IMPACT

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Workshops: They're Big Business

Hand it to them: MHMR workshop clients are making money for Texas industries, large and small. They offer helping hands to corporations involved in communication, construction and computers. (Top left) worker cleans telephones; (lower left) highway bridge star lugs are produced; and (lower right) digital watches are assembled. Small businesses profit from the available, trained work force, too. (Upper right) belly button fuzz is packaged. (Story begins on page 2.)

During the last year, did you talk on the telephone...wear a belt...go fishing in a boat...buy a bottled drink...drive on a highway...purchase plants and shrubs...stay in a motel...eat candy...write with a pen...type a letter...use a calculator...give a toy...ride a skateboard...stop at a fast food spot?

If you did any of these things, you may have consumed goods and services involving MHMR clients. And this is but a partial list of the varied types of contracts procured to train clients in work activity and sheltered workshops sponsored by TDMHMR facilities and community MHMR centers throughout Texas.

The endeavor is big business. It employs 6,843 clients and 856 supervisors and produces an annual income of $2,117,295. The payroll amounts to $1,301,898, and most of this is from a new money source created within the decade.

This information was revealed in a recent survey of TDMHMR and community MHMR center work programs.

Where and how is all of this accomplished? Some of it evolved after concerned hospital or school staff members, impatient about the waste of human resources, sought out small projects that could benefit the clients. They painstakingly and patiently trained severely handicapped or immobile clients to sort, count, package, or whatever was needed, to do a task. The clients' motivation became the money they earned, often their first and only personal fund.

The opposite of these simple ward activities may be an elaborate, separate community workshop. Multiple production lines operate simultaneously. Massive amounts of parts and material are delivered for assembly. Power tools buzz; jigs guide; boilers bubble; spray guns spew; assembly belts roll; and scales teeter toward balance.

Between these extremes are numerous, uncomplicated projects. Clients work in donated quarters and utilize makeshift equipment. But they are escaping from lonely inactivity and the imprisonment created by their mental illness or mental retardation. These work programs make it possible for them to be trained and to learn and earn money in noncompetitive settings.

The services provided and products created appear unlimited. Eager procurement personnel constantly seek new business. They woo. They plead. They inform. They innovate. They recruit professional skills from volunteers. And they are sincere in realistically selling the clients' capabilities and versatility to perform tasks. At the same time, employers recognize this trained work force helps them comply with affirmative action requirements.

The manual dexterity of clients is utilized by numerous telephone companies for sorting, assembling, identifying and packaging as many as 1,000 telephone parts. Workshops in Abilene, Longview, San Angelo and Waco reported on their telephone contracts, including disassembly and salvage of telephone components. San Angelo's SAC Industries packages heavy gravel for use as insulation for underground telephone wires.

Intricate stitchery for a leather belt maker challenges clients in several workshops. More than a half million gun racks have been assembled for a West Texas businessman who relies solely upon SAC Industries for this work. Hundreds of hours of hospital, school, state center and community MHMR center clients annually are devoted to satisfying fishing fans. Line, lures, sinkers and bait are packaged and shipped to sporting goods outlets. One boat maker contracts with the Austin State School Vocational Rehabilitation Center for boat seat assemblies.

Instead of the waste of discarding damaged bottled drink cases, many clients clean, repair and paint the cases for reuse. The Bexar County MHMR Center Opportunity Workshop has a contract with a San Antonio brewery to repair all reusable beer cases.

Survey stakes by the thousand, heavy duty street brooms, engine repair and commercial car washing are direct and indirect ways clients contribute to the highway construction and transportation industry. Lufkin State School has a foundry contract involving star lugs used in bridge construction.

Clients appear to have an affinity for the miracle of growth---from seeds to blossoms. From the Red River to the Rio Grande they nurture plants, shrubs, vegetables and trees. Customers purchase acres of these nursery items, plus containers, wrappers, signs and fertilizer dispensers produced at workshops of all sizes.

Classroom demonstrations of techniques and equipment, followed by on-the-job training, lead many clients to community employment and living as maids, food service employees, janitors and groundskeepers.

An imaginative Mexia State School employee salvaged unused candy-making equipment and a new industry for the mentally retarded clients resulted. The Cen-Texas Community Program ships hundreds of pounds of peppermint and peanut candies to Texas dealers, and all of it is produced by the school's trained residents. A Fort Worth candy maker contracts with the Benbrook Work Activity Center for workers to package candy.

Nimble fingers and watchful eyes take over when machines won't do the task. Trained clients assemble parts for electric typewriters, computers and ballpoint pens or align and attach material into proper positions. Puppets, games, wooden toys, dolls, novelties and skateboards represent some of the fun items clients prepare for marketing. Fast food companies provide ongoing contracts for picnic packs (plastic cutlery, seasonings and napkin). Such contracts are appropriate for many of the workers' levels of skill.

Publishers and printers, among other businesses and organizations, rely upon workshops to collate, staple, bind, address, sort and package for mail publications and monthly statements.

Travis State School residents create a variety of wooden indoor and outdoor furniture that is popular throughout Central Texas. Austin's Darrell Royal Workshop builds rabbit hutches and pet carriers. Shipping crates are among the items produced at the Wichita Falls' Opportunity Workshop of the Industrial Development Center, Inc.

The Beaumont State Center for Human Development clients are among those meeting industries' need for great quantities of cleaning rags. Tons of discarded fabric are cleaned and cut into proper sizes for wiping machinery.

These work assignments describe only a portion of the contracts and the clients' skills. They range from the most elementary hand tasks to complex work with power tools and equipment.

All of this activity is not without frustration and problems. Marion Truitt, Abilene, president of the State Contract Procurement Association and director of Abilene State School's work programs, outlined concerns common to a majority of the directors. They include the need for:

1. Continuing contracts to eliminate "down time" and inconsistent training programs.

2. Educating business and industry owners, policy makers, legislators, administrators and the public about the availability of workshops and the capabilities of client workers.

3. Coordinating client activities to avoid conflicts with work assignments and to insure work forces sufficient to complete contracts on schedule.

4. Permitting workshop production of state-purchased commodities.

5. Funding systems flexible enough to

allow workshops to obtain equipment and supplies quickly to compete for and complete contracts.

6. Recruiting business-oriented managers, trained on the job in the rehabilitation method and philosophy, rather than teaching business management to rehabilitation personnel.

7. Coordinating workshop standards, compliance and consistency of operation by a single agency.

It all adds up to caring about the clients and how they can be propelled along the course toward greater independence and personal development. In the process of fulfilling an assignment, large or small, clients receive formal and informal training in safety, personal and social adjustment, money management and employment practices. Production is only a portion of their training.

TDMHMR clients are not exploited. A department rule covering client workers is explicit in regard to such matters as compensation of client workers, work placement and assignment, the number of work hours and methods of payment. These rules protect the client and clarify the responsibility of the facility and employees.

By working together, workshop directors are developing, expanding and marketing their production more successfully. They are seeking and using volunteer technical assistance from groups such as the Senior Corps of Retired Executives (SCORE) and the American Association of Industrial Engineers. They are united in their insistence upon quality performance. And they explore the potential organizational structures that might permit maximum opportunity for operation within the complicated laws governing workshop activity.

The numbers of people and dollars involved in the TDMHMR and community MHMR center workshops represent only a portion of those in Texas. Goodwill, public school, blind and independent workshops make a great contribution to people and the economy.

Truitt said, "The total amount would be staggering. Workshops are a valuable service to the client and a big business."

Texas MHMR clients are earning and learning more and more about this action. ■ *H.C.*

LEFT: The required quality workmanship prompts a Lufkin State School trainee to correct a mistake made on a pallet, a product for Lufkin Industries. TOP RIGHT: Austin's Darrell Royal Workshop client Robert Ockletree wields a power stapler to produce a popular sale item, a pet cage. BOTTOM RIGHT: Hiram Bearden, a graduate of the work training program, stepped out of Abilene State School as a resident and into a private hospital as an employee.

Behavior Therapy Saves Lives

By Jeffrey C. Enzinna

RICHMOND---The use of behavior therapy at Richmond State School actually has saved the lives of three profoundly retarded clients residing in the Colorado Unit. These clients displayed behavioral problems which were life-threatening.

Jim, 18, displayed a behavior known as rumination. He had been regurgitating and subsequently reingesting his vomitus for approximately a year. The weight of this 5-foot-6 client dropped from 115 to 87 pounds.

After a variety of medical procedures and physiological tests indicated the problem was not organic, the client was referred to the unit psychologist. At this time he was close to death from dehydration and starvation.

Observation indicated that the client ruminated continuously. It was speculated that the motivation for ruminating could have been a combination of pleasure in merely performing the behavior and the pleasure of reconsumption, as he created countless occasions to eat.

It was decided that the consequence of ruminating must be changed from one of enjoyment to one of displeasure, and that other means of obtaining pleasure must be made available. Based on these assumptions, a behavior treatment program was developed to decrease rumination.

During treatment, when the client gagged in an attempt to vomit, he was reprimanded verbally. When he vomited, a correction procedure was used which required the client to clean up the vomit with a rag or a mop, hence eliminating the possibility of reconsumption which potentially was rewarding this behavior.

If he reingested the vomitus, the client was required to brush his teeth, a chore which he apparently did not enjoy. This was used to cleanse the mouth and to provide an unpleasant oral consequence for his oral response.

Alternative behaviors to rumination were rewarded in a process called "differential reinforcement of other behaviors," in which the client is rewarded after a period of time during which his undesirable behavior does not occur. Jim, for instance, was praised and given snacks following specified intervals during which he made no attempt to vomit. These intervals were increased gradually from one minute to two hours. If he attempted to vomit, the interval was reset, thus producing a longer waiting period before the next reinforcer was available.

Through the use of this behavior treatment program, rumination was eliminated essentially in three days. The client displayed this behavior on rare occasions for the next four months after which time it disappeared totally. His weight increased six pounds the first month and he continued to gain. Now, more than 18 months later, rumination remains absent. Jim now weighs 128 pounds.

Norma, age 20, had vomited excessively for more than two years and less frequently for more than six years. The weight of this 4-foot-9 client dropped from 77 to 51 pounds in the past year. No organic cause could be found, and she was near death when referred to the unit psychologist.

Observation over two days indicated she vomited at an incredible average rate of 10 times an hour. This behavior was viewed as a form of self-stimulation pleasurable in itself, since the client did not reingest the vomitus or attempt to play with it.

Interestingly, when a staff member was standing close to the client, she rarely attempted to vomit. She also gained considerable attention when she was cleaned after vomiting.

Her behavior treatment program, similar to Jim's, involved differential reinforcement of other behaviors. Because attention also seemed to be a factor in Norma's behavior, the therapist initially was positioned nearby and gradually moved farther away following the successful delivery of a specified number of successive reinforcers.

Through the use of this behavior treatment program, the rate of vomiting decreased by 98 per cent in one day. She gained eight pounds during the first week of treatment. After three months of treatment, the client made no more attempts to vomit and had attained a weight of 69 pounds. She continued to gain weight until it stabilized at 74 pounds, which she has maintained up to the present time, many months after initiation of treatment.

Don, 19, displayed a behavior known as pica. He constantly ingested dangerously massive amounts of non-edible materials, primarily clothing and hair.

Referral to the unit psychologist was made after the client nearly died from intestinal obstruction. Records indicate that he had displayed this behavior for more than nine years and had been hospitalized previously as a result of this problem. Observation indicated that he ingested objects at an astonishing average rate of three times a minute.

The behavior treatment program used again involved differential reinforcement with edibles and praise following gradually extending intervals during which pica was absent. If the client attempted to ingest foreign materials, he was warned verbally. If he proceeded to ingest the materials, he was reprimanded verbally and required to brush his teeth.

This behavior treatment program resulted in a 99 per cent reduction of this behavior in one day, and the rate continued to drop. Don, who previously had not responded to verbal commands, quickly began to react to the verbal warning procedure. He also began responding to his name and to a variety of simple verbal commands. Also, eye contact and social interaction increased greatly, both of which previously were essentially absent.

Elimination of the behavior problems described above also made possible the enrollment of these clients in several greatly needed skill training programs. Such programs had been recommended by the unit's interdisciplinary staffing team, but due to the severity of these behaviors as well as long-term admissions to the school's infirmary for problems resulting from these behaviors, the clients were excluded from many programs.

These cases provide evidence that significant, even life-saving changes can be accomplished through the use of behavior therapy with the profoundly retarded. Programs such as these are indicative of the ever-evolving role of the unit psychologist in Texas state schools in providing treatment to clients for maladaptive behavior problems and training in new skills, as well as training of staff members to provide these services.

But the process of behavior treatment is not easy. It requires first a cooperative physician, such as Blas Picardi, M.D., who recognizes that some problems can be

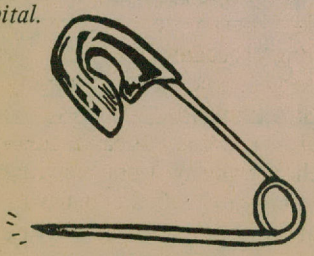
resolved by a behaviorist rather than a physician. This discrimination is important since many behavioral problems are first referred to the physician because their effect creates physical problems.

Before beginning treatment programs, staff members made extensive observations and collected data which were analyzed carefully in an attempt to discover the client's motivation for maintaining the maladaptive behaviors. Treatment programs were tailored to the needs, level of functioning and strength of the problem behaviors of each individual client. The proposed procedures were discussed with the client's parents. Consent was obtained regarding the use of any specific aversive elements, which were used only as a last resort in these life-threatening situations. (Aversive elements are those which the client finds unpleasant. If such elements are introduced following an undesirable behavior, a client learns to avoid them by not performing the behavior.)

The programs were then reviewed and approved by behavior therapy and modification committees. The staff to be involved in the program were provided with extensive training. During implementation, the programs were monitored constantly to ensure competent and consistent delivery, to assess continually the results and to ensure that no undesirable alternative behaviors were simultaneously strengthened. The process of behavior treatment requires the sincere and untiring efforts of a team of dedicated, competent and highly trained paraprofessionals (therapist technicians and MHMR aides), the total commitment of the unit director and supervisors, and last and perhaps most important, it requires patience and time.

Jeffrey C. Enzinna is a psychologist at Richmond State School.

Mentally retarded clients of state schools are not the only beneficiaries of behavior therapy programs. The article below, written by Sigrid Glenn, a former psychology intern at Terrell State Hospital, describes a program she designed to help a patient at the hospital.



TERRELL---Peggy had a history of swallowing pins, straight pins or safety pins, open or closed, sometimes swallowing as many as five pins within three days.

Physicians expressed extreme concern about life-threatening damage to Peggy's bone marrow as a result of repeated X rays. The staff became vigilant, able to spot a pin from 50 paces, trying to keep the ward environment devoid of pins. But Peggy must have had an unknown source, because she continued to produce pins, apparently out of thin air. Several staff members discussed with Peggy the serious nature and consequences of swallowing pins and tried to learn what frustrations or problems were leading to this dangerous act---all to no avail.

The unit director decided this was a job for behavior modification and requested consultation from the psychology department. A doctoral intern in psychology from North Texas State University devised a program that the staff responded to with complete cooperation, carrying the program through to the letter. Peggy never swallowed a pin from the day the program began.

The program established rewarded behavior incompatible with swallowing pins: collecting pins. Peggy's pin collection was kept in the nurse's station in a small locked box. Every time she found a pin she could add it to her collection by taking the pin to the nearest staff member. The staff immediately congratulated Peggy on adding to her collection, gave her five cigarettes and reminded her when she collected 10 pins the psychologist would take her to lunch. Peggy collected 30 pins within five weeks and enjoyed three lunches in town.

As it became increasingly difficult for her to obtain pins, she appeared to lose interest in the collection. The psychologist continued to visit Peggy each week and found that Peggy wanted to work. The ward physician approved an industrial therapy assignment for Peggy since it was now safe. Peggy has worked successfully in the dining room for several months and has presented no problems for ward staff.

Volunteers Honored

Jack Y. Smith of Big Spring and Lena Stephens of Lubbock have been selected by Kenneth D. Gaver, M.D., TDMHMR commissioner, to receive the 1977 Commissioner's Awards for Volunteer Service.

Smith helped organize the first volunteer services council for Big Spring State Hospital in 1957 and served as its first chairman. He also served as chairman of the Volunteer Services State Council in 1963-64, and as treasurer of the hospital's All-Faith Chapel fund committee in 1969, raising more than $182,000 toward this project.

Gov. John Connally honored Smith in 1966 for his "immeasurable contributions on behalf of the mentally retarded citizens of our state" and again in 1968 for his contributions to the statewide planning for vocational rehabilitation. In 1970, he was given a "Friend of the Hospital" award by Big Spring State Hospital (BSSH).

Currently, Smith is treasurer of the Volunteer Council at BSSH. He was honored by Dr. Gaver at a public reception in November in Big Spring.

Lena Stephens, founder and owner of a department store in Lubbock, has used her professional success and expertise to create opportunities for the handicapped. In civic groups, service organizations and through her church affiliation, she has been instrumental in initiating many projects for the benefit of the physically disabled, the mentally ill, the elderly, orphans and students who need financial help in educational pursuits.

Her imagination, initiative and direct financial aid led to the formation of a department of podiatry at Lubbock State School which treats as many as 40 patients each month. Stephens donated all the major equipment used in the department and also has donated funds to purchase corrective shoes for the residents.

The doors of her department store are open to furnish clothing for many residents. Along with large amounts of donated merchandise, she pays personal attention to the people being clothed.

Stephens was honored by Dr. Gaver at a public reception in Lubbock.

THE STARVATION DISEASE

By Nona Miller

CAMERON---When faced with the dilemma of a 17-year-old who refuses to acknowledge her suspected fatal disease, the question arises as to what is best for a human life. The minor refused to come to Austin State Hospital's Milam County Outreach Center (MCOC) for treatment of anorexia nervosa, and the parent refused to take action, even though the problem and potential consequences had been explained in detail. Staff members' hands were tied, because clients come to MCOC only on a voluntary basis.

Anorexia nervosa is a serious psychiatric syndrome. An anorexic gradually will starve herself to death through a slow process of dieting and exercise. The anorexic views herself as obese, regardless of actual appearance. Food may become an obsession, but its consumption is either limited or purged through self-induced vomiting or administration of laxatives. The mortality rate is high. The disease typically affects females between the ages of 13 and 30, with onset often following a traumatic event.

One Milam County 18-year-old female died from anorexia two years ago after the family discontinued utilizing outreach services, and this was the county's second incidence of the disease. The pattern of family resistance already had begun, with both client and mother hesitant to admit that there was a serious problem.

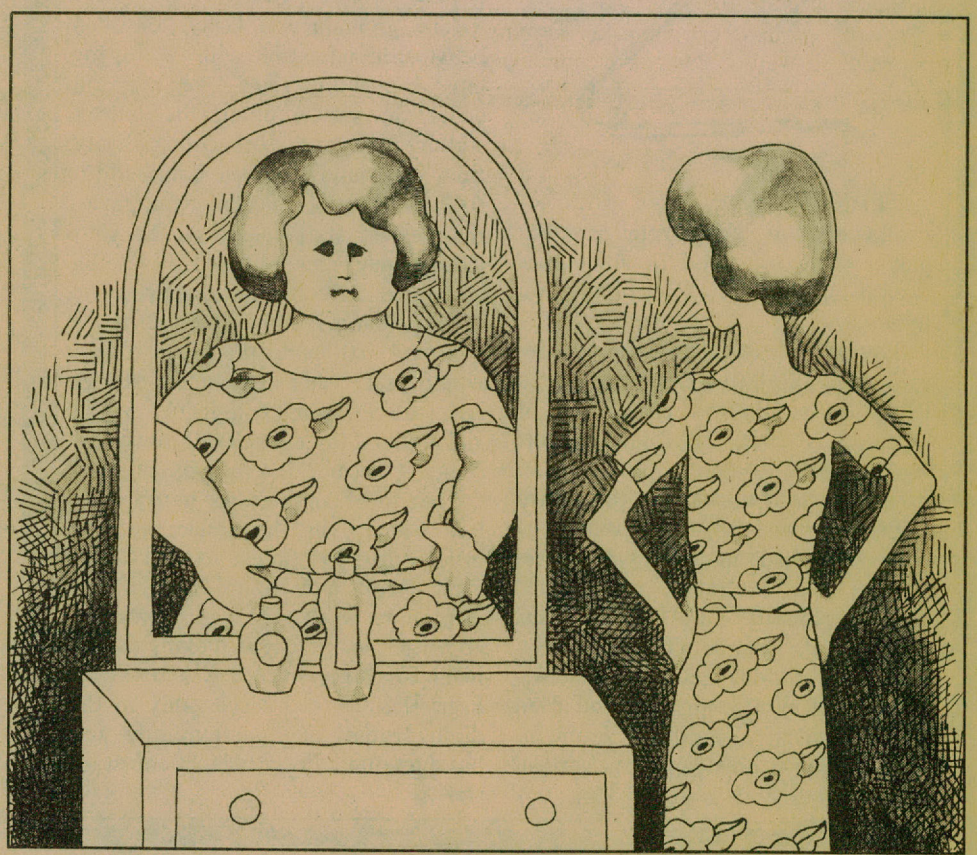
Outreach staff members learned from the Protective Services Division of the Texas Department of Human Resources (DHR) that DHR could intervene in cases of denial of necessary medical attention. Since DHR never had dealt with this situation, outreach staff members provided education on the diagnosed anorexia. Cooperation and education of local law enforcement officers, court officials and lawyers also were necessary.

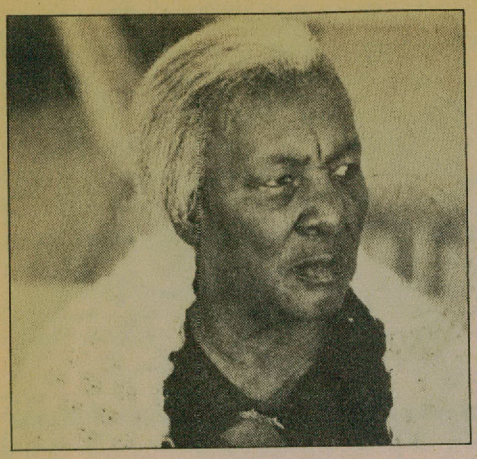
Throughout the process of admitting the client to the hospital Adolescent Unit, the primary concern of each individual and agency involved was the well-being of the client and her family members. Plans were made for family counseling during her hospitalization and for individual and family follow-up after discharge. Her prognosis was good because of quick, appropriate action and genuine concern by the client.

And what was the result? The client was treated successfully and was discharged from the hospital. She is enrolled in school, healthier than ever, and works part time. Equally important, she and her family continue to receive counseling at MCOC.

This particular case is a good example of the many, yet sometimes complicated, responsibilities of an outreach center, and the quality of care that is available at the center and at Austin State Hospital. The dedication of staff and community inter-agency cooperation provided the means of saving and restoring a life in this and many other similar situations.

Nona Miller is director of the Milam County Outreach Center in Cameron.

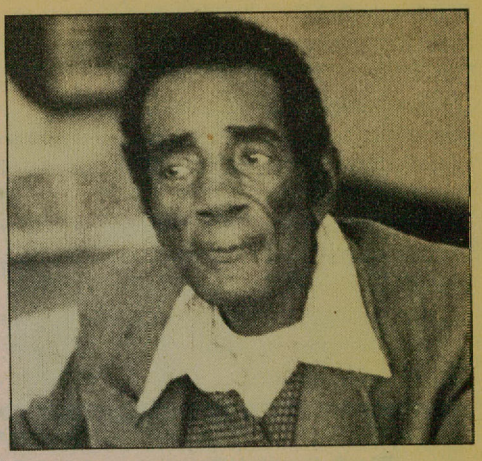




"Hey, We're Alive!"

Therapy for the Elderly

By Marsha Recknagel



HOUSTON---After three years of leading a therapy group in the Texas Research Institute of Mental Sciences (TRIMS) geriatric clinic, Jerry Werner is finally making some headway with the participants. Progress is painfully slow for eight elderly clients suffering from organic brain syndrome (OBS).

"I asked nursing homes to refer their most difficult cases," Werner says, "patients whom the staff saw as severely impaired, hard to manage. Nursing home staff and families tend to write these people off, to think of them as 'half-alive.'" Impaired judgment and memory, loss of intellectual capacity, disorientation as to time and place are all symptoms of classic organic brain syndrome.

Werner's first session with his group was a staring contest. No one said a word, he recalls. He began with reality orientation, "getting them back in touch with the real world." Over and over he asked, What is today? What is the month? What is the year?

"Patients know they should know these things, and they get angry at themselves for not remembering. I had to avoid hurting their feelings. They knew they were vulnerable, but I was pointing it out," he says.

Then the group began painting, learning to express feelings in artwork. Says Werner, "We have come from staring at each other, to reality orientation, to art therapy, to expressing feelings."

The patients, who used to sit all day in the nursing homes doing nothing (all have been hospitalized for psychiatric care at one time), are now making their presence felt. Some of them roll wheelchair-bound patients to the dining room. One patient takes in sewing, and another is allowed to go to the corner store (OBS patients often wander off and become lost).

One day last May, Werner, suffering from a cold, had trouble finding a meeting room for his group. Finally in a room, he looked around. No one was talking; some members were dozing. Frustrated, he told them, "Let's just quit meeting; this is useless. We've come nowhere in three years."

"You can't do that," one woman said.

"You're supposed to do your job," said another. "We come here and you are supposed to ask us questions so we can answer."

Werner says, "In essence, the patients were telling me: This is an important aspect of our lives. They were insisting on exactly what I have been trying to teach them---Hey, we're alive and we have rights."

Marsha Recknagel is a journalist at the Texas Research Institute of Mental Sciences in Houston. Photos by Jefferson Fegley.

Understanding Mental Illness

By Harrison Kinney

The primary reason for readmissions to mental hospitals is the failure of patients to follow through with aftercare plans following their discharges. Last year, as a caseworker at Austin State Hospital, I decided to find out why some patients discharged from Bayou Unit had not kept their mental health center appointments.

A pattern emerged from this investigation. The most frequent reasons given were:

1. Patients denied having mental disorders.
2. They felt that they were "cured."
3. They were embarrassed about having mental disorders.

In fact, most did not know their diagnoses, even though they may have had multiple hospitalizations.

Along with Ping Chu, a mental health worker at the hospital, I noted a paradox: in cases of physical pathology, a patient almost always is informed about the case; but, with psychiatric pathology, the patient may not be told the diagnosis, much less understand it. This situation leads to patients' misconceptions of mental illness. Most patients reported feeling that mental illness is a function of an abnormal personality. They felt degraded by being called "mentally ill." They thought they could control it strictly with will power. All these feelings contributed to their discontinuation of treatment after discharge.

We felt that most patients were competent when stabilized on medications and that a thorough understanding of mental illness would enable them to help themselves.

After reviewing literature on the subject, we found that an "understanding mental illness" group had never been explored. Thus, we had to devise our own structure.

The group currently runs for one hour daily for one week. The initial session presents the concept of personality and mental illness. Three points are stressed, based on the premise that psychosis is not a personality defect (i.e., part of the personality), but an illness that *affects* the personality. Thus, the first point made is that an individual can be mentally ill *and* a good person. Also, a person cannot wish or will mental illness away; it requires treatment. Finally, an individual must take responsibility for obtaining and continuing treatment.

(Continued on next page)

Understanding Mental Illness (Cont'd.)

The second session presents the major affective (disturbance of mood and/or feeling) and thinking disorders, and the behaviors associated with them, in order to desensitize patients to the nature of psychosis.

During the third session, the patient is told his diagnosis and why the diagnosis was given.

The fourth session centers on the current theories of etiology (the study of causes) and treatment.

The final session centers on what the person can do for himself to stay out of the hospital and how he feels about having a mental disorder. In essence, we are trying to help each person understand why he needs treatment, trying to make the label of "mental illness" less threatening and trying to show the person that, by his own action, he can keep his psychosis in remission.

Subjectively, the group has appeared successful. Patients volunteer for this group after hearing about it from others. The standard remark is that the group makes them feel like adults because they finally understand *why* they need to continue treatment after discharge.

We may soon have a more objective evaluation of the group. A current research project is underway to determine whether the Understanding Mental Illness group increases the probability of aftercare follow-through by outpatients.

Harrison Kinney is a caseworker at Austin State Hospital.

BATTERED WIVES: A Research and Counseling Project

By Lore Feldman

HOUSTON---When the Houston Coalition for Abused Women finally succeeds in establishing a temporary residence for women fleeing from violent husbands---what then?

The refuge will, of course, fill an enormous need of women and children who have no other place to go. But afterward, who will counsel the women and what will be the message? What about husbands who need help as well? What about couples who wish to stay together in peace and war?

A number of therapists at Texas Research Institute of Mental Sciences (TRIMS) are active in organizations concerned with the care of battered women. In the TRIMS marriage and family clinic, Karen Howes Coleman leads a counseling and research project that may answer some questions about conjugal violence. Like other issues concerning women, this one has long been obscured by myths and fairy tales.

Do the women invite attacks? Do they goad their husbands into beating them up? Do the aggressors and victims come from families in which fathers beat mothers? Were they abused as children?

Coleman has been working with 17 couples involved in conjugal violence and is collecting data from interviews with 30 battered wives and a control group drawn from the TRIMS clinic population. Together with Lou Ann Todd Mock, Ph.D., and Toby Myers, Ed.D., she has applied for a research grant from the National Institute of Mental Health, hoping that the study will illuminate better methods of treatment and, most important, prevention of violent behavior in families.

Coleman has drawn some early conclusions she is using to train other therapists working with abused women.

First of all, she says therapists who treat couples in conflict must be alert to signs of conjugal violence, willing to look behind subterfuges and ask embarrassing questions. They must proceed slowly. Advising wives to leave their husbands may frighten both of them into leaving therapy altogether, she warns. Often, when she has scheduled separate appointments for wife and husband, one would come with the other and wait outside. Placing husbands and wives into separate therapy groups should wait until at least three or four sessions have gone by.

Battered wives are bound to their husbands not by economic ties alone, and not by masochism.

"The wives' overriding characteristic seems to be passivity," Coleman says, "an extension of the image of the good women as passive, inoffensive, accepting." Two of her female patients were raised in orphanages, and they are terrified of breaking up even a dangerous marriage.

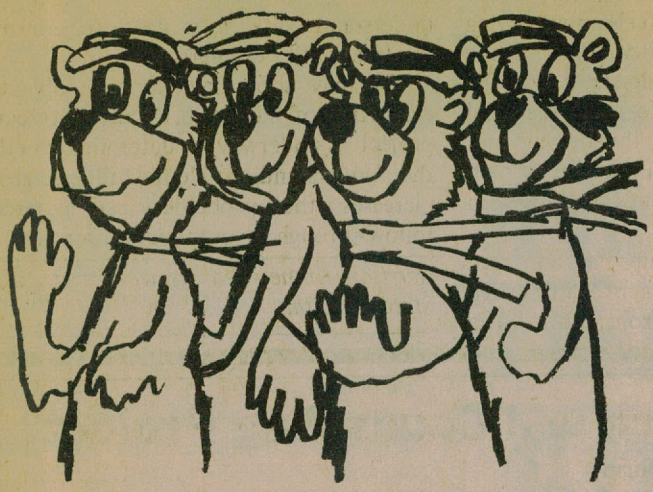
Most of the women do not see themselves as precipitating violence, just as they see their husbands as not completely responsible for it, she says. "There is always an excuse: 'If he didn't drink, this wouldn't have happened' or 'If he didn't have so much tension in his work, he wouldn't be like this.' " So Coleman has learned that asking a woman why she doesn't leave her husband is not helpful.

Coleman considers it an achievement when violent episodes decrease and are spaced farther apart, and when the woman initiates an activity she wants to pursue (like going bowling with friends, or attending church despite her husband's disapproval).

More information about this study of battered women is available from Karen Howes Coleman, Texas Research Institute of Mental Sciences, 1300 Moursund, Texas Medical Center, Houston, TX 77030.

Lore Feldman is information director for the Texas Research Institute of Mental Sciences in Houston.

Dr. Toby Myers (left) and Karen Howes Coleman of TRIMS speak at a seminar on conjugal violence. Photo by Mike Wallace.



A Special Talent

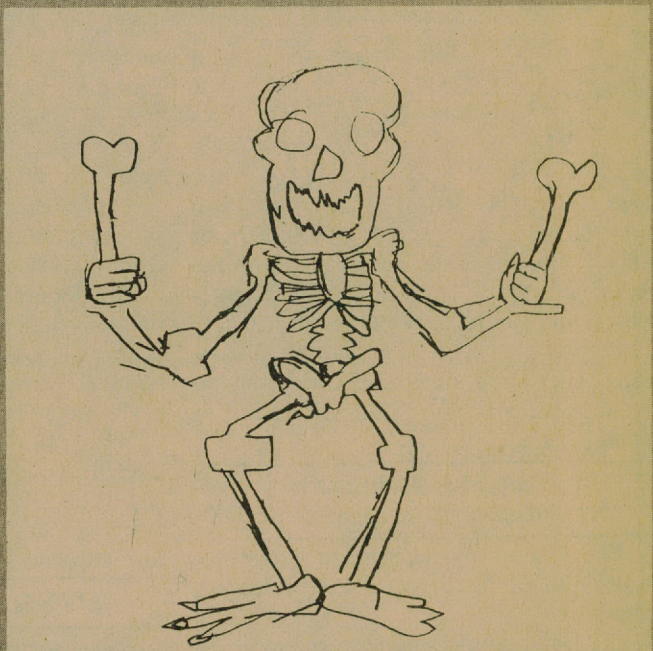
By Lillian Wilder

BRENHAM---Errell Jordan, a mentally retarded resident of Brenham State School, loves people, animals and art. He has combined the three to reflect a great deal of talent in sketching. He occasionally uses charcoal and crayons, but the pencil is his best medium. It works faster, and Errell likes to produce. The illustration of the bears (top left) took only six minutes.

Sesame Street themes are his big inspiration, but his own sense of humor and imagination shine through in the freehand sketches. In drawing, Errell starts at the top and seldom lifts his pencil, often making peculiar sounds that sometimes approximate words. He has poor verbal abilities but very good visual motor skills. He demonstrates an amazing sense of color and perspective.

Errell celebrated his fourteenth birthday last fall, sharing honors with his identical twin brother, Sherrell, who is also a resident of the school and draws a little.

Lillian Wilder is director of public information and coordinator of volunteer services for Brenham State School.



CLIENT ABUSE:

1. Identify It
2. Prohibit It
3. Report It
4. Prevent It

Because client abuse is recognized to be an intolerable situation, the Texas Department of Mental Health and Mental Retardation has adopted many rules to establish standards of care and policies relating to the use of various treatment modalities.

Nevertheless, there were 381 allegations of abuse of clients by staff members during the past fiscal year. Investigations led to the termination of employment of 124 employees. An additional 16 employees were suspended, 97 employees received some other type of disciplinary action and, in 148 instances, the allegations could not be substantiated. The allegations in 14 instances were referred to law enforcement agencies.

A recently-adopted rule, dealing specifically with client abuse, is intended to identify and prohibit client abuse by employees of the department and to prescribe procedures for its report and prevention. Following is an excerpt of rule No. 302.04.19, to which readers are referred for further reference and full details.

What is client abuse?

"Client abuse" means any act or failure to act:

(1) If it is done with the intent to cause physical or psychological pain to the client that is unjustified by the circumstances, and

(2) If pain results from that act or failure to act.

"Client abuse" does not include:

(1) The proper use of restraints or seclusion (see rule 302.04.06), the approved application of behavior modification techniques (see rule 302.04.07) or other actions taken in accordance with the Rules of the Commissioner of Mental Health and Mental Retardation or

(2) Actions that an employee reasonably believes are immediately necessary to avoid imminent harm to himself, clients or other persons.

How are allegations of client abuse handled?

Client abuse by department employees is prohibited. The head of each facility is responsible for:

(1) Determining whether the employee accused of client abuse should be granted emergency leave immediately after it is reported pending investigation

(2) Investigating fully, within five working days, all reports of client abuse

(3) Implementing prompt and proper preventive action when a charge of client abuse is substantiated

(4) Implementing prompt and proper disciplinary action when a charge of client abuse is substantiated.

Disciplinary action may include removal from a direct care position to another position, suspension for less serious cases of abuse (such as those involving poor judgment or failure to report abuse) or dismissal for substantiated cases of client abuse.

The head of a facility may appoint a multidisciplinary committee comprised of five staff persons to assist in the investigation of alleged incidents of client abuse. The terms of membership shall be one year. The committee must:

(1) Investigate fully any alleged incident of client abuse within five working days from the date it is reported

(2) Report to the head of the facility its opinion that there is or is not cause to believe that client abuse occurred. That opinion, however, is not binding on the head of the facility.

When the head of a facility takes disciplinary action against an employee based on client abuse, he or she must notify the employee in writing of any right to a grievance hearing.

How is client abuse reported?

Each employee who has knowledge of, or is involved in, client abuse is obligated to make an immediate verbal report. The employee also must make a written incident report, and, if appropriate, an accident report within 24 hours to the head of the facility. Employees failing to make such reports will be considered in violation of the rule and subject to disciplinary action.

Any person who believes abuse has occurred to a client may make his/her concerns known to the Public Responsibility Committee composed of volunteers at each facility.

Whenever the head of a facility believes, after appropriate investigation, that any client abuse-related crime has been committed, he or she shall report the occurrence to local law enforcement agencies and make a Criminal Occurrence Report as provided in rule 302.04.03.

If he or she believes that a child has been or may be adversely affected by abuse and/or neglect (whether or not by department employees), the head of the facility or his/her designee shall make a report as required by Sections 34.01 and 34.02 of the Family Code. Initial verbal reports can be made to the Texas Department of Human Resources child abuse hotline or the local Department of Human Resources field office. A final report concerning the completed investigation of the alleged abuse or neglect will be sent to the Department of Human Resources. When such report is made, the person who initiated the report to the head of the facility will be informed of that in writing. Any person reporting in good faith and without malice is immune to liability, civil or criminal, that might otherwise be incurred or imposed.

The parents, guardian, spouse or other appropriate relative of a client who has been abused will be notified within 24 hours after the client abuse has been confirmed by preliminary investigation unless such notification specifically is prohibited by law (see rule 302.04.16 and other rules relating to confidentiality). If notified of the incident, they also shall be informed of the results of any investigation.

When it appears that client abuse may have occurred and that it is either serious in nature or resulted in contact with parents, the head of the facility shall report the occurrence by telephone to the

appropriate Central Office deputy commissioner within 24 hours of learning of the incident. When death or serious injury results, this report can be made in conjunction with the report required by rule 302.04.03.

When child abuse is involved, the deputy commissioner shall make reports on appropriate forms to the Commissioner's Office to be forwarded, as required, to the Governor's Office of Youth Care Investigation (Criminal Justice Division).

Are staff members trained to prevent abuse?

The rules concerning client abuse will be read and explained to or read by all employees of each facility. All new employees will be given the content of these rules during their orientation training. Acknowledgement of this instruction will be certified by the employee and filed in his/her personnel file. Within 60 days after the effective date of these rules (Nov. 23, 1977), all current employees will be oriented to the contents of these rules. Acknowledgement of this instruction will be certified by the employee and filed in his/her personnel file.

Those employees in frequent contact with clients will receive additional instruction on the prevention and therapeutic management of aggressive, combative behavior or similar volatile situations within the employee's six months' probationary period of employment.

All supervisory personnel are responsible for continued training at least once each calendar year.

A record is kept on each employee receiving orientation, annual training or additional instruction in compliance with this rule, including the date training was provided and the name of the individual conducting the training. A copy of the record shall be furnished to the facility staff development office.

The head of each facility is responsible for duplicating and disseminating copies of these rules to any client, employee or other person desiring a copy. He or she also must display prominently copies of these rules at nursing stations and on bulletin boards within each facility.

Mentally disabled clients entrusted to the department, like the one enjoying the swing above, deserve the patience and attention of skilled caregivers. Hiring temperamentally suited employees and training them for their positions is made more difficult by the 40 per cent annual turnover rate. Rules such as this one, however, are intended to enforce the prohibition against client abuse or neglect of any kind and to ensure the highest quality care possible. Photo by Dan Bayless.

On the Inside-Looking Out

CORPUS CHRISTI---Sherry Edwards, age 28, is an author in search of a publisher for her new book. She is also nonverbal and suffers from such severe spastic quadriplegia that normal means of communication---even sign language---are not possible for her. That also makes it difficult to determine the degree of her mental retardation.

She communicates through head gestures and arm and eye movements. The idea for a book about her experiences originated during therapy sessions with psychologist Tom Burkig of Corpus Christi State School, where Edwards resides.

Burkig had an interest in writing a book about institutions for the mentally retarded and their effects on both residents and employees. Edwards, who had lived 22 years in institutions and had known both depression and loneliness, had a story to tell.

Edwards' portion of the book required more than six months of daily sessions with Burkig, two each day lasting one hour each. Identifying topics, specifying words and piecing together sentences was a slow process of Burkig asking questions and Edwards gesturing "yes" or "no."

The manuscript is nearly complete, and the authors are looking for someone to help them tell others what it's like "On the Inside---Looking Out," the title they have chosen for their work.

Sherry Edwards has coauthored a book with psychologist Tom Burkig. Photo by Lee Dodd, courtesy of *Corpus Christi Caller-Times.*

Abilene St
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By H

ABILENE---People are rushing to work. Boys and girls are hopping with excitement at being made up for the school choir program. Boy Scouts are directing traffic to a luncheon. Teen-agers are huffing and puffing to exercise away those holiday bulges.

Does this sound like an average town and its activities? It is, except that all of these busy people are residents at Abilene State School. They are mentally retarded. No longer is this facility a place where its inhabitants loll about idly watching the cars go by or the wind move dust across a pasture. When they get up each morning, the citizens of this community have things to do and places to go.

If one word could describe the people at Abilene State School, it would be BUSY.

Visitors often are surprised to learn that Abilene State School is something like a flourishing, active suburb, complete with a school, a small factory, a church, a soda shop, a clothing store and much more. But the most important thing is the air of purposeful activity which is ever present.

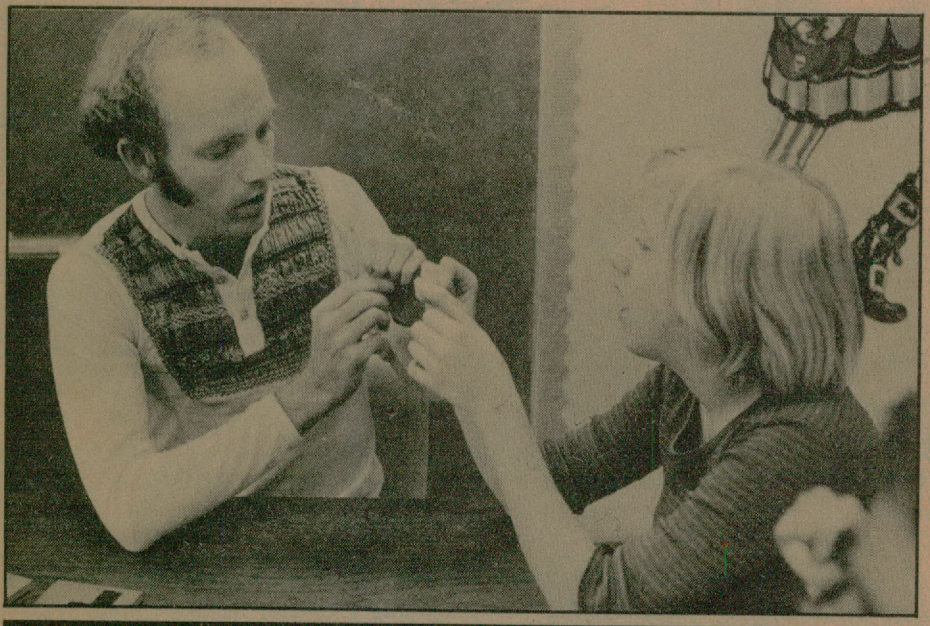
Things have not always been this way. "Only with funds for increased personnel have we been able to accomplish these steps forward," states Supt. L. W. (Bill) Cain.

The mentally retarded clients of Abilene State School now are able to do many things which heretofore only had been dreamed of, but their achievements have been slow in coming and then only as the result of persistent hard work on the part of trainers.

"Dedicated" is a frequently overworked word and not always justified, but the majority of the staff members at Abilene State School seem to feel that their position is more than just a job. This attitude is reflected by a note a unit director received recently from a trainer of severely handicapped boys: "Today I had an experience I feel should be shared with you. I am on a feeding program. I have been working since October with a 19-year-old blind boy. He has never fed himself. Today for the first time he completely fed himself the entire tray. The support and encouragement we receive from our dorm charge and dorm personnel have made this possible.... Knowing that the boys I work with won't regress while I'm off or on vacation has made me even more determined to be an asset to the dorm and the training program." This trainer also worked with the parents of the client on her time off in order for them to carry on his training while he was at home for a visit.

As if mental retardation were not enough, many clients have other handicaps such as blindness and deafness, but these people now are receiving special training which is helping extend their small worlds.

Providing avenues of communication for the deaf requires great patience and skill. BELOW: Staff member Jerry McNeil uses alphabet cards to practice sign language with Melissa Perry. RIGHT: Mary Ann Tachibana practices communicating.



te School:
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Training of the deaf residents requires an infinite amount of patience and love, and the trainers often use the students' inappropriate behavior as a tool for teaching proper conduct.

For example, it was breaktime in the classroom for the deaf. One girl let her teachers know that she did not want orange juice by the simple expedient of throwing the cup on the floor. In doing so, she knocked over her neighbor's juice, saturating him with the cold, sticky liquid. Calmly, the teacher removed the girl from the group and mopped up the floor, after which she returned the culprit to the scene of the crime. The teacher then encouraged her to make the circular motion over her heart which means "I'm sorry" to the deaf. She did. Both she and the victim were again the best of friends. The teacher then proceeded to explain to the girl in simple signs that there were other, more acceptable, and drier, ways of expressing dissatisfaction.

This is probably not the end of the story. Chances are it will have to be repeated under different circumstances, but at least there is now a means of communicating the basics of acceptable behavior where only a few months ago there was not. No longer are the deaf mentally retarded so frustrated when they see lips move, but cannot get the message.

In a class for the blind, both teachers and students are much aware of Behavioral Characteristics Progression goals, and there is much elation when a hurdle has been overcome and a student has progressed. One teacher was instructing the class in counting to 10 when, just for fun, he counted to 10 by 2's. One student felt that was an admirable feat and shouted, "Jerry, I am going to progress you!"

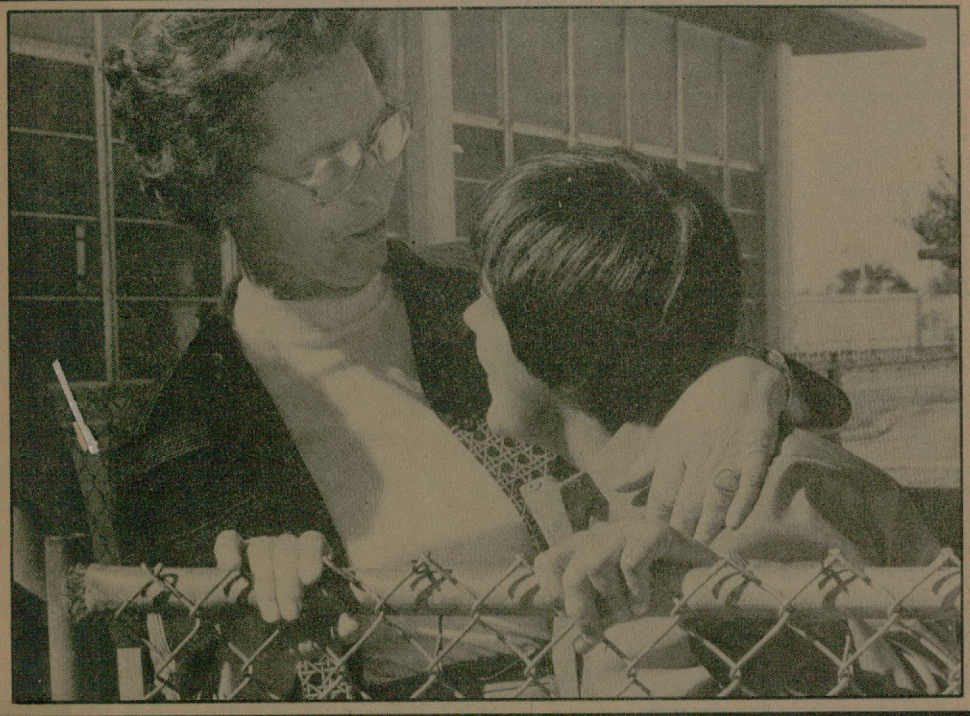
Teachers find it rewarding when clients themselves reinforce the instructions which they learn in training. It is not uncommon for the visually impaired to call out warnings to their totally blind friends of some hazard or obstacle in their path.

In the area of physical education, the training is not limited to the building of stronger bodies. The spirits of fair play and determination are instilled constantly into participants.

Chubby clients huff and puff and give their all in the weight control program, the school's answer to a health spa. They are involved in aerobics, a cardiovascular physical fitness program, in which they exercise to music. Some participants have difficulty because of physical handicaps, but their determination is exemplary, and the results are even more admirable for it.

A sensory integration trainer glows with pride when she tells of one client who, after years of lying on his back with resulting circulatory problems, now stands alone by holding onto his bed. A little girl in the infirmary, formerly nonverbal, now tells her, "I love you." This is another of her victories.

The scene was Memorial Stadium in Austin. The best teams in the state were competing in the 440-yard relay for the Texas



LEFT: Dedicated staff members take time to dispense affection along with education and physical care. BELOW: L. W. "Bill" Cain is superintendent of Abilene State School.

Special Olympics championship. As tension built, one member of the Abilene State School team dropped the baton, putting the entire team out of the running. It might seem that that was a disastrous loss, but to their coaches it was a victory. The boys accepted their defeat without anger, with no blame cast on the offending runner. They had learned a hard lesson in fair play and self-control.

Swimming is one activity in which many of the physically handicapped are able to participate, and with the use of an enclosed, heated pool, a gift of the Volunteer Services Council for the school, they are able to exercise weak muscles throughout the year. Additionally, some of the special education classes at Houston school in Abilene are able to have good workouts under the close supervision of physical education personnel.

There is an exodus at 8:30 each morning and again at 1:30 each afternoon to the prestige spot on Abilene State School grounds---the workshop. This phase of training and activity goes by many names, but they all mean the same thing to the clients. That's the place where one can do something productive and get paid for it at minimum wage proportionate to one's ability to produce.

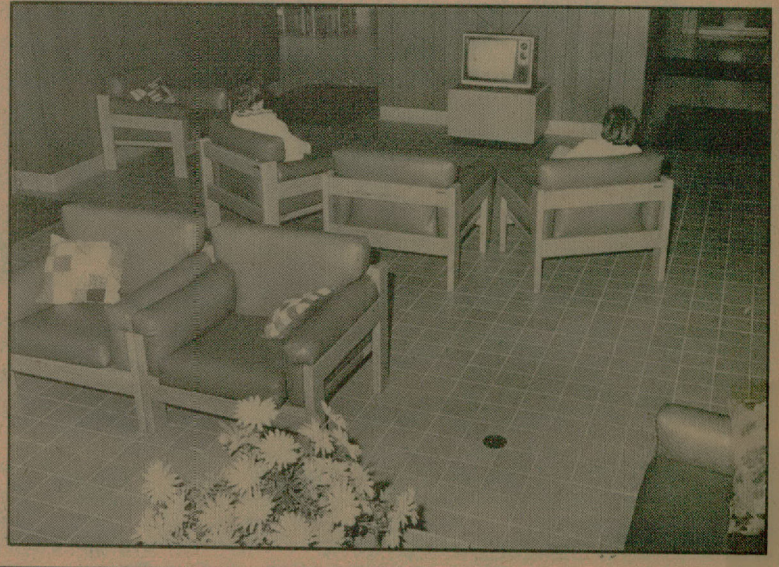
Workshop employment has probably had as much to do with improved behavior as any one factor. A long-time supervisor of the workshop program enthusiastically tells the story of one of his best workers. A number of years ago, the client was tested and diagnosed as severely retarded, and in addition, he was an uncontrollable "firebug." All efforts had been made to prevent damage he could cause simply by keeping him away from matches, and he was placed in a "controlled" dorm. Eventually he was included in a workshop training program. He was told if he worked and behaved acceptably he would be allowed to smoke his pipe at breaks, under close supervision. From that time on he blossomed. Supervisors discovered that his manipulative skills were superior, and he was put to work using a micrometer on telephone parts, operating on a tolerance of 1/1000 of an inch. His span of concentration was brief, but he eventually was given more and more challenging jobs. He progressed from dorm to dorm and is now living on a cottage which allows him more privacy and independence, plus additional responsibility for his own care and well-being.

Another Cinderella story concerns a girl who is confined to a wheelchair. She has been consistently the top wage earner in the workshop program, turning out work faster than some of her instructors, once she learns the task. She functions at 65 per cent of a normal worker's production. When asked how much money she had in her trust fund, she did not know the exact amount. She bought herself a traveling case at Christmas time, but she had no desire for a personal television nor even a stereo. She likes records, and owns some, but she works just because she likes to work.

This love of being productive is typical of most of the workshop clients. They exhibit great pride in doing their job well, although most of the boys' ultimate goal is to progress at age 18 to the saws where they create shadowbox pictures, toy automobiles and other items made of wood.

Essentially, the success of the workshop program rests on the

When institutions take into account the individuality of those they serve, the result is often a process called "humanization." Clients' rights are more carefully respected, individual treatment plans are developed and living environments are made more homelike. At Abilene State School, one step toward humanization has been the opening of eight houses designed for 15 clients each. Bedrooms (left) provide more privacy with a maximum of four occupants per room, and living areas (below) offer many of the comforts of any home. Photos by Larry Fink.



A love of being productive and a pride in what they produce characterize the residents employed at the campus workshop. Contracts range from packaging and sealing bags of plastic cutlery (below) to preparing plastic pipe liners for oil field pipes (right). Photos by Larry Fink.

fact that the people involved simply want to work and become productive.

One of the benefits derived from becoming a responsible, productive member of the workshop program is that the client may be able to live in one of the new cottages. These residences, although still on the grounds of Abilene State School, are more nearly like private homes than are the dormitories. Eight houses, each designed to house 15 clients, offer more privacy with a maximum of four occupants per room. But along with the luxury of privacy and more independence goes more responsibility. Eventually clients will learn to care more for themselves, including cleaning, laundry and, ultimately, food preparation. The pride of those now occupying the cottages is immeasurable. On being asked how she liked her new home, one client ecstatically replied, "Oh, it's just beautiful! I love it! You've got to come visit me. I'm at 671 Circle Drive." Having guests is a part of life, too.

As work is a necessary part of life, so are spiritual guidance and inspiration. The chapel is full to overflowing with each service. Now located in part of a building which was constructed in 1901, the present chapel has been outgrown by its congregation. Night services are held outdoors during the long, hot West Texas summers. Currently, the Volunteer Services Council is working to raise funds for a new, more adequate and attractive structure, dedicated to those people who cannot do it for themselves.

In the meantime, both ambulatory and wheelchair worshipers cluster in their old building and make the windows rattle with their enthusiastic singing of well-known hymns.

At least one of the concepts which are taught by the chaplain has carried over into other aspects of the clients' lives. A group of less handicapped teenagers found absolutely no challenge in singing many of the songs their school choir director introduced to them. When she suggested that they prepare a puppet show, she received wholehearted support. They built the stage, made the puppets and took great pride in performing for the younger children on the grounds. They quickly learned the rewards of sharing their talents with others.

Being a part of the choir teaches them other things, too. Recently, they went to a local college to perform for a group of special education teachers. One tiny bright-eyed 12-year-old in a wheelchair rolled center stage and sang her spirited version of "Love" with great joy. At the conclusion of the song many in the audience unashamedly wiped their eyes. The soloist turned to her teacher and excitedly exclaimed, "Hey, I left 'em in tears."

Clients at Abilene State School may not realize it, but every day of their busy lives they leave a positive impression on many who may not know about mental retardation. The most important point was summed up by a psychologist at the school who told a group of Abilenians, "The mentally retarded may be different, but they are more like the rest of us than they are unlike us."

Ms. B. J. Mann is director of public information and coordinator of volunteer services for Abilene State School.

Partners for Mental Health

Center Holds Seminar For Police Officers

By Katharine Johanns

TEMPLE---One of the most potentially dangerous calls a police officer can respond to is a family disturbance. Many times, the persons involved in the conflict will turn on the officer, injuring or possibly killing him. In these and other situations, today's officer finds his or her role is that of a social worker.

Domestic squabbles are among the most dangerous calls a police officer can answer.

To help, many law enforcement agencies are trying to educate their officers in understanding more about mental and emotional problems, crisis handling, the police officer's role as the law enforcer and that officer's needs as a human being.

One year ago, instructors with the Central Texas Police Academy at Central Texas College in Killeen asked if staff from Central Counties Center for MHMR Services in Temple could develop a week-long, 40-hour seminar on mental health problems and the police officer's role. Raymond Finn, Ph.D., director of training, consultation and evaluation at Central Counties Center, began drafting such a program.

The seminar was held last May at the college. There were 17 police officers involved, representing five area police departments.

Twelve staff members from Central Counties Center conducted the classes, ranging in subjects from mental health concepts and values to Black history and culture. Other topics included alcohol and drug abuse, intervention strategies, personality development, family systems, child abuse, Chicano family and culture, parenting, disturbances of adult functioning, adolescence, the psychology of police work and police officers as people. Also studied were the services and programs available at Central Counties Center.

At the conclusion of the classes, the police officers were asked to evaluate the program. Their responses were generally favorable. But the one response found to be dominant was that the officers enjoyed talking about their role, job-related problems and themselves. As one officer put it, "I enjoyed being me...learning more about myself and how my actions and reactions affect others."

Dr. Finn believes that the seminar also proved educational for the MHMR staff by better acquainting them with the problems in law enforcement as well as the problems of the individual officers. He said, "We found that the officers actually felt emotionally isolated from each other because of the nature of their work, that there was little group support."

The Central Counties Center staff is studying the possibility of conducting this seminar on an annual basis for the Central Texas Police Academy as part of their training program.

Katharine Johanns is director of public information for Central Counties Center for MHMR Services in Temple.

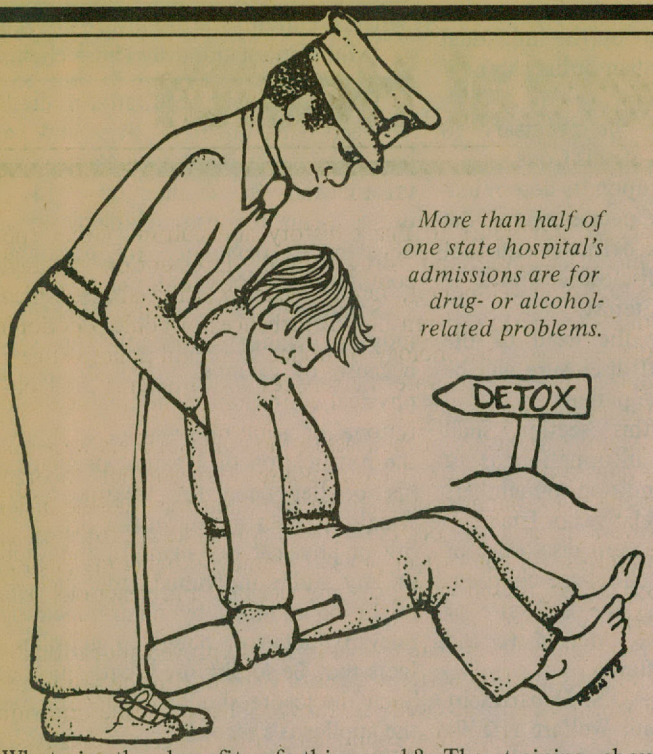
Hospital Opens Doors To Train Cadets

By Rob Sterk

Cadets of the Austin Police Department have the opportunity to work in community agencies to learn more about their functions. Choosing which agency is the decision of the cadet, and many select Austin State Hospital (ASH) as part of their training.

Ned Anderson, coordinator of training for the cadets, met with Paula Womack, ASH coordinator of volunteer services, to develop special assignments for the cadets. Discussion focused on those treatment areas having the greatest contact with the police department. They agreed that Admission and Screening, Adolescent and Capital Units would be included in the program. Capital and Adolescent Units have proportionately large patient populations from Austin. Admission and Screening Unit is each patient's (and, sometimes, escorting police officer's) first contact with the hospital.

The first student to work at ASH in this 20-hour program was Cadet Jim Fealy. His first four-hour day included a general orientation and tour of the hospital. The remaining four days were spent working on Capital A & B Unit with mental health workers and attending a patient progress review meeting. He attended an admission staff conference and a staff meeting on Adolescent Unit.



More than half of one state hospital's admissions are for drug- or alcohol-related problems.

What is the benefit of this work? The training should accomplish several objectives:

1) Familiarize the cadet with hospital function and structure

2) Orient him to the nature and different aspects of mental illness

3) Help him feel the human element within the institutional framework.

Apparently, Cadet Fealy's reactions to his experience at ASH were good. He reported to his class his impressions of different treatment services. As a result of his positive attitude, three more cadets entered the ASH police cadet program, with one change in the original plan. In addition to their duties on Adolescent and Capital Units, they will work on the Alcohol and Drug Abuse Treatment Center (ADATC). ADATC is an important treatment area for cadet training: over half of ASH's admissions are treated for alcohol- or drug-related problems.

Cadet Jerry O'Connor worked on Adolescent Unit. Mental health specialist Clive King worked closely with him.

"When he first came to the unit," says King, "I think he may have had some of the same old misconceptions about the hospital---you know, the ones from grandma's times. I think he was really surprised and pleased to see how things really are."

How does King feel about cadet training?

"I think it's great. We need to see a lot more of this kind of cooperation between city and state agencies."

Rob Sterk is assistant coordinator of volunteer services and assistant director of public information for Austin State Hospital. He is also editor of The Envoy, *the hospital's newsletter where this article first appeared.*

Alcohol Abuse Among the Young

By Roy E. "Buck" Byers

VERNON---The Vernon Center Project for Drug Dependent Youth, funded by the Texas Legislature in 1971 and opened in March 1974, is designed to deal with youth (at least 13 years of age but not yet 22) who are known to abuse dangerous drugs, controlled substances, alcohol and/or inhalents.

Alcohol abuse, in particular, is a growing problem. According to a recent study conducted by the National Institute on Alcohol Abuse and Alcoholism, there is an increase in the use of alcohol as a primary drug of choice as well as a supplement to other abused substances by young people. Among the drug unit population, alcohol is the second most commonly used drug (marijuana is first), with 71.3 per cent of the patients using alcohol on an average of three to four days per week prior to admission to the unit. Each patient spent an average of $13.96 per week on alcohol during the month prior to admission.

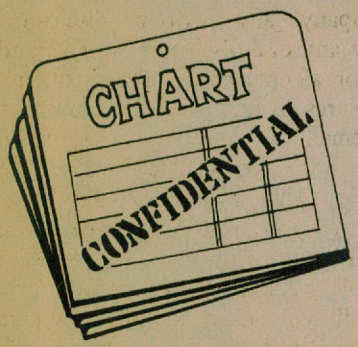
Information gathered on discharged patients indicates 80.1 per cent still use alcohol after leaving the project. This 12 per cent increase in the number of patients using alcohol is probably related to a "substitution phenomenon" where persons substitute a legal, less potent drug for their previous drug of preference. Although there is an increase in the number using alcohol after discharge, the rate of usage declines from three to four days per week to one or two. This result is reflected in a 37 per cent decrease in patient expenditures for alcohol after discharge from Vernon Center.

To further combat this problem in the drug unit's population, a specific program of Alcohol Orientation and Education (AO&E) was implemented by the unit staff in January 1976. Patients are assigned to the AO&E program based on an admitted and/or documented history of alcohol abuse.

The program provides patients with facts about psychological and physiological effects of alcohol abuse, as well as associated environmental, cultural, economic and legal problems. The instruction complements the educational, recreational, vocational and occupational segments of the rehabilitation process.

Buck Byers is director of public education and information for Vernon Center. The statistics used in the article are from "Vernon Project for Drug Dependent Youth: Assessment of Effectiveness," a report published March 1977 and available from Dan Sheehan, Ph.D., Director, Program Support Services, Texas Department of MHMR, P.O. Box 12668, Capitol Station, Austin, TX 78711.

New Rule On DISCLOSURE



Below are excerpts from a department rule regarding confidentiality of records of mental health and drug and alcohol abuse clients of TDMHMR. (A new rule soon will cover disclosure of client-identifying information contained in records of mental retardation clients. Excerpts will be published in a subsequent issue of IMPACT.) The following rule, No. 302.03.15, incorporates proposed amendments expected to be adopted by March. Copies of the entire rule will be available at each facility, and employees and others are encouraged to read the full version for details and further references.

Why is this rule necessary?

The purpose of this rule is to collect laws and department policies about disclosure of information that identifies mental health and alcohol and drug abuse clients and group them in a single set of guidelines.

Careful distinctions must be made among mental health, alcohol abuse, drug abuse and mental retardation clients whenever a determination concerning disclosure of information is made. Any questions concerning the status of a client and which law governs disclosure in a given situation should be addressed to the department's Legal Division.

What statutes and federal regulations govern disclosure?

The state statute which governs the disclosure of information concerning mental health clients (other than drug and alcohol abuse clients) is in Vernon's Annotated Civil Statutes (Article 5547-87):

"(a) Hospital records which directly or indirectly identify a patient, former patient or proposed patient shall be kept confidential except where:

"(1) Consent is given by the individual identified, his legal guardian or his parent if he is a minor.

"(2) Disclosure may be necessary to carry out the provisions of this Code.

"(3) A court directs upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to the public interest.

"(4) The Board or the head of the hospital determines that disclosure will be in the best interest of the patient.

"(b) Nothing in this section shall preclude disclosure of information as to the patient's current condition to members of his family or to his relatives or friends."

Federal regulations govern disclosure of educational records of school-age children. Any questions regarding the disclosure of such records should be referred to the department's Legal Division.

The Secretary of the U.S. Department of Health, Education and Welfare (HEW) has promulgated extensive regulations governing the disclosure of alcohol and drug abuse patient records.

How should requests for client-identifying information be made?

All requests for client-identifying information (except by employees and agents of the department who need the information to fulfill their duties to the department and community MHMR centers) should be made to the head of the facility from which the client receives or has received services. Such requests should not be made to the Program Analysis and Statistical Research Section of the department's Central Office.

In which situations is consent for disclosure not required for mental health clients?

Those situations are stated in Vernon's Annotated Civil Statutes quoted previously and in the following paragraph.

Client-identifying information can be disclosed without the consent of the client or the client's legal representative:

(1) To a community MHMR center which serves the area in which the client resides if such disclosure:

(a) Has been determined by the head of the department facility to be in the best interest of the client or

(b) Is necessary to carry out the provisions of the Texas Mental Health Code.

(2) To employees and agents of the department who need the information to carry out their departmental duties.

When is consent for disclosure not required for alcohol and drug abuse clients?

Consent is not required for disclosure between department facilities and personnel of the department having a need for the information in connection with their duties. (This does not include disclosure by department personnel to personnel of community MHMR centers.)

Sometimes a program director may judge a minor applicant for services, because of extreme youth or mental or physical condition, to be unable to make a rational decision on whether to consent to the notification of a parent or guardian of his or her need for treatment. If the situation poses a substantial threat to the life or physical well-being of the applicant or any other individual, and such threat might be reduced by communicating the relevant facts to a parent or guardian, such facts may be so disclosed, without consent. Such disclosure should be documented in the applicant's records.

Consent is not required in the following specific situations described in HEW regulations governing disclosure of information contained in an alcohol or drug abuse client's record:

(1) Information to medical personnel to meet a medical emergency and to the U.S. Food and Drug Administration when it is necessary to notify a client of a dangerous drug.

(2) Information for research, audit and evaluation purposes, subject to HEW limitations on the manner in which persons receiving information may utilize it.

(3) Information to state or federal governmental agencies performing research, audit or evaluation in accordance with HEW requirements.

(4) Information for examinations of financial records, management effectiveness or adherence to standards of operations, provided the examiner furnishes a statement restricting his use of client identifying information.

(5) Information for the supervision and regulation of a narcotic maintenance or detoxification program by state or federal regulatory agencies.

Consent also is not required for disclosure of client-identifying information in response to a specific court order which meets HEW requirements. A subpoena alone is not sufficient to allow disclosure of the information without consent.

Whenever a situation arises involving a disclosure as described in the section above related to HEW regulations, the Legal Division of the department should be contacted immediately and its advice

sought prior to the disclosure.

What form of consent is proper for mental health clients?

Whenever the proper person gives written consent to the disclosure of client-identifying information, no other consent is necessary.

A proper consent form contains at least the following information:

(1) The client's name

(2) A description of the client-identifying information covered by the consent form

(3) The person to whom the information is to be disclosed

(4) The signature of a person who has the authority to consent to the disclosure

(5) The date on which the consent form was executed.

A copy of the consent form is attached to the rule.

If the client is a competent adult, then the client is the only person who can consent.

If the client is an incompetent adult, then the guardian of the person of the client is the only person who can consent.

If the client is a minor, only a parent, guardian or managing conservator has the power to authorize disclosure.

What form of consent is proper for alcohol and drug abuse clients?

Consent for disclosure of information pertaining to an alcohol or drug abuse client to persons other than the client's attorney must be written and contain the following information:

(1) The name of the program which makes the disclosure

(2) The name or title of the person or organization to which disclosure is to be made

(3) The name of the client

(4) The purpose or need for the disclosure

(5) The extent or nature of information to be disclosed

(6) A statement that the consent is subject to revocation at any time except to the extent that action already has been taken, and a specification of the date, event or condition upon which the consent will expire without express revocation

(7) The date on which the consent is signed

(8) Consent for disclosure evidenced by the appropriate signature or signatures.

If the client is a competent adult or a minor being treated for drug abuse, then the client is the only person who can consent.

If the client is an incompetent adult, then the guardian of the person of the client is the only person who may consent.

If the client is a minor treated for alcohol abuse, consent to the disclosure must be given by both the minor and his parent, managing conservator or guardian.

Disclosure of information pertaining to alcohol or drug abuse clients may be made available to a client's attorney upon written application of the client endorsed by the attorney.

A copy of the consent form is attached to the rule.

What governs disclosure of information to a competent adult client?

The content ot a competent adult client's record is to be made available to the client upon request. However, parts of the record may be withheld if the treating physician determines that access to those parts would not be in the client's best interest. The physician's reasons must be well documented in the client's medical record.

When a competent adult client has authorized an attorney to have access to the records, the records shall be made available. If it has been determined that access by the client to parts of the record would not be in his best interest, this fact should be brought to the attention of the attorney, but the attorney should be permitted to view such parts.

What governs disclosure of information to an incompetent adult client or to a minor who is not a drug abuse client?

Access to their records may be denied to these clients. They shall be allowed access to their records when:

(1) Disclosure is necessary to carry out the provisions of the Texas Mental Health Code.

(2) The head of the department facility determines that disclosure will be in the best interest of the client.

(3) A court directs that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to the public interest.

(4) The parent, managing conservator or guardian of the person, as appropriate, authorizes the department facility to allow the client to have access to his or her record.

What governs disclosure of information to a minor drug abuse client?

A minor drug abuse client may not be denied access to his or her record. However, parts of the record may be withheld if the treating physician determines that access to those parts would not be in the client's best interest.

Is disclosure of information concerning alcohol and drug abuse clients treated in a special way?

The following written statement must accompany any written disclosure or follow any oral disclosure from records of drug or alcohol abuse clients (other than disclosures to employees and agents of the department who need the information to carry out their official departmental duties): "This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

If an oral disclosure of information is made without consent in a medical emergency, a written memorandum shall be made which shows the following:

(1) The client's name or case number

(2) The date and time the disclosure was made

(3) An indication of the nature of the emergency

(4) The information disclosed

(5) The names of the individuals by whom and to whom information was disclosed.

How do staff members comply with depositions, subpoenas and subpoenas duces tecum?

If consent of the client or other authorized person has been given, facility staff, when asked to testify either in court or by deposition on matters relating to the client's history or to make available records in reference to such client, shall do so. If consent has not been given by the client or other authorized person, the court should be notified immediately. Every effort should be made by facility staff to cooperate and work out an arrangement which is satisfactory to all concerned and which adequately protects the rights of the client.

If facility staff are unable to work out a satisfactory arrangement, then the department's Legal Division should be contacted immediately and its advice sought.

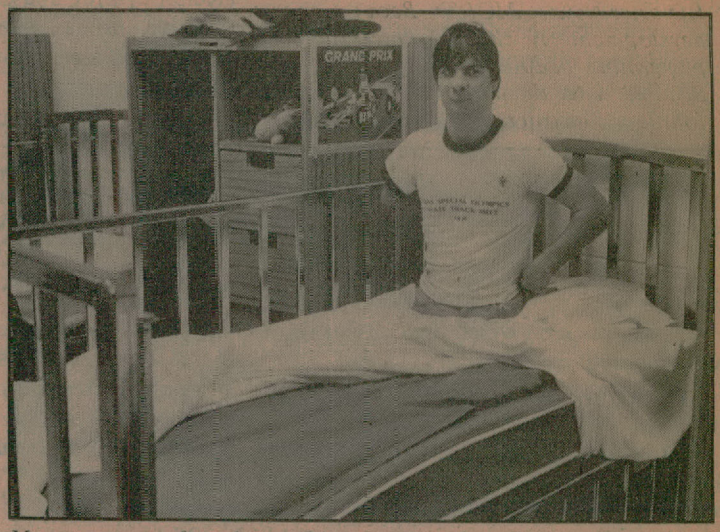
Whenever there is doubt as to the proper procedure to be followed in such matters, the subpoenaed party should contact immediately the department's Legal Division.

Creative Caring

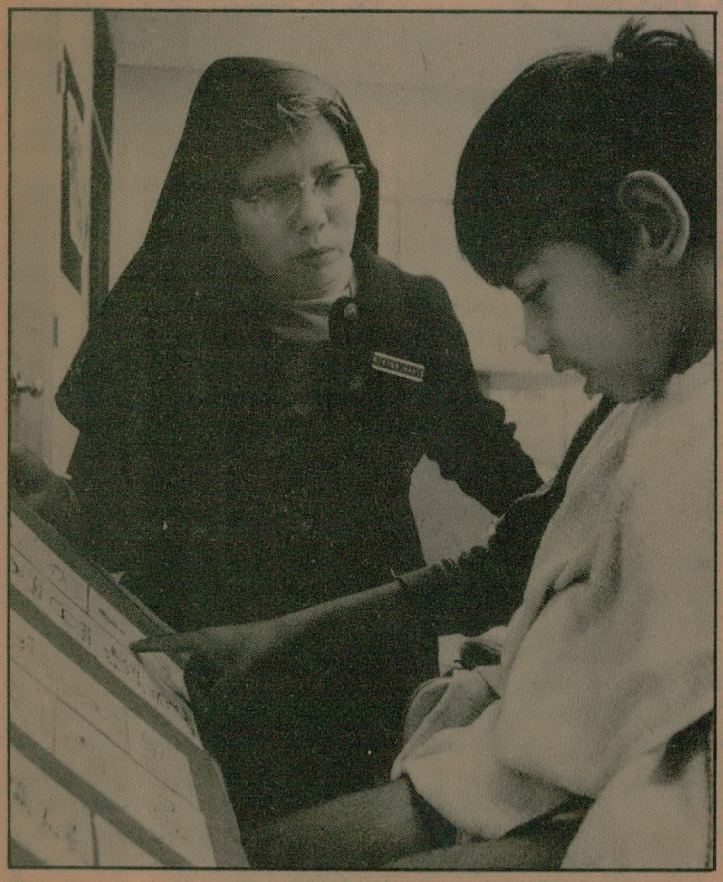
Mental retardation is a handicap. Add to that blindness or deafness or both, an ambulation problem requiring use of a wheelchair or restriction to bed, perhaps accompanied by cerebral palsy---and that is a multiple handicap, the plight of many state school residents. A group of people once passed over 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.

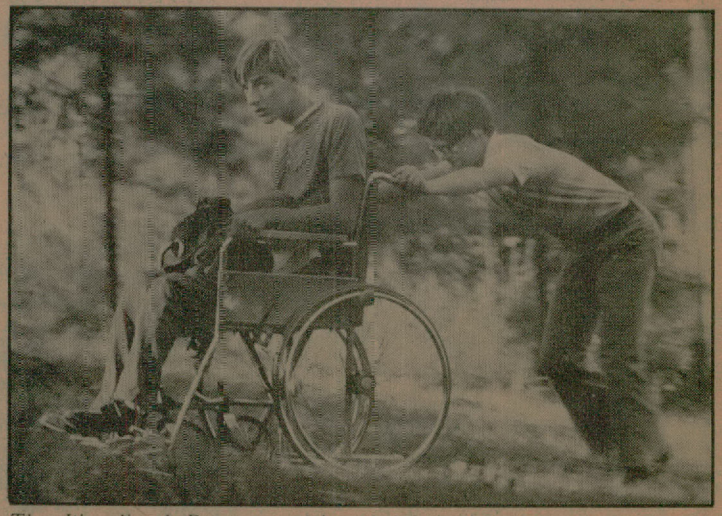
They have designed custom wheelchairs and playgrounds. They have created outdoor retreats for use by the blind and nonambulatory, converted air mattresses into water-filled cushions for the immobile and developed language boards that enable the nonverbal to communicate. These photographs illustrate creative ways of caring for the multihandicapped.



Many types of pads, cushions and other devices have been developed to prevent and help heal decubitus ulcers (also known as pressure sores or bedsores). One program for the immobile and semiambulatory clients of Richmond State School involves the use of inexpensive water mattresses developed through a simple adaptation of air mattresses. One beneficiary of their effectiveness is Jimmy Miller, a teenager born without limbs except for one arm. He's active, swinging himself from bed to wheelchair and back, but his sitting position makes him susceptible to the decubitus ulcers. The water mattress, on top of his regular mattress, helps tremendously. Photo by Ron Quarles.



A young resident of Corpus Christi State School, unable to communicate through speech, has learned to make simple thoughts known by use of a language board. Sister Maxie Cruz, speech therapy technician, helps the boy express himself by pointing in sequence to words and pictures on a board he carries on his lap. Photo by Lee Dodd, courtesy of *Corpus Christi Caller-Times.*



The Woodland Retreat, with special facilities to accommodate multiple disabilities, is a volunteer project being built adjacent to the Lufkin State School campus. Donations to the project, valued at more than $82,000 to date, have created two nature trails (one for ambulatory residents and the Big Wheels Trail for wheelchairs), signs that identify vegetation coded also in Braille, picnic area, fishing pier, pavilion for group activities, shelters for overnight camping, comfort station and animals for the residents to enjoy. Photo by Dan Maxwell.

BELOW: State-appropriated funds enable Abilene State School to customize wheelchairs for the handicapped in all state facilities on a cost reimbursement basis. School craftsmen make sized-to-fit seats and backs and also fabricate prescriptive footrests, leg braces and other items. Here, trainer Linda Lazarin entertains a resident who is being fitted for a lap tray. Photo courtesy of *Abilene Reporter-News. RIGHT: Because movement experiences are important to the development of children, recreation therapist Linda LaBar designed a special playground adapted for use by the multihandicapped residents of Denton State School. After the playing, those residents on wheels can quench their thirst from a fountain constructed with their needs in mind.* Photo by John Stark.

Conference Calendar

Feb. 16-17
Child Abuse Conference
Ninth annual conference
Held in Dallas
Registration: $25, or $17.50 for full-time students
Contact: Mental Health Association of Dallas County
2500 Maple Ave.
Dallas, TX 75201
(214) 748-7825

Feb. 20-21 (22nd annual institute)
Feb. 21-24 (35th annual conference)
American Group Psychotherapy Assn., Inc.
Held in New Orleans
Contact: American Group Psychotherapy Assn., Inc.
1995 Broadway, 14th Floor
New York, NY 10023
(212) 787-2618

March 3-5
Time/Life Planning: The Seasons of Our Lives
March 7-9
Coordinating Human Services II: Applications
March 15-17
Group Leadership Skills
April 3-5
Depression: Theories and Treatment
April 27-28
Coping With Stress
May 8-10
Applied Research Methods for Decision Makers
May 10-12
Crisis Intervention: A Workshop for Practitioners

May 22-24
Assertion Skills for Women in Management
Held in Austin
Fees range from $50-$70
Contact: Continuing Education Program
Center for Social Work Research
School of Social Work
The University of Texas at Austin
Austin, TX 78712
(512) 471-4387 or STS 821-4387

March 27-31
American Orthopsychiatric Assn., Inc.
55th annual meeting
Held in San Francisco
Contact: American Orthopsychiatric Assn., Inc.
1775 Broadway
New York, NY 10019
(212) 586-5690

★★★ PEOPLE & PLACES ★★★

Newsmakers

★**Exter F. Bell Jr., M.D.**, director of professional services at **Rusk State Hospital**, was named acting superintendent of the facility in January. The former superintendent, **Robert B. Sheldon, M.D.**, was discharged from his post following an investigation of alleged abuses at the hospital last fall. His first replacement, **Robert M. Inglis, M.D.**, served as acting superintendent until Dr. Bell was named. Dr. Inglis has now returned to his full-time position as superintendent of **San Antonio State Hospital.**

★**B. R. "Bill" Walker, Ph.D.**, superintendent of **Austin State School**, has been appointed by Gov. Dolph Briscoe to the Texas State Board of Examiners of Psychologists.

★**Larry Cotten, Ed.D.**, assistant to the superintendent of **Vernon Center**, has been named director of the Vernon Project for Drug Dependent Youth, the center's south campus. Dr. Cotten fills a position left vacant by the resignation of **Kenneth Coleman**, who moved to Huntsville following his appointment late last year as one of six commissioners of the Texas Board of Pardons and Paroles.

★**Peter Churchill**, occupational therapist at the Vocational Education Center (VEC) of **Wichita Falls Community MHMR Center**, has been commended by VEC program manager **Phyllis Blagg** for his emergency action during a grand mal epilepsy seizure suffered by a special education student. When Churchill reached the girl, he found no pulse or breathing.

Churchill cleared her airway and began cardiopulmonary resuscitation (CPR) procedures; within minutes, her color returned and her breathing was spontaneous. His skill prevented the loss of a special person. At that time, Churchill was the only VEC employee qualified to administer CPR. The entire VEC staff has since been trained.

★**John J. Kavanagh, M.D.**, assumed the duties of deputy commissioner for mental health services for TDMHMR Jan. 3. Dr. Kavanagh formerly served as a psychiatrist and director of residential services at **San Antonio State Hospital.**

★Appointment of seven members to the Texas State Mental Health Advisory Council was confirmed in December by the Texas Board of MHMR.

The new council members are:

Charlotte Douglas of Plano and **Arturo Volpe, Ph.D.**, of Laredo, representing consumers of mental health services.

David F. Briones, M.D., of El Paso, assistant professor of psychiatry, Texas Tech University School of Medicine, and **Leonard E. Lawrence, M.D.**, of San Antonio, a member of the medical staff at San Antonio Children's Center, representing providers of mental health services.

Frank A. Borreca, Ed.D., of Houston, executive director of the Harris County Center for the Retarded, Inc., representing nongovernment organizations.

Stan Pinder, Ph.D., of Austin, director of community services, Texas Youth Council, and **Vernon M. Arrell Jr.** of Austin, deputy commissioner, Texas Rehabilitation Commission.

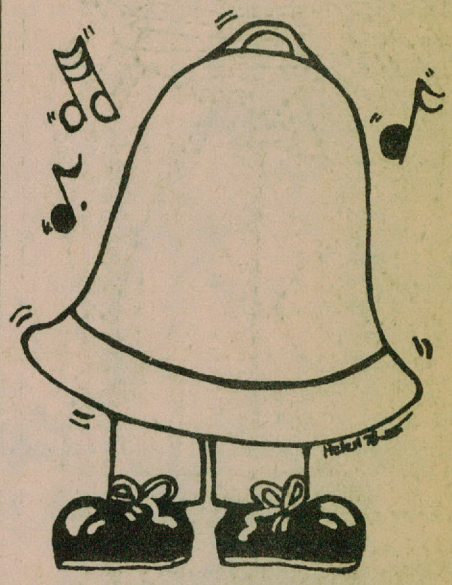
Other members of the council are **Helen Farabee** of Wichita Falls, **Ward R. Burke** of Diboll, **Vivienne Mayes, Ph.D.**, of Waco and **Robert L. Leon, M.D.**, of San Antonio.

The council advises the commissioner on the state's mental health needs and approves the state plan for mental health.

★**Kenneth D. Gaver, M.D.**, resigns as commissioner of TDMHMR effective Feb. 28 to pursue professional activities in the private sector.

★**Gary D. Hughes**, director of personnel and staff development for **Austin State School**, has accepted an invitation from Gov. Dolph Briscoe to serve as the voluntary chairman for state employees' participation in the 1978 savings bond campaign.

★**Gary V. Sluyter, Ph.D.**, superintendent of **Corpus Christi State School**, resigns effective March 15.



With Bells On

Thanks to an unusual donation, mentally retarded clients at **Fort Worth State School** performed during the Christmas season with bells on.

The Xi Alpha Chapter of Beta Sigma Phi donated the funds needed to establish the 30-member Fort Worth State School Bell Choir. The instruments can be played by clients who have limited control of motor skills. By strapping the bells to a wheelchair or to an appendage, the clients are able to play them with little or no trouble. The mallets that are used to strike the bells are also custom-fit according to the client's needs.

The musical group is directed by a special education teacher who uses verbal and visual cues. Both methods are necessary because some of the musicians are also deaf or blind.

The bells help develop eye and hand coordination, self-esteem, social behavior skills and music appreciation. Also important is the fact that the clients are learning to take personal pride in properly caring for the equipment. The school plans to utilize the bells in its programs throughout the year.

Workshops For Judges

The mental retardation services division of **Central Office** has received a $50,000 developmental disabilities grant to conduct a series of five regional training workshops for all county judges and judges with juvenile court authority in Texas.

The subject of the workshops is the role and responsibility of the judges in relation to the Mentally Retarded Persons Act of 1977, the Limited Guardianship Act, the mentally retarded juvenile offender and the Texas Advocacy and Protective Services System.

The first workshop was scheduled for Lubbock Jan. 25-26. Others will be held as follows: Odessa, Feb. 28 and March 1; Austin, March 22-23; Houston, April 5-6; and Dallas, April 26-27.

David B. Sloane is special project director for the workshops.

What's New

★**Wichita Falls Community MHMR Center** has graduated the first class of paraprofessional aides within TDMHMR to be trained in a curriculum whose development was funded by a grant from the National Institute of Mental Health.

★Because a volunteer is someone who cares, **Lufkin State School** counts among its volunteers the men of Eastham Unit of the Texas Department of Corrections. For the past three years, they have collected money to provide a better Christmas for the school's residents. This year, the men presented a check for $1,300 to Sheila Champion, coordinator of volunteer services for the school.

★When their son was a seven-year-old resident of **Austin State School**, Mr. and Mrs. James Robinette of Bryan began a project to provide candy for the school. Today, 13 years later, the couple's efforts continue to make available a steady supply of candy, especially for holidays, for their son and his friends.

Citizens of the Bryan area, particularly employees of Texas A&M University where Mrs. Robinette is employed, donate money to purchase candy from a wholesaler who also contributes to the cause. Personnel of the 420th Engineer Brigade's Headquarters Company, who make regular trips to Austin, deliver the treats.

★Two large grants boosted progress on the natatorium planned for **Richmond State School** residents. With awards of $175,000 from the George Foundation and $150,000 from the Moody Foundation, the school's Volunteer Services Council is well on its way to collecting the more than $300,000 needed to cover the largest pool on campus to provide year-round enjoyment of the facility.

Peer Review

A major annual task of **Deep East Texas Regional MHMR Services**, headquartered in Lufkin, is the peer review evaluation. The approach adopted by the board of trustees is an unusual method for community MHMR centers in Texas. Rather than conduct an internal peer review subject to built-in biases or have one handled by a group from another MHMR center, the Deep East Texas approach is to use an external evaluation team.

The psychology department at Stephen F. Austin State University was contracted to conduct the peer review. The review included a rating of mental health, mental retardation and chemical dependency services; educational, social work and medical services; administrative and support services; and a client satisfaction survey.

This last section of the evaluation can be one of the most important ways for assessing the quality of human services. Through the survey, the peer review team received direct client feedback concerning accessibility of the agency, reception by agency personnel, speed of service delivery, status of the presenting problem or situation, helpfulness of staff, amount of time spent in problem resolution, willingness to recommend services to others, willingness to make future contacts with agency and opinion of overall services.

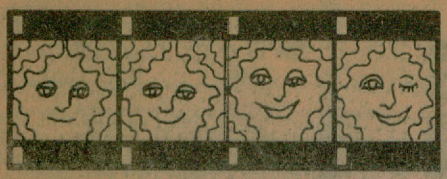
The results of the peer review process utilizing an outside objective evaluation team proved to be an overwhelming success. The review pointed out both positive and negative aspects of the services offered, providing information of significant benefit to both the administrative and direct services staff members.

Let's Play

The Joseph P. Kennedy, Jr. Foundation, whose Special Olympics now involves more than 650,000 mentally retarded children and adults, has developed a comprehensive curriculum of play and recreation activity to be used by parents and teachers of physically, mentally and emotionally handicapped children.

One feature of "Let's-Play-To-Grow" is its self-contained incentive and award program. When a class or a family has completed 30 hours of any kind of play outlined in the guides, each child receives from the Kennedy Foundation a colorful press-on patch featuring a favorite athlete or celebrity and a certificate of achievement signed by that person.

Information on "Let's-Play-To-Grow" can be obtained by writing to Mrs. Eunice Kennedy Shriver, The Joseph P. Kennedy, Jr. Foundation, 1701 K St., N.W., Suite 205, Washington, DC 20006. The price per kit, including incentive materials for up to 60 hours of play, is $2.50.



New Films

Funds made available by the community services division of **Central Office** have enabled the purchase of new films for the department's film library. Distribution of the films---available on two-week loan to responsible individuals or groups in Texas---is handled along with health films by the Texas Department of Health film library.

Titles include "Child/Parent Relationships" (ways to have fun together and learn at the same time), "Count Me In" (normalization for the handicapped), "One Step at a Time" (an introduction to behavior modification), "Troubled Campers" (documentary of emotionally disturbed boys), "Try Another Way Film Training Series" (eight films about Dr. Marc Gold's methods of teaching the severely mentally retarded complex tasks) and "Wednesday's Child" (genetic counseling).

For a film catalog (or a list of new films only, or both) plus ordering information, write Judy Osborn, Arts, Graphics and Educational Services, TDMHMR, P.O. Box 12668, Capitol Station, Austin, TX 78711.

Home to Roost

A bird in the aviary is worth two in a bush to Kerrville State Hospital patients who have a chance to feed the pigeons and guineas housed in this newest addition to the hospital grounds. Designed and constructed by maintenance employees of the facility, the aviary is 20 feet high and 40 feet wide. Supporting pipes provide roosting space, and a plastic shade cloth offers protection from sun and rain.

IMPACT

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