coast Center this year accepted the challenge of providing training and paid employment to adult clients.

The various program units which make up the Human Development Services were selected as sites for implementation of vocational training and sheltered workshop activities. These programs traditionally had taught community living skills such as time and money management, personal hygiene, communication, home management, avocational and prevocational skills. This programming was maintained on an adjusted schedule, and the staff began working toward vocational activities.

Grants were written, contracts and equipment researched and training undertaken. Three programs now are providing productive work and paychecks to an average of 80 clients a month. The programs are Mainland Industries in Texas City, Community Living School in Alvin and Brazoria County Work Activity Center in Brazosport.

How was the center able to provide sheltered workshop activities without a great increase in funding? Grants paid off in some areas such as the greenhouse facilities at the Alvin Community Living School. In other areas, such as the production of lead fishing weights, the center purchased equipment and materials with long-term plans for the operation to "pay for itself."

"The major reason for the success in vocational programming," according to Billings, "is the excellent community support we have received both in contracts for work and in purchasing our products."

From Court to Community

James was a walking, talking, breathing 15-year-old challenge. From the time his mental retardation was first diagnosed until his most recent scrape with the police, James had been a challenge to his mother, his physicians, the schools and, finally, the juvenile justice system. From vandalism to petty theft to assault, James' problems with the law grew to significant proportions.

Puzzled by having to deal with a youngster who not only was delinquent but also mentally retarded, judges had been lenient with James in the past. Declining to commit him to a state institution or to a detention center, they sent James home where the cycle of poverty, verbal abuse, physical violence and crime were perpetuated.

For James and the 25,000 other mentally retarded juvenile offenders (MRJO) in Texas, this story has been repeated all too often. Until recently, there were no existing services designed especially for the MRJO---the challenge went unmet.

In early 1976, two events occurred which, for the first time, came to grips with the challenge of the MRJO. First, a task force convened by TDMHMR outlined priorities for the treatment of the MRJO. Second, a pilot program for treating MRJO's was created by the mental retardation department of the **MHMR Authority of Harris County** (MHMRA) in Houston with the assistance of local juvenile justice officials, the support of youth advocacy groups and other community agencies and a grant from TDMHMR.

With the beginning of fiscal year 1977, MHMRA established two residential treatment centers for 20 MRJO males between the ages of 13 and 17. A third center will open in 1978, bringing the number of clients served to 28.

The ultimate goal is to return the MRJO to the community to live independently or within a family setting. Once the MRJO is back in the community, the program seeks to involve him in public schooling, skills training or job placement.

In the first year of operation, 10 residents have been returned to the community. Of these, eight have remained in the community, engaged in employment or school and work training, and only two have returned to the program.

Performing a job that earns a paycheck is the first step toward better social and personal adjustment for many mentally handicapped persons.

The Elderly in Isolation

Fred, 65, is a long-time resident of a small rural town. Considered retarded by members of his family, he always has been a social isolate.

Until recently, the relationship between Fred and the town could best be described as one of mutual toleration, leavened with distrust. There were no real problems until Fred developed cancer on his lower lip, which over a period of time destroyed half of his lower lip and the inside of his cheek. For two years, the family tried to take Fred to a doctor, but to no avail. He had an abiding distrust of doctors and adamantly refused to see one.

Residents of Fred's town called the local office of the Texas Department of Human Resources (DHR) to report that something needed to be done about this "crazy" man who hit people with a board when possible medical treatment was discussed. Because of the uncertainty of Fred's mental status and of the need for medical treatment, a special crisis team made a home visit.

The crisis team originated because practitioners in social services and health fields have long been aware of the practical difficulties encountered in providing services to aged persons like Fred. A key problem is that of gaining access. A contract between the ABD (Aged, Blind or Disabled) Unit of DHR and the **Heart of Texas Region MHMR Center** in Waco has provided that access.

The crisis team found Fred to be a shy and lonely little man with a great deal of fear of what a doctor might do to him. With the use of patience, human warmth and understanding, Fred was agreeable to a home visit by a family practice resident. This was the beginning of several physical evaluations for him.

The final diagnostic evaluation revealed a poor prognosis. Radical surgery would be only a temporary solution. Fred, with full awareness of his options, chose to forego any future treatment. For once in his life, he had and took the opportunity to make an independent decision, knowing full well it may mean an early death for him.

MHMR staff members feel it is impossible for a single agency to serve the elderly in isolation because of their complex needs. The combined efforts of MHMR and DHR staff give the client the benefit of each agency's expertise. Fred's story highlights the combined efforts to give clients the best the agencies have to offer.

Keeping Score

To help determine the effectiveness of its programs, **Lubbock Regional MHMR Center** initiated two research/evaluation projects during the past year.

The first project involved the methadone maintenance program. Working in close coordination, Oscar Jones, director of Drug Abuse Services, and Mike Berren, director of Research and Evaluation, developed a system that allows for rapid retrieval of data related to impact of the methadone program. For example, within only a few days of the end of a month, the staff members of the methadone program receive information documenting the month's methadone dosage levels, employment status changes, urine sample analyses, legal problems and other information for all clients in the program. Summaries and information are available for all clients who have been through the program as well as for the active caseload. In addition to using this information to check management and program efficiency, staff members also can demonstrate accountability for funds to the community, the State of Texas and other funders.

Another research/evaluation project is the utilization of a social functioning outcome measure for outpatient mental health programs. The measurement device, called "The Five-Concept Scale of Functioning Ability," is an easy-to-use instrument. All clients entering outpatient programs are scored at both admission and termination. To the gratification of the staff, it appears that many clients leaving center services function at a higher level than when they entered.

Dreams to Build On

In March 1977, **Northeast Texas MHMR Center** in Texarkana received a small supplemental state grant-in-aid to fund volunteer services. It was a carrot-dangler, replete with temptations and challenges.

The funding was limited to five months, and the grant was contingent upon the center's continuing the program into fiscal year 1978. The temptation was to charge into the three-county service area and mobilize armies of volunteers who would revolutionize MHMR programs in northeast Texas. When that hallucination passed, it was decided the best investment would be to link volunteers to existing services in two counties and count on their contributions becoming so valuable that continued funding could be secured.

In Bowie County, volunteers were recruited to work with the telephone crisis intervention service (Call-Anon), the activity program for retarded young adults and the Vocational Training Center. When the project began April 1, there were five volunteers; by August 31, there were 18. In addition, several civic groups were providing support as sponsors for special activities.

In Red River County, the hallucination recurred, but the decision was made simply to implement a parent advocacy program. Home visits were made to parents of children with MHMR disabilities who were receiving services from the center. A core group of seven parent volunteers, supported by center staff, set a goal of providing resource contacts and a support system for other parents of disabled children. A coordinator has been employed for the program.

The hallucination has become a dream, and Northeast Texas MHMR Center is building volunteer services from a small but secure beginning.

Saving the Children

There is a quiet self-confidence in the way Chris approaches the trampoline. Although his is not the polished performance of a veteran acrobat, it is, all in all, a rather commanding performance for a seven-year-old child who learned to walk less than a year ago.

Chris Ortega's trampoline routine is part of the daily physical education instruction he received as a student at the **Nueces County MHMR Community Center**'s Parkway School for Retarded Children in Corpus Christi. He is one of 40 children currently enrolled in the school, which has for the past six years provided special education and training for retarded children in Nueces County.

School director Marion Moore says the school's goals are twofold. "I suppose the most obvious goal is to prepare our students for the public school system or a vocational program. But just as important is to make each child more self-sufficient at home so that he or she will become a more acceptable member of the family."

To this end, Parkway's classes emphasize sensory stimulation and self-help skills such as toileting, feeding, dressing, communication, physical development, prevocational training and socialization.

A trainer actually extends the school program into the home by teaching the family how to work with the child. Home training, according to Moore, has been enthusiastically received by the parents.

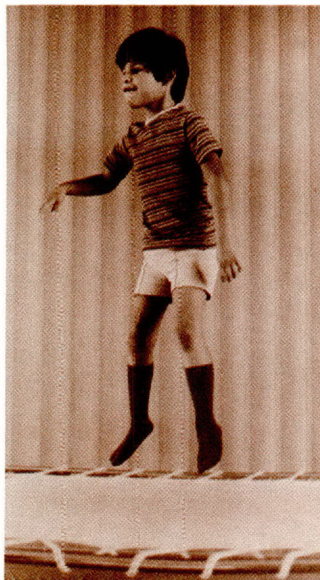
From the child's standpoint, this consistency in the way he is fed or dressed or toilet trained helps him to retain those things he is learning at school.

Community Spirit

The citizens of the Midland-Odessa area take the word "community" in "community MHMR center" seriously. They feel, and rightfully so, that the **Permian Basin Community Centers for MHMR** (PBCCMHMR) belong to them. Their interest has been demonstrated often, but probably never so strongly as when the existing alcoholism detoxification facility needed to be either renovated or replaced. The facility, Park Place, had been in operation eight years, serving both Midland and Ector County residents by providing short-term alcohol detoxification as a first step on the road to recovery.

A portion of the Park Place beds has been replaced by a 14-bed polydrug detoxification facility in Odessa. Funds for the facility were provided by the City of Odessa, and land was made available by Ector County. Replacement beds for the Park Place facility are also being planned in Midland County. This project, scheduled for completion in 1978, is being made possible through funds provided by the County of Midland and the Midland Council on Alcoholism. Land for the facility was donated by a Midland family.

Says Bob Dickson, executive director of PBCCMHMR, "This is just another example of how communities can get together and support an MHMR center. These two new facilities will enhance our service delivery system and help us to attain our goal of providing treatment close to home."



A year ago, he couldn't walk. Today, he's a fledgling acrobat.

Centers

Under One Roof

A desperate need for an alcoholism and drug addiction treatment center for East Texas provided the challenge for the **Sabine Valley Regional MHMR Center** (SVRMHMR) to begin a program for those faced with a chemical addiction.

The service became a reality in 1976 when the Oak Haven Nursing Home board of directors leased a building five miles from Marshall, no longer needed as a nursing home, to SVRMHMR for one dollar a year.

Bob Howell, program director of Oak Haven Recovery Center, and staff members began operations with a detoxification unit capable of serving 13 persons and an intermediate care area for 16 persons. There is also a follow-up service for the 181 patients who have been through the Oak Haven program.

Fain Williams, executive director of the East Texas Council on Alcoholism and Drug Abuse (ETCADA), believes that Oak Haven is the only state-funded, community-based program of its kind in Texas.

"Having detoxification, intermediate care and follow-up under one roof is a first, and we at ETCADA are proud of it. It's something we have needed for a long time," Williams observed.

Addiction is first handled on the theory that underlying emotional or psychological problems which might have led to addiction can't be treated until the chemical dependence is arrested.

Following release from the detoxification area, each patient is screened for admission to the intermediate care program. Alternate placements are recommended for those whose needs cannot be met by the program.

Patients participate in two group therapy sessions and one lecture session every weekday. In addition, each patient has an individual counselor whom he sees regularly, and he participates in relaxation therapy as time allows.

Oak Haven's recovery rate now stands at an above-average 47 per cent. The civic clubs of Marshall can be proud of the fact that their investment in humanity, made years ago when they built the Oak Haven facility, continues to pay off.

A Change in Diagnosis

It's not easy finding the right placement for someone whose diagnosis has been changed from "mentally retarded" to "mentally ill." But Larry's future depended on it.

Larry, age 28, had been a resident of Lufkin State School for the mentally retarded for 17 years. Not long ago, the staff there found themselves unable to deal with his increasingly inappropriate behaviors, such as standing outdoors in freezing rain until he developed respiratory problems, limping with no apparent medical cause and having auditory hallucinations.

The decision was made to transfer Larry to the Villa VanZandt residential program of **MHMR of Southeast Texas** in Beaumont. This meant he would once again be near his home and family in Orange.

Larry moved into Villa VanZandt with other mental health clients who previously had been long-term patients in Rusk State Hospital. He was scheduled to attend the day activity program for intensive therapeutic services.

Initially, he walked hunched over and kept his distance from others. When he talked at all, he mumbled and slurred his words. The mental health workers encouraged him to participate in recreational and socialization activities, as well as group and family therapies. They also taught him to take responsibility for his own needs, such as pouring his own coffee. When he was late for group activities, he waited alone for the hour's duration. If he slurred his words during conversation, he was asked to repeat them until the meaning was comprehensible.

After several weeks, the staff observed his behavior to be much more normal. He began to walk erect and socialize with other clients. His limp had disappeared after only one day.

After a period of time, the Villa VanZandt staff recommended a termination of their services and suggested participation in the day activity program. His parents took him into their home.

Several weeks later, the day activity staff made arrangements with the Orange County Association for Retarded Citizens for Larry to work in the sheltered workshop. It soon became apparent that Larry had found a suitable placement.

With each advancement on his job, his behavior indicated an increasing self-regard. He dressed neatly, enunciated clearly, initiated interesting conversations and socialized appropriately with the opposite sex. The remaining traces of his emotional disturbances were alleviated while in the sheltered workshop program.

Today, his mother expresses astonishment at the transition in Larry's behavior from that of an institutionalized person to that of a self-assured young man. After 17 long years of adapting to a residential environment for the mentally retarded, he met the challenge of changing his life-style to fit the environment of his home community.

Benefits Beyond Dollars

A careful look at fees for client services was taken by the board of trustees of the Denison-based **Texoma Regional MHMR Center** in their continuing efforts to develop a strong program of community services. The board recognized that although such income could not be expected to provide a primary source of operational funds, the collection of properly assessed fees nevertheless contributes to the center in at least three ways:

1. The income demonstrates to local funding sources that the board has a responsible attitude toward financial support. While not refusing service due to an inability to pay, the center staff is not involved in a giveaway, either.

2. Clients who pay for their services, even on a sliding scale, tend to place more value on those services. The payment of reasonable fees gives a client a greater sense of investment in his treatment process and actually can indicate therapeutic progress.

3. Clients who are paying their way, even on a subsidized basis, expect quality services and timely results. In that way, the payment of fees can affect the quality assurance and client satisfaction levels of a center.

Based upon these factors, the board and staff began developing an integrated system of assessing and collecting client fees, both private and third party. Business office and clinical staff members worked together to establish the sliding scale and design the collection process. With this involvement by clinicians, much anticipated staff resistance to "taking money from clients" was eliminated.

Another concern was the expected resistance of clients asked to pay for services previously rendered "free" since no effort had been made to collect. Careful training of admissions staff on how to approach clients appropriately has resulted in few, if any, complaints about money. In fact, clients have responded positively to being expected to pay for services.

Results of the new system have been impressive during the first six months. In addition to benefits to clients, average monthly dollar income from fees increased by 98 per cent over the preceding six-month period. To be able to demonstrate such an increase in the "earned income" proportion of the total budget was especially helpful when requesting support from local funding sources.

It is easy to justify not emphasizing client fees early in the development of a center, especially since subsidies are available. But the Texoma experience has convinced the board and staff that collection of fees produces benefits to clients and the center far beyond the actual dollars collected.

Citizen Planners

Planning for the future is always a challenge.

Planning that involves broad-based citizen participation is a challenge indeed.

In 1977, **Trinity Valley MHMR Authority** (TVMHMRA) in Fort Worth accepted the challenge of developing a comprehensive plan to provide mental health, mental retardation, alcoholism and substance abuse services to the citizens of Tarrant County. The TVMHMRA Board of Trustees invited community participation in the planning process and appointed a planning control group to oversee the development of the plan.

The planning control group included representatives of the Association for Retarded Citizens, the Council on Alcoholism and the Mental Health Association, TVMHMRA staff and Tarrant County Commissioners' Court. The board's secretary, Bonnie Siddons, served as chairperson.

More than 100 volunteers participated in the planning process, including consumers, citizen advocates, members of the Tarrant County legislative delegation, professional planners, and representatives from the Fort Worth State School, Wichita Falls State Hospital and local service agencies.

After dividing into five task groups, the volunteers addressed segments of the plan dealing with needs, existing resources, purposes and objectives for the authority, relationships between various service providers and the design of an ideal service continuum. Additional groups later studied priority service areas and funding needs.

In addition to providing a plan to direct TVMHMRA for the next five years, the planning process brought together a group of concerned citizens who now are well-informed about the authority and who have an investment in helping to insure that the goals of the plan are implemented.

Because of the investment and talent of the planning process participants, and the commitment and dedication of the TVMHMRA board, the citizens of Tarrant County are assured of a viable plan designed to meet the needs of the emotionally disturbed, mentally retarded and substance-abusing consumers.

Less Is More

As the drug problem escalated in the Lower Rio Grande Valley, drug treatment agencies often found their efforts were not as effective as they desired. A lack of communication between those agencies was identified as one of the major causes of the difficulty. But once the lines of communication were opened, the cooperative spirit that emerged dramatically changed the agencies' interaction.

Since many drug offenders are placed initially on probation, a good working relationship between the Hidalgo County Adult and Juvenile Probation Departments and the addiction services component of the **Tropical Texas Center for MHMR** in Edinburg seemed an appropriate place to begin to coordinate efforts. The first step in establishing rapport was to explain the Tropical Texas Center's services to the probation departments' staff members.

After a referral to the center has been made by the probation department, an assessment is made of the probationer's problem and a proposed plan of action is suggested. It is understood that the probation department has overall responsibility for the client while he is in the community; the center's responsibility lies in the area of treatment for the drug problem. However, the probation department's cooperation can make a tremendous impact on the client's ultimate success or failure in the treatment program.

The center's addiction services designated a liaison to monitor probationers referred to the drug program and coordinate interagency communication and problem-solving. Since the inception of the liaison worker concept, more options have been opened to the drug abuser than were available in the past.

Because of the success of these initial efforts, the Tropical Texas Center plans to expand its involvement with related service agencies. This innovation is truly a case where less is more: "less" red tape, duplication of efforts and poor communication leading to "more" benefits to clients, rapport and good working relationships among colleagues.

Measuring Up

Several changes at **Wichita Falls Community MHMR Center** during the past year are the results of attempts to meet standards imposed by other agencies.

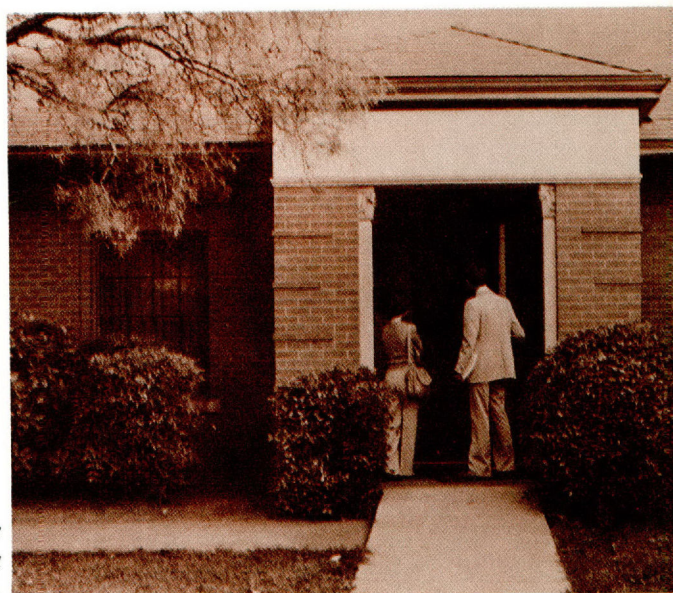
Emergency services, for example, were expanded with employment of two caseworker assistants to provide evening and weekend telephone coverage for on-the-spot answers or referral to a center therapist. Because this service was required under a staffing grant from the National Institute of Mental Health, the center now provides face-to-face interaction to anyone expressing the need for emergency mental health intervention.

Services certified under ICF-MR (Intermediate Care Facilities-Mentally Retarded) were initiated for 23 beds. One group home already in operation, Horizon House, was reprogrammed and staffed to meet the standards. The other, called the Extended Living Facility, was begun under ICF-MR certification during the fall of 1976.

Obtaining client eligibility for funds under Title XIX programs, once a facility and its program were certified, was a challenge. It involved working with two sets of ICF-MR standards, a catalog of interpretations, coordination with three state agencies and one federal agency, a battery of forms in constant revision and ever-shifting protocol for the establishment of client eligibility.

Making the challenge worthwhile is the fact the subsequent state and federal funding offer hope for community residence as an alternative to state school placement for the mentally retarded.

Another new service is the Protective Services Program, which employs a full-time psychologist to assist the child welfare staff of Family Court Services. The program offers a diagnosis and evaluation to abused and neglected children and their families, thereby filling a void which had existed in the community.

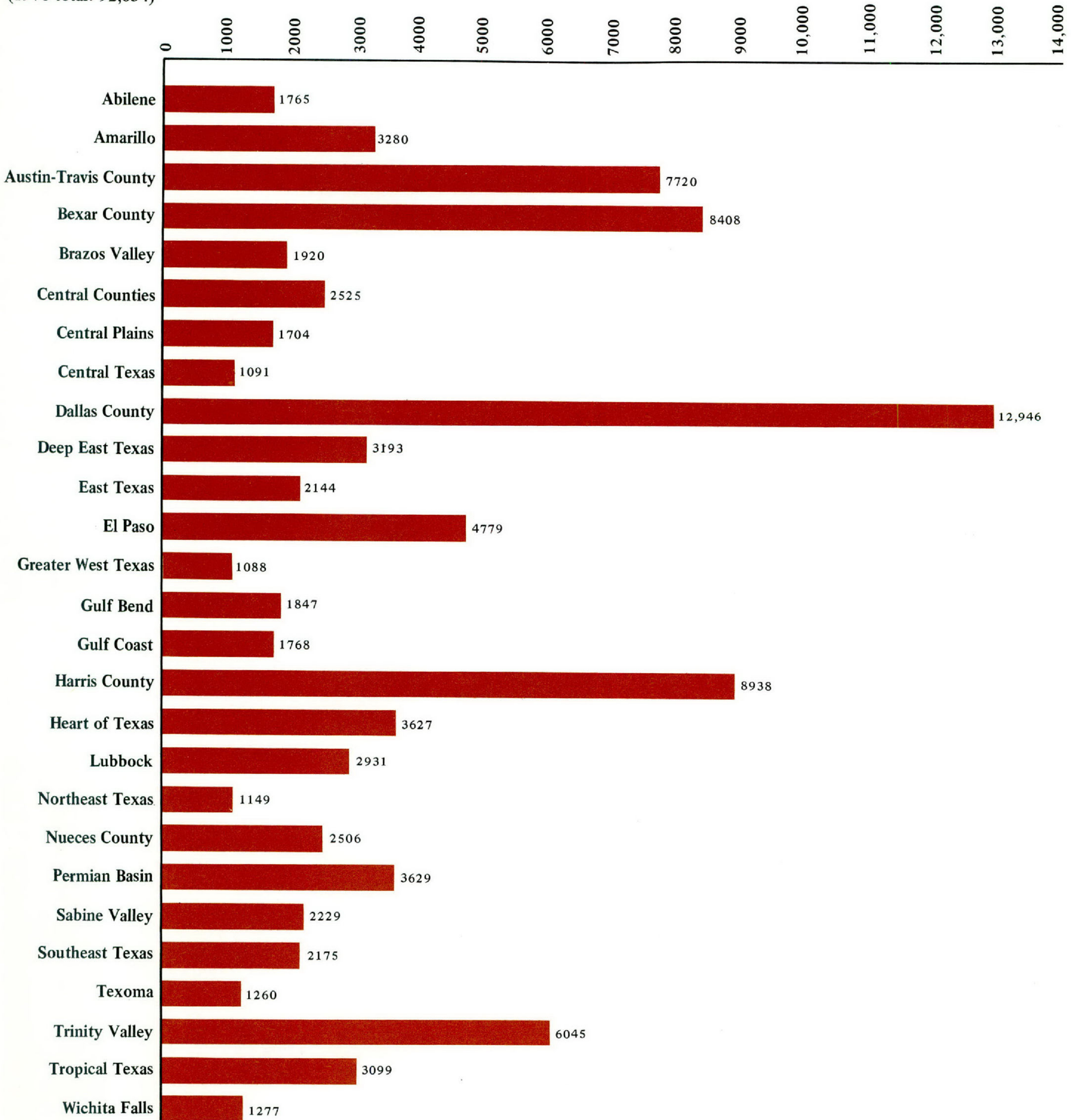


New programs, more personnel and immense paperwork usually precede certification of a community residence for the mentally retarded.

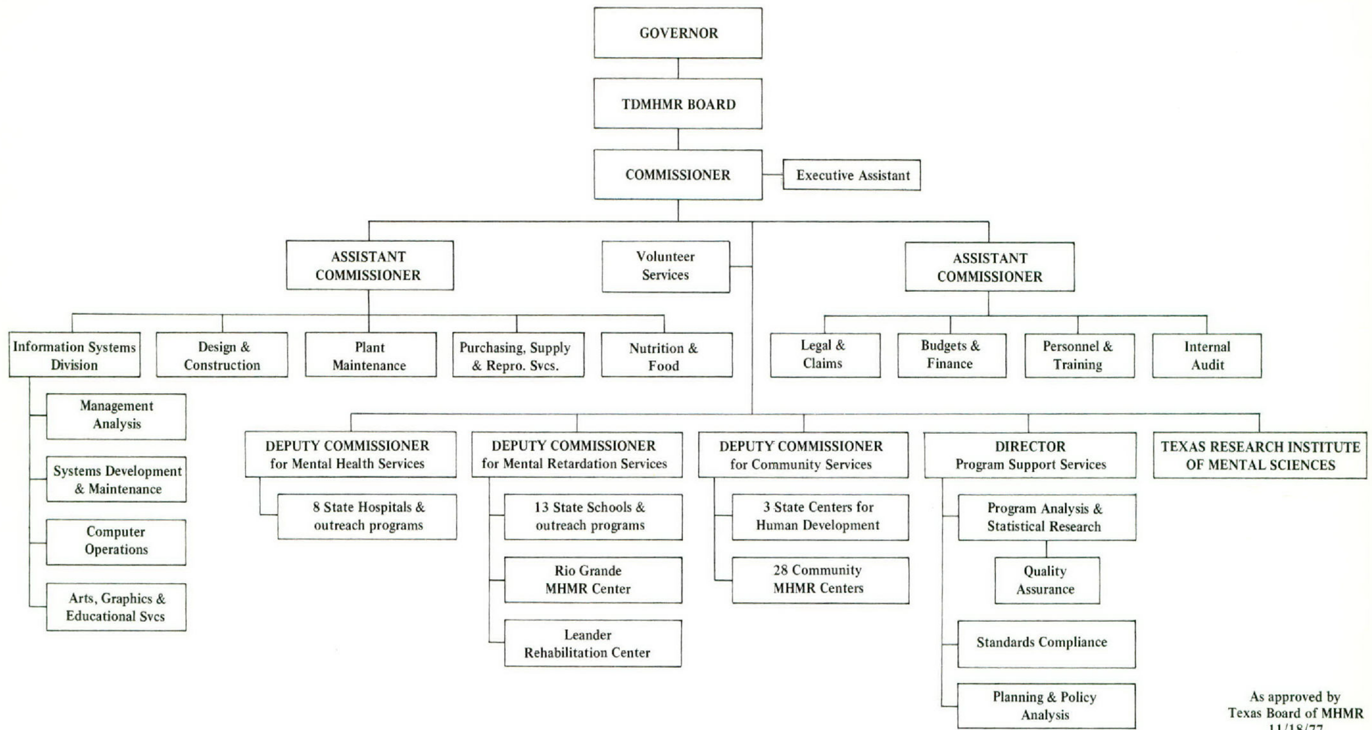
Community Centers

Clients served

1977 total: 95,043
(1976 total: 92,634)



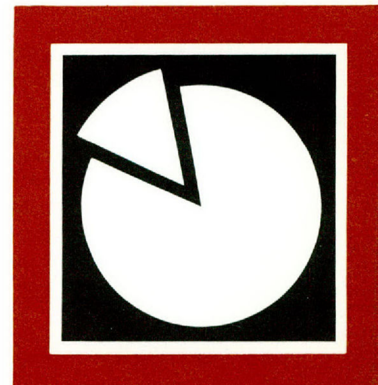
Organizational Chart



Fiscal Facts

Program Operating Costs

Hospitals	$ 94,614,000	30.9%
Schools (includes Rio Grande)	135,345,000	44.2%
Community Services (includes Central Administration)	39,854,000	13.0%
Research and Training	7,318,000	2.4%
Central Administration (excludes Community Services)	7,371,000	2.4%
Human Development Centers and Outreach Services (for all facilities)	21,794,000	7.1%
Total	$306,296,000	100.0%



Sources of Funds

State Appropriations	$291,394,000	95.1%
Federal Funds	8,679,000	2.8%
Special Funds and Grants	1,534,000	0.5%
Contracts for Service	4,689,000	1.6%
Total	$306,296,000	100.0%

Directory

Hospitals

Austin State Hospital
Luis H. Laosa, M.D., Superintendent
512-452-0381
4110 Guadalupe
Austin 78751
Serving: Austin, Bastrop, Bell, Blanco, Bosque, Brazoria, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Fort Bend, Galveston, Grimes, Hamilton, Harris, Hays, Hill, Johnson, Lampasas, Lee, Limestone, McCulloch, McLennan, Milam, Mills, Robertson, San Saba, Travis, Waller, Washington and Williamson Counties

Big Spring State Hospital
Adolph Supak, Acting Superintendent
915-267-8216
P.O. Box 231
Big Spring 79720
(Hwy. 87)
Serving: Andrews, Borden, Brewster, Cochran, Coke, Concho, Crane, Crockett, Crosby, Culberson, Dawson, Ector, El Paso, Fisher, Gaines, Garza, Glasscock, Hockley, Howard, Hudspeth, Irion, Jeff Davis, Jones, Kent, Loving, Lubbock, Lynn, Martin, Midland, Mitchell, Nolan, Pecos, Presidio, Reagan, Reeves, Runnels, Scurry, Sterling, Taylor, Terrell, Terry, Tom Green, Upton, Ward, Winkler and Yoakum Counties

Kerrville State Hospital
Luther W. Ross, M.D., Superintendent
512-896-2211
P.O. Box 1468
Kerrville 78028
(721 Thompson Dr.)
Serving: Bandera, Edwards, Gillespie, Kerr, Kimble, Llano, Mason, Menard, Real, Schleicher and Sutton Counties

Rusk State Hospital
R. M. Inglis, M.D., Acting Superintendent
214-683-3421
P.O. Box 318
Rusk 75785
(Hwy. 69 North)
Serving: Anderson, Angelina, Chambers, Cherokee, Freestone, Gregg, Hardin, Harrison, Henderson, Houston, Jasper, Jefferson, Leon, Liberty, Madison, Marion, Montgomery, Nacogdoches, Newton, Orange, Panola, Polk, Rusk, Sabine, San Augustine, San Jacinto, Shelby, Smith, Trinity, Tyler and Walker Counties

San Antonio State Hospital
R. M. Inglis, M.D., Superintendent
512-532-8811
P.O. Box 23310, Highland Hills Sta.
San Antonio 78223
(5900 S. Presa)
Serving: Aransas, Atascosa, Bee, Bexar, Calhoun, Colorado, Comal, DeWitt, Dimmit, Frio, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kinney, LaSalle, Lavaca, Live Oak, McMullen, Matagorda, Maverick, Medina, Nueces, Refugio, San Patricio, Uvalde, Val Verde, Victoria, Wharton, Wilson and Zavala Counties

Terrell State Hospital
Luis M. Cowley, M.D., Superintendent
214-563-6452
P.O. Box 70
Terrell 75160
(Brin St.)
Serving: Bowie, Camp, Cass, Dallas, Delta, Ellis, Fannin, Franklin, Hopkins, Hunt, Kaufman, Lamar, Morris, Navarro, Rains, Red River, Rockwall, Titus, Upshur, Van Zandt and Wood Counties

Vernon Center
Frankie E. Williams, M.D., Superintendent
817-552-9901
P.O. Box 2231
Vernon 76384
(Between Hwys. 70 and 287)
Serving: Armstrong, Bailey, Baylor, Briscoe, Carson, Castro, Childress, Collingsworth, Cottle, Dallam, Deaf Smith, Dickens, Donley, Floyd, Foard, Gray, Hale, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hutchinson, King, Knox, Lamb, Lipscomb, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Stonewall, Swisher, Throckmorton, Wheeler, Wilbarger and Young Counties

Wichita Falls State Hospital
Mark Huff, M.D., Superintendent
817-692-1220
P.O. Box 300
Wichita Falls 76307
(Lake Rd.)
Serving: Archer, Brown, Callahan, Clay, Coleman, Collin, Comanche, Cooke, Denton, Eastland, Erath, Grayson, Hood, Jack, Montague, Palo Pinto, Parker, Shackelford, Somervell, Stephens, Tarrant, Wichita and Wise Counties

Schools

Abilene State School
Leonard W. Cain, Superintendent
915-692-4053
P.O. Box 451
Abilene 79604
(27th and Maple Sts.)
Serving: Borden, Brewster, Brown, Callahan, Coke, Coleman, Comanche, Concho, Crane, Crockett, Culberson, Eastland, Ector, El Paso, Erath, Fisher, Glasscock, Haskell, Hood, Howard, Hudspeth, Irion, Jeff Davis, Jones, Loving, Midland, Mitchell, Nolan, Pecos, Presidio, Reagan, Reeves, Runnels, Schleicher, Scurry, Shackelford, Somervell, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Val Verde, Ward and Winkler Counties

Austin State School
B. R. Walker, Ph.D., Superintendent
512-454-4731
P.O. Box 1269
Austin 78767
(2203 W. 35th St.)
Serving: Bandera, Bexar, Blanco, Comal, Edwards, Gillespie, Guadalupe, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, McCulloch, Medina, Menard, Real, San Saba, Travis, Uvalde and Wilson Counties

Brenham State School
Jimmy R. Haskins, Ed.D., Superintendent
713-836-4511
P.O. Box 161
Brenham 77833
(Hwy. 36 South)
Serving: Austin, Brazos, Burleson, Chambers, Grimes, Hardin, Jefferson, Liberty, Madison, Milam, Montgomery, Orange, San Jacinto, Walker, Waller and Washington Counties

Corpus Christi State School
Gary V. Sluyter, Ph.D., Superintendent
512-888-5301
P.O. Box 9297
Corpus Christi 78408
(902 Airport Rd.)
Serving: Aransas, Atascosa, Bee, Brooks, Calhoun, Cameron, DeWitt, Dimmit, Duval, Frio, Goliad, Hidalgo, Jackson, Jim Hogg, Jim Wells, Karnes, Kenedy, Kleberg, LaSalle, Live Oak, McMullen, Maverick, Nueces, Refugio, San Patricio, Starr, Victoria, Webb, Willacy, Zapata and Zavala Counties

Denton State School
Richard L. Smith, Superintendent
817-387-3831
P.O. Box 368
Denton 76201
(I-35 East and Denton State School Rd.)
Serving: Archer, Bowie, Cass, Clay, Collin, Cooke, Delta, Denton, Fannin, Franklin, Grayson, Hopkins, Hunt, Jack, Kaufman, Lamar, Montague, Morris, Palo Pinto, Parker, Rains, Red River, Rockwall, Titus, Van Zandt, Wichita, Wise and Young Counties
Branch:
Genetics Screening and Counseling Service
Edwin W. Killian, Director
817-383-3561
404 W. Oak St.
Denton 76201
Serving: All Texas residents through regional clinics

Fort Worth State School
Vearl McDaniel, Ph.D., Superintendent
817-534-4831
5000 Campus Dr.
Fort Worth 76119
Serving: Dallas and Tarrant Counties

Lubbock State School
John W. Gladden, Ph.D., Superintendent
806-763-7041
P.O. Box 5396
Lubbock 79417
(N. University and Loop 289)
Serving: Andrews, Armstrong, Bailey, Baylor, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Foard, Gaines, Garza, Gray, Hale, Hall, Hansford, Hardeman, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Knox, Lamb, Lipscomb, Lubbock, Lynn, Martin, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, Wilbarger and Yoakum Counties

Directory

Lufkin State School
William W. Beaver, Superintendent
713-634-3353
P.O. Drawer 1648
Lufkin 75901
(Hwy. 69)
Serving: Anderson, Angelina, Camp, Cherokee, Gregg, Harrison, Henderson, Houston, Jasper, Marion, Nacogdoches, Newton, Panola, Polk, Rusk, Sabine, San Augustine, Shelby, Smith, Trinity, Tyler, Upshur and Wood Counties

Mexia State School
William H. Lowry, Ph.D., Superintendent
817-562-2821
P.O. Box 1132
Mexia 76667
(Hwy. 171)
Serving: Bosque, Coryell, Ellis, Falls, Freestone, Hamilton, Hill, Johnson, Leon, Limestone, McLennan, Mills, Navarro and Robertson Counties

Richmond State School
James A. Law, Superintendent
713-342-4681
2100 Preston
Richmond 77469
Serving: Brazoria, Fort Bend, Galveston, Harris, Matagorda and Wharton Counties

San Angelo Center
R. A. Williams, Superintendent
915-465-4391
Carlsbad 76934
(Hwy. 87)
Serving: Texas

Travis State School
Victor Hinojosa, M.D., Superintendent
512-926-2410
P.O. Box 430
Austin 78767
(Webberville Rd.)
Serving: Bastrop, Bell, Burnet, Caldwell, Colorado, Fayette, Gonzales, Lampasas, Lavaca, Lee, Travis and Williamson Counties

Special Units

Amarillo State Center for Human Development
Harry Heyman, Director
806-355-9791
P.O. Box 3070
Amarillo 79106
(901 Wallace Blvd.)
Serving: Armstrong, Briscoe, Carson, Castro, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher and Wheeler Counties

Beaumont State Center for Human Development
Burtis Hollis, Director
713-833-1485
P.O. Box 3846
Beaumont 77704
(655 S. 8th St.)
Serving: Chambers, Jefferson, Liberty and Orange Counties

Central Office
Kenneth D. Gaver, M.D., Commissioner
512-454-3761
P.O. Box 12668, Capitol Sta.
Austin 78711
(909 W. 45th St.)
Serving: All TDMHMR facilities

El Paso State Center for Human Development
Aurelio G. Valdez, Director
915-779-0800
6700 Delta Dr.
El Paso 79905
Serving: Brewster, Culberson, El Paso, Hudspeth, Jeff Davis and Presidio Counties

Leander Rehabilitation Center
Calvin Evans, Director
512-258-1234
Rt. 3, Box 75
Leander 78641
(14121 Hwy. 183 North)
Serving: Primarily TDMHMR facilities; if space available, other non-profit MHMR groups

Rio Grande State Center for MHMR
Blas Cantu, Superintendent
512-423-5077
P.O. Box 2668
Harlingen 78550
(2115 N. 28th St.)
Serving: Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Starr, Webb, Willacy and Zapata Counties

Texas Research Institute of Mental Sciences
Joseph C. Schoolar, Ph.D., M.D., Director
713-797-1976
1300 Moursund St.
Houston 77030
Serving: Harris County

Community MHMR Centers

Abilene Regional MHMR Center
Russ Evans, Administrative Director
915-698-3016
P.O. Box 3253
Abilene 79604
(733 S. Leggett)
Serving: Callahan, Jones and Taylor Counties

Amarillo MHMR Regional Center
Clark E. Wooldridge, Administrator
806-353-7235
P.O. Box 3250
Amarillo 79106
(7201 Evans St.)
Serving: Armstrong, Carson, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Potter, Randall, Roberts, Sherman and Wheeler Counties

Austin-Travis County MHMR Center
Larry Miller, Ph.D., Administrative Director
512-447-4141
1430 Collier
Austin 78704
Serving: Travis County

Bexar County MHMR Center
Aaron Liberman, Ph.D., Executive Director
512-225-4011
611 N. Flores
San Antonio 78205
Serving: Bexar County

Brazos Valley MHMR Center
Linda S. Davis, Ph.D., Executive Director
713-779-2000
202 E. 27th St.
Bryan 77801
Serving: Brazos, Burleson, Grimes, Leon, Madison, Robertson and Washington Counties

Central Counties Center for MHMR Services
Steven B. Schnee, Ph.D., Executive Director
817-778-4841
P.O. Box 1025
Temple 76501
(302 S. 22nd St.)
Serving: Bell, Coryell, Hamilton, Lampasas and Milam Counties

Central Plains Comprehensive Community MHMR Center
John C. Thomas, Executive Director
806-296-2726
2700 Yonkers
Plainview 79072
Serving: Bailey, Briscoe, Castro, Floyd, Hale, Lamb, Motley, Parmer and Swisher Counties

Central Texas MHMR Center
Roy A. Cronenberg, Executive Director
915-646-9574
P.O. Box 250
Brownwood 76801
(308 Lakeway)
Serving: Brown, Coleman, Comanche, Eastland, McCulloch, Mills and San Saba Counties

Dallas County MHMR Center
Bob L. Carpenter, Ph.D., Executive Director
214-630-6100
1200 Stemmons Tower N.
2710 Stemmons Frwy.
Dallas 75207
Serving: Dallas County

Deep East Texas Regional MHMR Services
Wayne Lawrence, Ph.D., Executive Director
713-639-1141
4101 S. Medford Dr.
Lufkin 75901
Serving: Angelina, Hardin, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity and Tyler Counties

MHMR Regional Center of East Texas
Ray Thomson, Acting Executive Director
214-597-1351
10th Floor, Bryant Bldg.
305 S. Broadway
Tyler 75702
Serving: Henderson, Rains, Smith, Van Zandt and Wood Counties

El Paso Center for MHMR Services
Miss Della Haddad, Executive Director
915-532-6203
P.O. Box 9997
El Paso 79990
(149 N. Raynolds)
Serving: El Paso County

MHMR Center for Greater West Texas
James M. Young, Executive Director
915-655-5674
244 N. Magdalen
San Angelo 76901
Serving: Tom Green County; contracts with Coke, Concho, Crockett, Irion, Reagan and Sterling Counties

Gulf Bend MHMR Center
Tom G. Kelliher, Jr., Executive Director
512-578-5262
P.O. Box 2238
Victoria 77901
(2105 Pt. Lavaca Dr.)
Serving: Calhoun, DeWitt, Goliad, Jackson, Lavaca, Refugio and Victoria Counties

Gulf Coast Regional MHMR Center
John Billings, Executive Director
713-763-2373
P.O. Box 2490
Galveston 77553
(507 Tremont)
Serving: Brazoria and Galveston Counties

MHMR Authority of Harris County
Eugene Williams, Executive Director
713-526-2871
P.O. Box 25381
Houston 77005
(2501 Dunstan)
Serving: Harris County

Heart of Texas Region MHMR Center
Dean Maberry, Executive Director
817-752-3451
P.O. Box 1277
Waco 76703
(1401 N. 18th St.)
Serving: Bosque, Hill, Limestone and McLennan Counties

Lubbock Regional MHMR Center
Ron Whittington, Ph.D., Executive Director
806-763-4213
1210 Texas Ave.
Lubbock 79401
Serving: Cochran, Crosby, Dickens, Garza, Hockley, King, Lubbock, Lynn, Terry and Yoakum Counties

Northeast Texas MHMR Center
J. J. Gonzales, Executive Director
214-793-6776
615 Olive St., Suite 4
Texarkana 75501
Serving: Bowie and Red River Counties

Nueces County MHMR Community Center
William S. Lambkin, Executive Director
512-888-5321
1630 S. Brownlee
Corpus Christi 78404
Serving: Nueces County

Pecan Valley MHMR Region
(open 9-1-77)
Theresa B. Mulloy, Ed.D., Executive Director
817-968-4181
P.O. Box 973
Stephenville 76401
(906 Lingleville Hwy.)
Serving: Erath, Hood, Palo Pinto, Parker and Somervell Counties

Permian Basin Community Centers for MHMR
Robert Dickson, Executive Director
915-563-0271
3701 N. Big Spring
Midland 79701
Serving: Ector and Midland Counties

Sabine Valley Regional MHMR Center
Frances H. Willis, Executive Director
214-758-8243
P.O. Box 1128
Longview 75601
(321 Gum St.)
Serving: Gregg, Harrison, Marion, Panola, Rusk and Upshur Counties

MHMR of Southeast Texas
Roger Pricer, Ph.D., Executive Director
713-838-0541
590 Center
Beaumont 77701
Serving: Chambers, Jefferson and Orange Counties

Texoma Regional MHMR Center
James E. Snowden, Executive Director
214-786-2902
203-A Grayson Dr.
Denison 75020
Serving: Cooke, Fannin and Grayson Counties

Trinity Valley MHMR Authority
Tommie Duncan, Executive Director
817-335-5371
P.O. Box 2603
Fort Worth 76101
(1319 Summit Ave.)
Serving: Tarrant County

Tropical Texas Center for MHMR
Marion Shirah, Executive Director
512-383-0121
P.O. Drawer 1108
Edinburg 78539
(1425 S. 9th)
Serving: Cameron, Hidalgo and Willacy Counties

Wichita Falls Community MHMR Center
James R. Zug, Executive Director
817-322-1196
1800 Rose St.
Wichita Falls 76301
Serving: Wichita County

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Benchmarks

bench·mark *n* a standard or point of reference in measuring quality ; *syn* see **CHALLENGES 1977**

What challenges did the Texas Department of Mental Health and Mental Retardation people confront in 1977?

This report contains a myriad of satisfying and frustrating experiences by those of us who attempt to meet the many needs, the many demands. They reveal a lot about the clients and the employees as individuals, and about the climate of hope created for those who are victims of mental disabilities.

The cover graphics offer clues to the challenges that are part of the department's charge to conserve and restore the mental health of the state's citizens and to develop the capacities of those who are mentally retarded.

It is almost a "how-to" collection of solutions for others to adapt to their own challenges. They include ways to seek answers through research, counsel troubled families, teach social and work skills, plan coordinated community services, reduce the handicapped person's physical discomfort, provide aftercare, nurture the elderly, train disabled children, assure quality service, comply with multiple regulations, extend help in new ways to greater areas and operate efficient programs. The stories illustrate how better cooperation among department facilities and community MHMR services led to better client care.

Allies joined us in meeting these challenges. Volunteers continued to prove beyond doubt that their partnership in client care measurably enriches our programs. Almost 10,000 individuals each month contributed time during the year that would have cost the State $1,849,400 had they been paid the minimum wage of $2.30. Other cash, clothing, food and gifts, including those from organizations, brought the total of contributions by volunteers to more than $4.5 million.

Government was also our ally. Greater demands for less restrictive treatment alternatives, more concern for the individual and assurance of clients' rights were accompanied by funding increases of almost 20 per cent by the Texas Legislature. By seeking voluntary program certification and by complying with increasing federal regulations, we closed the year with renovated facilities, better documentation of treatment and improved services.

The challenge of well-trained staff members was met by development of a competency-based curriculum for paraprofessional personnel. With subjects ranging from work area management to basic emergency care, the training is designed to produce skills that have been identified as necessary for certain jobs. The department's continuing education program for professional staff members enabled them to earn 430 per cent more continuing education credits than the previous year.

There has been greater concern for both ends of the client care spectrum---emphasis on prevention of mental disorders and a more tolerable life for those long institutionalized. Expansion of community programs prevented admissions to institutions and permitted discharge of long-time residents. The Genetics Screening and Counseling Service based in Denton increased its number of regional clinics from five to 10, reaching 671 persons.

Internal controls for accountability were strengthened. Additions to department rules were made regarding client workers; criteria for placement of residents in community intermediate care facilities; admissions, transfers, furloughs and discharges for state schools; adoption of the Texas State Plan for Comprehensive Mental Health Services; and criteria for awarding grants-in-aid to community MHMR centers. Also, the legislature funded positions (effective Sept. 1, 1977) in each state hospital and state school for Quality Assurance and Program Evaluation (to establish criteria for assessing quality of care) and Standards Compliance (to monitor and advise facilities on how to meet standards of care).

The challenges of 1977 were varied, complex and poignant. And yet, in the sense of people helping people, they simply were day-to-day tasks that thousands of dedicated, conscientious employees performed to serve the mentally impaired.

Also, the challenges of 1977 serve as the springboard for what lies ahead in 1978. Those challenges of one year will guide each of us in striving toward even better performances in the years ahead.

Challenges 1977 are the benchmarks toward better quality of care to those who deserve our best.

Kenneth D. Gaver, M.D.,
Commissioner, Texas Department of
Mental Health and Mental Retardation

IMPACT

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