IMPACT

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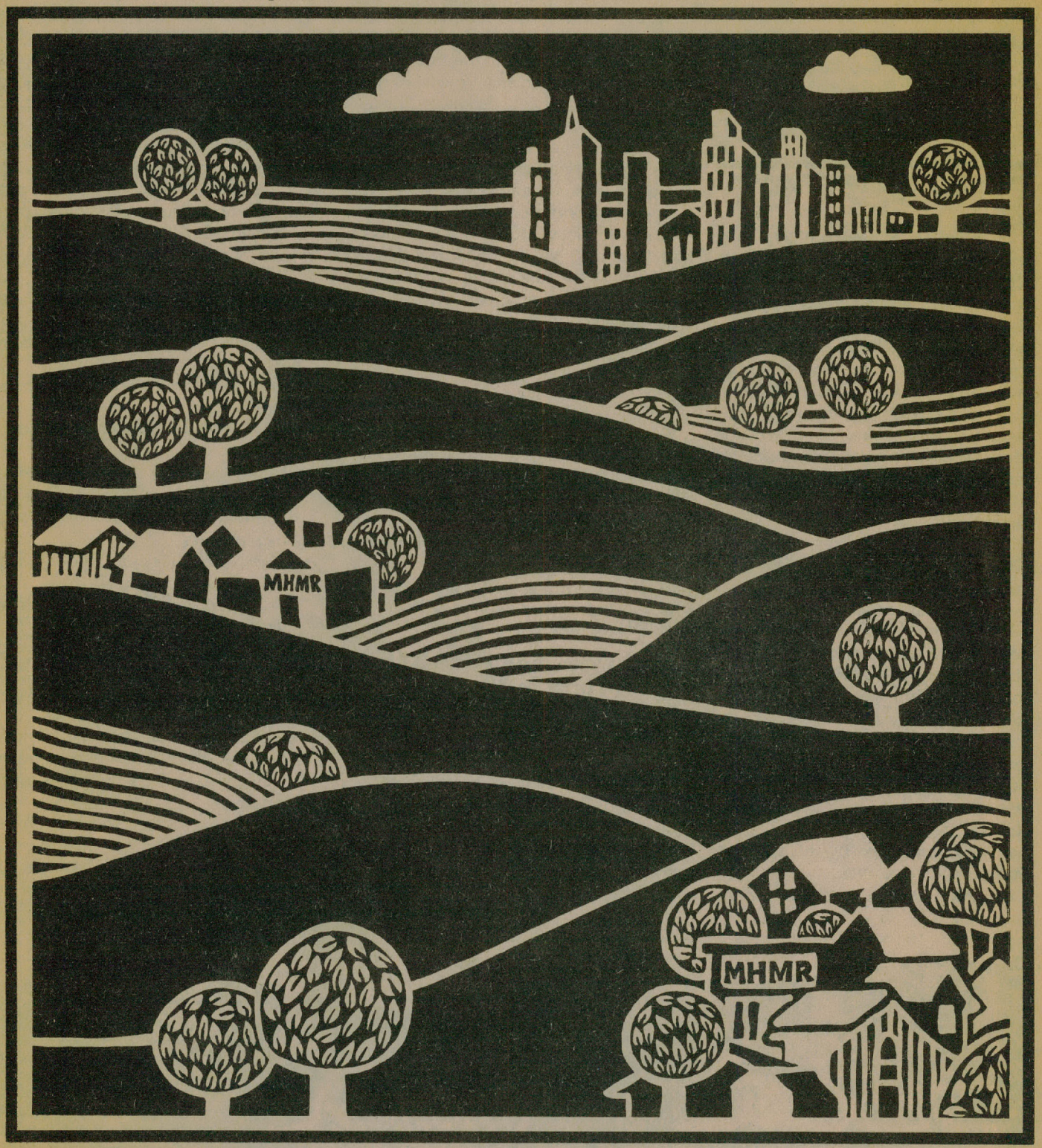


A Guide to Our Community Mental Health and Mental Retardation Centers►

Texas Centers

What Is a Community Mental Health and Mental Retardation Center?

Often called "MHMR centers," they provide a wide variety of mental health and mental retardation services to Texas citizens close to their homes. The goal is to make programs easily available so people can achieve more normal and satisfying lives within the circle of family, friends and community. The centers help avoid unnecessary admissions to psychiatric hospitals and residential facilities for the mentally retarded, and they help discharged clients readjust to life in the community.

The first Texas center opened in 1966, and there are now 30. The names vary, but most are named after their region, city or county and contain the words "MHMR Center." Each provides service to one or more counties; although some counties aren't assigned to a center, most of the state's population has access to services.

Local agencies—usually a city, a county, a hospital district or a school district—may establish and sponsor a center. Each is governed by a board of trustees, generally consisting of nine members, appointed by the sponsoring agency or agencies.

Community centers receive money from many sources. At the local level, sponsoring agencies provide direct funding and even buildings. Local money also may come from contracts with other agencies, from client fees and from donations. This community support is important because state and federal governments often require a center to obtain local dollars before their funding will be made available.

Most of the state money received by centers comes from grants-in-aid given by the legislature to the Texas Department of Mental Health and Mental Retardation (TDMHMR), which sets rules and standards to ensure adequate services. Centers also may receive money through contracts with other state agencies, and from the federal government through a number of agencies and programs.

These independent community MHMR centers are the subject of this booklet. Similar services are provided in some small communities by outreach centers operated directly by TDMHMR residential facilities.

How Does Someone Know If Help Is Needed?

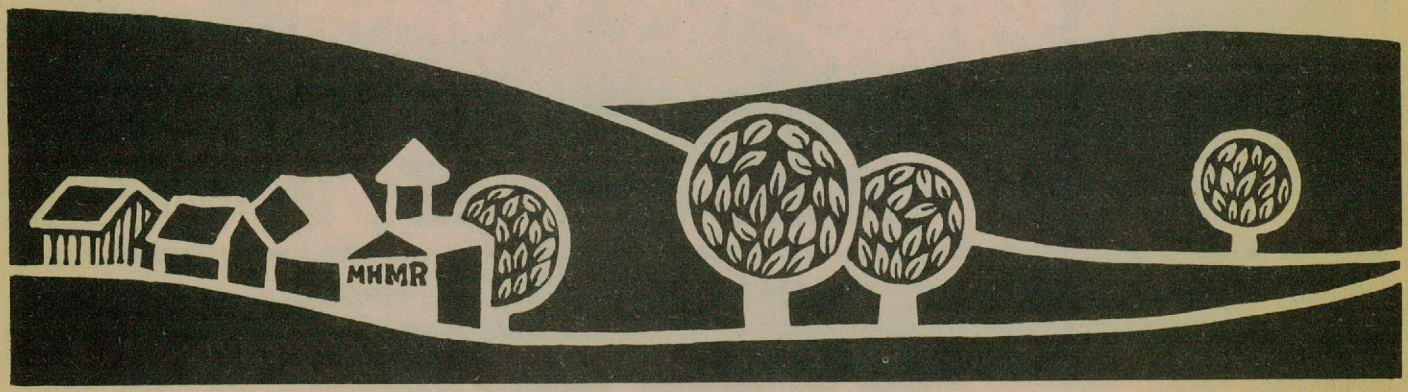
Mental health. A mentally healthy person can cope with life. Things happen that cause anger, anxiety and fear, but these feelings should only be temporary, not a common response to life's everyday problems.

Sometimes, however, problems and frustrations can make anyone unable to enjoy life or take care of responsibilities. That is why centers are available. Although neighbors, friends and family may comfort by listening and advising, there are occasions when an objective, professional opinion is needed. A center can help with emotional problems, with difficulty in relationships, with adjustment to disturbing events. Therapy can help someone gain more control over life, reduce stress and get along better with others.

These signs may indicate help is needed:

- Deep anxiety, a state of constant fear.
- Depression that takes hold and is followed by withdrawal, loss of confidence and a feeling of helplessness.
- Abrupt changes in mood and behavior.
- Poor performance in school or at work.
- Hostility and aggression toward others.
- Disruption at home or at work because of drinking or drugs.
- Inability to cope with a new job, divorce, death, retirement or other challenges and changes that must be faced.

Although some problems, such as chronic bed-wetting, and some physical ailments, such as allergies or asthma, are not usually thought of as



signs of emotional disturbance, they too may signal a need for psychological help.

Mental retardation. Children and adults who are slow to develop and learn may benefit from center programs. The earlier treatment and training begin, the more effective they can be in assisting people to cope with developmental handicaps, both mental and physical.

People in these situations should consider seeking help:

- A couple is planning to have a baby (or the woman already is pregnant), and they wonder if their child will inherit a defect. Genetics screening can determine the chances of that happening, and counseling can provide family support.
- A new baby is not growing as fast as most other babies the same age, and seems less responsive and slower to walk and talk. Infant stimulation programs can promote a child's development and prevent more serious problems.
- An adult, once slow to learn in school, now is having trouble organizing everyday matters and taking on responsibility. There are problems managing money, finding a place to live and getting a job. To help, centers offer special education, job training, sheltered workshops and group living.

What Services Are Offered?

Each center is managed and staffed by local people and tries to meet the needs of its community with a full range of programs. Generally these include:

Diagnosis and evaluation. This screening procedure helps identify mental health problems and recommends the services best suited to the client's needs. The process also is used to determine eligibility for mental retardation services.

Referral. A person must have many needs met in order to lead a useful and happy life. So, in addition to providing direct help, center staff tell clients of other places that can assist them in such ways as employment, housing, education, physical health and financial support.

Outpatient services. Individual counseling, the most common type of therapy, helps people talk about their problems and find different ways to deal with them. Medication may be prescribed. Sometimes what seems to be an individual problem actually requires treatment for the whole family. If the therapist can lead the family members to see each other in a new light, then their relationships with each other can improve. Group therapy takes place when a few people gather to discuss their individual problems under the guidance of a therapist who offers insights as needed. Play therapy may be recommended for young children because they can communicate their problems well this way. Many centers also have special programs for certain age groups, such as adolescents and the elderly, or for certain problems, such as alcohol and other drug abuse.

Inpatient services. Short-term, 24-hour hospital care includes comprehensive treatment programs for emotional and medical problems.

Day activities. Part-time care allows clients to maintain daily contact with family, school and work while spending days, evenings or weekends in a program that gives emotional support and encourages personal growth.

Emergency services. These are available around the clock for people who need immediate help. Emergency services include telephone hotlines and walk-in counseling.

Consultation and education. Center staff members share their knowledge and skills with community agencies, businesses and individuals who want help or information. The service may be in the form of consultation on particular problems or classes on popular topics. Also, centers work with other community groups—including schools, police and social service agencies—to try to solve local problems.

Workshops. Work activities and job training in a sheltered environment teach productive skills and can lead to employment.

Group homes. Supervised living in the community offers structure for those who are not fully independent.

Education and training. For those whose mental disabilities prevent them from joining ordinary classrooms, special classes are held to stimulate the senses, encourage motor development, teach personal and social skills and provide academic instruction.

Who Can Help?

A center staff consists of people trained to help clients cope more effectively and reach their full potential.

Clinical psychologists, for example, are trained in the area of human behavior to measure personality and intellectual traits and to treat emotional difficulties. *Occupational therapists* help clients develop lifetime skills, and *recreational therapists* improve social and activity skills. *Psychiatric nurses* are professionals trained in prevention and treatment of mental health problems. *Psychiatric social workers* provide referrals and consultation, diagnose problems and conduct individual counseling. *Psychiatrists* are medical doctors with special training in mental disorders and are licensed to prescribe medicine.

Are Records Kept Confidential?

A client's right to privacy is important to the center staff. In addition, many laws protect the right to confidentiality, so disclosure of information without consent is severely limited.

How Much Does It Cost?

Fees are based on each client's ability to pay, considering income and number of dependents. Even if the client is unable to pay anything, services still are available. Sometimes health insurance policies help cover the expense.

How Can Someone Find a Center?

The 30 centers operate scores of programs throughout the state. To find a service location near you:

•Look in the yellow pages in the telephone directory under "Mental Health Organizations," "Clinics" or "Health Agencies."

•Call the local Mental Health Association or Association for Retarded Citizens. These are citizens' volunteer groups that can provide referrals. The state offices also can help:

Mental Health Association—Texas
103 Lantern Ln.
Austin, TX 78731
(512) 459-6584

Association for Retarded Citizens—Texas
833 Houston
Austin, TX 78756
(512) 454-6694

•Ask a doctor or clergyman for help, or call the local public health department.

•Call or write for a directory of services from:

Public Information Services
Texas Department of Mental Health and Mental Retardation
P.O. Box 12668
Austin, TX 78711
(512) 465-4540

•Call or write the nonprofit organization of Texas centers:

Texas Council of Community MHMR Centers Inc.
1800 Houston, Suite 132
Austin, TX 78756
(512) 458-4159 or 458-4150

•Contact the community mental health and mental retardation center that serves your county:

ABILENE
Abilene Regional MHMR Center
915-698-3016 (Adm.), 698-2510 (Clinic)
P.O. Box 3253 (79604)
733 S. Leggett
Serving: Callahan, Jones and Taylor Counties

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

AUSTIN
Austin-Travis County MHMR Center
512-447-4141
1430 Collier (78704)
Serving: Travis County

BEAUMONT
MHMR of Southeast Texas
713-838-6203
P.O. Box 192 (77704)
2750 S. 8th St.
Serving: Chambers, Jefferson and Orange Counties

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

COLLEGE STATION
Brazos Valley MHMR Center
713-696-8585
P.O. Box 4588, Bryan (77801)
Texas 707 Complex, 707 Texas S., Suite 102-103D
Serving: Brazos, Burleson, Grimes, Leon, Madison, Robertson and Washington Counties

CORPUS CHRISTI
Nueces County MHMR Community Center
512-888-5321
1630 S. Brownlee (78404)
Serving: Nueces County

CORSICANA
Navarro County MHMR Center
214-872-2491
P.O. Box 1735 (75110)
216 N. Main
Serving: Navarro County

DALLAS
Dallas County MHMR Center
214-630-6100
1200 Stemmons Tower N.
2710 Stemmons Frwy. (75207)
Serving: Dallas County

DENISON
MHMR Services of Texoma
214-786-2902
203 Airport Dr. (75020)
Serving: Cooke, Fannin and Grayson Counties

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

EL PASO

El Paso Center for MHMR Services
915-533-1961
P.O. Box 9997 (79990)
1801 Wyoming
Serving: El Paso County

FORT WORTH

Tarrant County MHMR Services
817-335-5371
P.O. Box 2603 (76101)
1319 Summit Ave.
Serving: Tarrant County

GALVESTON

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

HOUSTON

MHMR Authority of Harris County
713-526-2871
P.O. Box 25381 (77005)
2501 Dunstan
Serving: Harris County

LONGVIEW

Sabine Valley Regional MHMR Center
214-297-2191
P.O. Box 6800 (75608)
Hwy. 80 at Sun Camp Rd.
Serving: Gregg, Harrison, Marion, Panola, Rusk and Upshur Counties

LUBBOCK

Lubbock Regional MHMR Center
806-763-4213
1210 Texas Ave. (79401)
Serving: Cochran, Crosby, Dickens, Garza, Hockley, King, Lubbock, Lynn, Terry and Yoakum Counties

LUFKIN

Deep East Texas Regional MHMR Services
713-639-1141
4101 S. Medford Dr. (75901)
Serving: Angelina, Hardin, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity and Tyler Counties

MCKINNEY

North Central Texas MHMR Services
214-542-9411
P.O. Box 387 (75069)
202 W. Louisiana St., Suite 201
Serving: Collin, Denton and Hunt Counties

MIDLAND

Permian Basin Community Centers for MHMR
915-563-0271
3701 N. Big Spring (79701)
Serving: Ector, Midland and Pecos Counties

PLAINVIEW

Central Plains Comprehensive Community MHMR Center
806-296-2726
2700 Yonkers (79072)
Serving: Bailey, Briscoe, Castro, Floyd, Hale, Lamb, Motley, Parmer and Swisher Counties

SAN ANGELO

Concho Valley Center for Human Advancement
915-655-8965
244 N. Magdalen (76903)
Serving: Tom Green County; contracts with Coke, Concho, Crockett, Irion, Reagan and Sterling Counties

SAN ANTONIO

Bexar County MHMR Center
512-225-4011
434 S. Main, Suite 400 (78204)
Serving: Bexar County

STEPHENVILLE

Pecan Valley MHMR Region
817-965-7806 (Adm.), 968-4181 (Clinic)
P.O. Box 973 (76401)
455 N. Belknap
Serving: Erath, Hood, Palo Pinto, Parker and Somervell Counties

TEMPLE

Central Counties Center for MHMR Services
817-778-4841
P.O. Box 518 (76501)
302 S. 22nd St.
Serving: Bell, Coryell, Hamilton, Lampasas and Milam Counties

TEXARKANA

Northeast Texas MHMR Center
214-793-7585
P.O. Box 5637 (75501)
1614 Hampton Rd.
Serving: Bowie, Cass and Red River Counties

TYLER

MHMR Regional Center of East Texas
214-597-1351
P.O. Box 4359 (75712)
2323 W. Front St.
Serving: Henderson, Rains, Smith, Van Zandt and Wood Counties

VICTORIA

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

WACO

Heart of Texas Region MHMR Center
817-752-3451
P.O. Box 1277 (76703)
110 S. 12th St.
Serving: Bosque, Falls, Freestone, Hill, Limestone and McLennan Counties

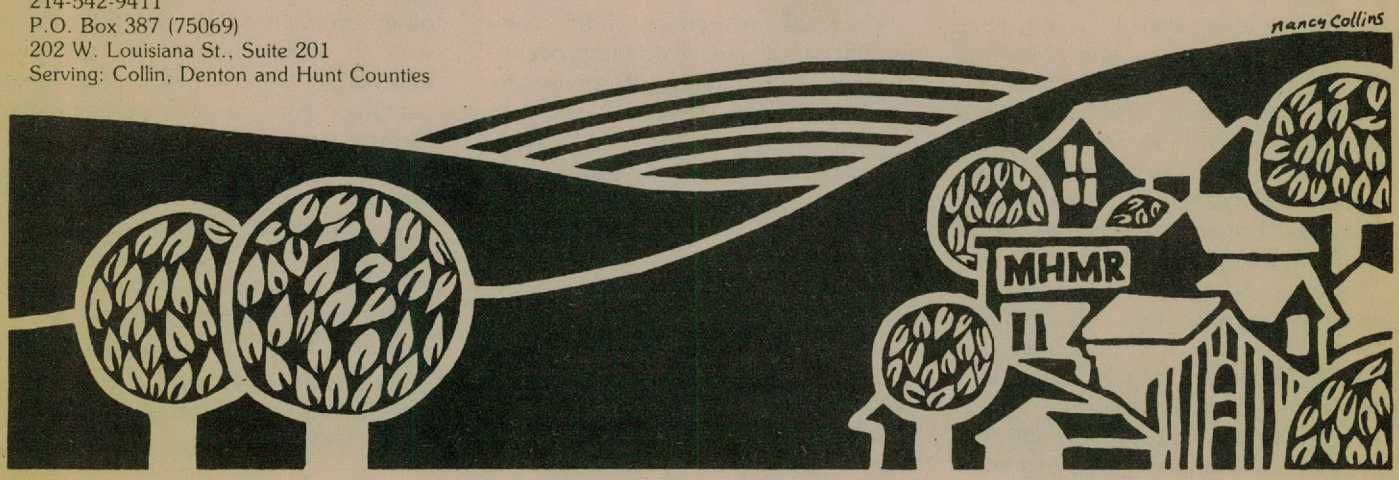
WICHITA FALLS

Wichita Falls Community MHMR Center
817-322-1196
1800 Rose St. (76301)
Serving: Wichita County

Remember...

The community MHMR centers are there to help. Everyone has problems with daily living at one time or another. If you need help, give a center—and yourself—a chance to make things better.

This material is available as a brochure in limited quantities; order from Harley Pershing, Director, Public Information Services, P.O. Box 12668, Austin, TX 78711. Reprinting permission is not necessary, but a credit line is appreciated. Each community MHMR center information director already has copies for local distribution.



Not By Bread Alone

By Callie Streitmatter

When your service area ranges from farmland to rapidly expanding cities, you need both rural and urban approaches to serve all the children and aged citizens effectively.

That's the way North Central Texas MHMR Center is meeting the needs of Denton, Collin and Hunt Counties, says Gary Smith, executive director of the McKinney-based center.

To design programs for rural residents the staff takes into consideration their isolation and need for self-reliance. That approach has led to Health Bread Fairs held periodically in area churches.

But why combine bread with mental health? The idea originated with research into area needs by a task force composed of blacks and Mexican-Americans. Their recommendations resulted in linking with an agency already successful in securing the trust of rural citizens—the Texas Agricultural Extension Service. The service's existing bread fairs became a vehicle for mental health education as well.

One recent fair for 40 grandparent- and grandchild-aged participants began with a movie and discussion on "Using Medicines Wisely." This was followed by trained minority volunteers leading everyone through the steps of a breadmaking-in-a-bag technique of yeast preparation. Then they shaped their loaves of bread, placed them in pans and hurried home to bake them.

The Health Bread Fairs are designed to:

- Create a positive image of mental health services and aging.
- Utilize existing resources and set precedents for local agency coordination.
- Reach out to area minority aged.
- Disseminate mental health self-help materials and provide mental health education concerning substance abuse among the elderly.
- Aid intergenerational understanding.
- Increase awareness of the community center service and improve accessibility to mental health services for aged residents.

Another program for rural residents will use bilingual paraprofessionals who try to prevent children's mental health problems by strengthening families through in-home parenting education. Other staff members will make home visits to assess older persons in crisis and make friendly calls on the homebound and institutionalized aged. Still in the planning stage is a training program for postal employees to help them spot elderly alcoholics through signs of household neglect, such as mail and newspapers not picked up.

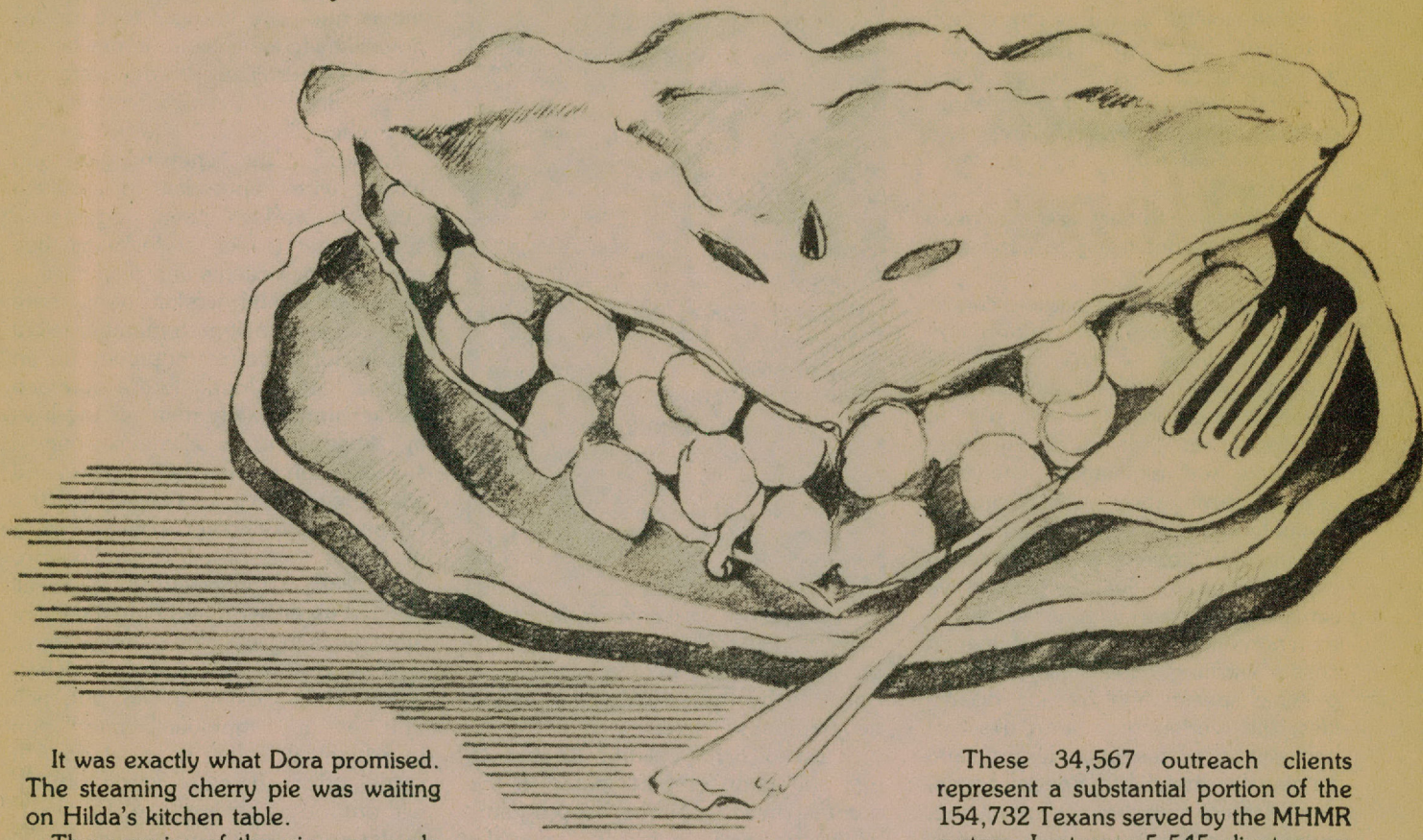
In Plano, an urban area, a volunteer resource brokerage is being planned to match trained older volunteers with single, working and/or recently moved families with young or problem children. The needs of older persons to contribute, influence and express are met by meeting these families' needs for extended nurturing.

A program serving families in both rural and urban areas involves volunteers who develop puppet materials and methods to work through traumas and difficulties associated with their children's developmental disabilites, mental retardation, terminal illness or other problems. The puppets are a way to utilize humor for effective education of both children and aged persons. Kits containing puppets, scripts and other materials are available on request for use by parents, day treatment programs or other community groups.

In North Central Texas they know that man does not live by bread alone. Mental wellness is important too. ■

Callie Streitmatter is coordinator of programs for the aged, for children and for volunteers at North Central Texas MHMR Center.

...Cherry Pie Is Nice, Too



It was exactly what Dora promised. The steaming cherry pie was waiting on Hilda's kitchen table.

The promise of the pie was made when Hilda was a client at the Big Spring State Hospital. Dora, the hospital outreach worker, had known Hilda all her life. They had grown up together in the same small town; they had the same friends.

Throughout Hilda's hospitalization Dora worked tirelessly to build the home support she instinctively knew Hilda needed at the hospital and when she could return to her family and hometown.

Dora arranged transportation in the hospital van for Hilda's neighbors to come to visit at the hospital. Several times Hilda went home and attended church picnics and family parties. Dora and Hilda talked about local people and events they had read about in the weekly paper Dora always brought along for the drive to and from home. This was part of Dora's effort to hold tight to the part of Hilda that was well.

When the date of Hilda's hospital discharge was certain, Dora, knowing it was a favorite of Hilda's, promised, "The day you go home there will be a hot cherry pie on your kitchen table waiting for you. I'll make it myself."

That pie helped to ease Hilda's tension. As the family gathered around the table and enjoyed the treat, they quickly began to talk and laugh as they always could before Hilda entered the hospital.

Not all of them received hot cherry pie but approximately 35,000 Texas citizens did benefit last year from the neighborliness of outreach workers employed at the many community programs of the TDMHMR facilities.

These clients live in rural areas, small towns or places isolated from MHMR residential or specialized services.

Last year 26,925 clients turned to neighborhood programs operated by the eight state mental hospitals, Rio Grande State Center for MHMR in Harlingen and the Texas Research Institute of Mental Sciences in Houston.

Another 7,642 had need of outreach services of the 13 state schools for the mentally retarded and the 4 state centers for human development.

These 34,567 outreach clients represent a substantial portion of the 154,732 Texans served by the MHMR system. Last year 5,545 clients were residents of the mental hospitals and 10,150 were enrolled at the schools. An additional 104,470 were clients of the 30 community MHMR centers.

What are the services outreach units offer? It is rare for any client to need a single service one time only.

As in the case of Hilda, most clients need supportive help over a period of time and by staff members possessing a variety of skills. It may begin at the time of the initial screening for admission to the MHMR facility. Repeated individual, group and family therapy sessions may follow, throughout hospitalization and following discharge.

With or without hospitalization outreach clients may require home visits, transportation, medication, home management supervision, emergency care, vocational counseling and resocialization training. Throughout these difficult times for clients and their families the concerned help of neighbors who happen to be outreach workers eases the difficult way.

Diagnosis and evaluation and family

counseling are at the top of the list of services needed by mentally retarded clients of the school and human development center outreach programs.

Other services available at MR outreach centers include individual and group therapy sessions, vocational rehabilitation counseling, special education classes, social rehabilitation, emergency care, staff home visits, parent training in infant stimulation, speech and hearing testing and therapy, work activity and sheltered workshop training.

The family members also may need therapy and counseling to cope with their needs.

This extensive list of services can be translated into terms of support and human kindness.

A caring MR outreach worker is on hand to give constructive support to the family at that crucial time of diagnosis and evaluation when the family learns their loved one is evaluated as mentally retarded.

Outreach workers promptly set in motion plans for years of supportive service. It may start with home visits to train parents properly to stimulate their child's learning capabilities. Alert to possible speech and hearing disabilities, the worker may see clues that necessitate professional testing and training for the client. Special education classes may be set up. Other outreach workers become involved as the client progresses toward training in work activity, sheltered workshop skills and home management.

Rewards for both worker and client come when it's time for a mentally retarded client to open a bank account with a workshop paycheck or to rent a suitable place to live. The outreach worker is on hand to applaud and guide each success.

The TDMHMR outreach services are used by clients of all ages.

Statistics on client usage last year show almost half (11,576) of those participating in mental health programs were in the age group 22-44 years. This age group also was the predominant user of outreach services operated by the state schools and the state centers for human development. That total last year was 3,168.

The second highest group in its use of mental health outreach services was 45 to 64 years old. That number last year was 5,836. Programs for the mentally retarded attracted only 973 clients in that age bracket.

For more information...

The National Association for Rural Mental Health is an organization of professionals and citizens interested in enhancing the delivery of mental health services to rural areas. This is accomplished by promoting and representing the unique needs and concerns of rural mental health programs and by sharing problems and solutions.

Membership is open by a donation of $10 or more per year. Members receive the *Rural Community Mental Health Newsletter* and a discount on the registration fee for the annual Rural Mental Health Summer Study Program in Madison, Wis. For more information contact U.W.E.X. for Rural Mental Health, 414 Lowell Hall, 610 Langdon St., Madison, WI 53706.

The number of clients 65 years and older totaled 3,970 in mental health programs and 177 in outreach services operated by the schools and human development centers.

A total of 1,935 children 12 years of age and younger participated in the mental health outreach programs while the services for the mentally retarded had 1,939 clients in that category.

Clients aged 13 to 21 years totaled 3,608 in the mental health program and 1,355 in the services for the mentally retarded.

More than half of all TDMHMR outreach clients (18,154) last year were females.

What about the ethnic origin of these clients? Although Anglos made up the majority (22,548), Spanish surnames are recorded for 6,577 and blacks numbered 5,066 of all outreach clients. There were 224 clients from other ethnic groups and the origin of 152 clients is unknown.

Not all clients are poor. The income of 8,191, about a fourth of all clients, was reported to be less than $50 a week. The $50-$99 weekly income level included another 5,002 clients. Clients with weekly incomes of $300 or more numbered 2,989.

This mix of client backgrounds, capabilites and needs daily confronts the MHMR outreach worker. Each worker has a minimum of readily available resources and must improvise. Using native, creative and imaginative skills, each worker quickly develops a network of friends willing to help, material resources available and services to be used. These elements often are brought together innovatively to aid a client. It may be impossible or unlikely to duplicate the same combination as effectively for any other client.

Experts at the "chewing gum and bailing wire" approach to survival, outreach workers patch together a system that works for them as they combine their clients and resources.

The alert MH worker does more than overhear a church member tell of a need for a live-in companion for an invalid parent. Mentally the outreach worker immediately matches the live-in situation to a client seeking a suitable community placement and who is ready to be discharged from the hospital. The worker could keep a protective eye on such a situation, make certain the client continues all needed medication and help the client adjust to living again in a familiar area.

A state school's outreach psychologist, while driving to an outreach unit, sees an "Employee Wanted" sign in a highway coffee shop window. It could offer an ideal work setting, without too much pressure, for a particular mentally retarded client from that area. The client is currently a school resident but completing work activity training. It only takes a few telephone calls, family visits and a promise of continued support and the process begins for a new, more independent life for that client, close to home and the client's family.

It was the same concern that made the difference for Hilda, throughout her hospitalization at Big Spring State Hospital. Dora, her outreach worker and longtime friend, created support for Hilda among her family and friends at home. They were told how much Hilda's recovery depended upon their help and attitudes. Dora kept Hilda's links with her church and community strong. When the day of discharge arrived, it was completely natural for Dora to make the extra effort and welcome Hilda home with a cherry pie. It was, for Dora, the neighborly thing to do.

Ask any dedicated outreach worker. That's what their work really is all about: helping neighbors in need. ■ *H.C.*

Too Much Geography, Too Few Resources

By L. Brent Walker and W.R. McAlpin

The past 10 years have seen a growing concern about mental health services in predominantly rural areas. Yet, despite this increased awareness, there still are those who say there is no real difference in providing services in a rural area versus an urban setting. Our response to this irrational belief is an unequivocal "sheep dip"! There are a number of problems unique to rural mental health services which affect both the therapist and the client.

The mental health professional working in a rural area is often highly visible. Off-duty behavior sometimes is closely scrutinized by local residents. Often there is the expectation that mental health professionals should be paragons of mental health.

Isolation from professional peers is common in the rural setting. Rural practitioners have only occasional opportunities to meet and interact with others in the field. If this problem is not countered, it can and does lead to frustration, stagnation and eventual early burnout.

Additionally, the rural practitioner often is forced into being a generalist in terms of clinical expertise. Rural mental health agencies typically are understaffed and cannot afford the luxury of clinical specialization.

Since many rural areas do not offer the recreational and educational advantages to be found in larger cities, recruiting and retaining quality staff to serve in such areas is often difficult. It takes a special type of person to deal with the professional isolation, the high level of responsibility and the autonomy that often exist in a rural setting.

"We at Terrell State Hospital have always been committed to hiring and retaining qualified staff," says Luis M. Cowley, M.D., hospital superintendent. "To this end, I strongly support the effort of Rene Somodevilla [director of Community Programs serving the rural areas] in recruiting and retaining quality staff through appropriate financial reimbursement."

This commitment has resulted in 50 percent of outreach clinical staff having postgraduate degrees, with many of the remainder either presently enrolled or having some graduate study. In addition, the average annual staff turnover in these clinical positions has been only eight percent over the past five years.

"As much as the travel budget will allow, we encourage our staff to attend quality workshops," says Somodevilla. "In this way we seek to counter professional isolation, improve knowledge and skills and provide an opportunity for staff to get out of town." All of this contributes to the continuity of the overall program and enhances the quality of services to the rural area and its residents.

The individual seeking mental health services in a rural area also faces special problems. The first is that of locating appropriate services.

In an urban area one need only pick up a telephone directory to find numerous agencies and private practice mental health professionals who offer a wide range of services. In a rural setting the nearest help may well be in a distant town unfamiliar to the client.

In some parts of the state it may be 50 miles or more to the nearest services, which are often provided by a state hospital outreach clinic or a community MHMR center. (Private practice mental health professionals are few and far between in the hinterlands. Psychiatrists are even more scarce.)

Transportation is the second problem the client faces. There is no public transit system in rural America, folks. If one doesn't own or drive an automobile, it can be tough getting from here to there. Even if one does own and drive an automobile, a 50- to 100-mile round trip for counseling once or twice per week can become rather expensive.

Most rural clinics strive to make area residents aware of available services via educational presentations to civic, church, professional and business groups and by utilizing local news media as much as possible.

Many clinics are willing to have staff make some home visits, although this approach is limited due to high client/staff ratios. Other rural clinics provide satellite clinics to surrounding towns. On the whole, however, these and similar efforts are stopgap (and sometimes sporadic) solutions at best.

In many areas, there is simply too much geography, too many clients and too few resources to meet the needs of the rural citizen.

What are the unique problems of rural areas? What are potential solutions? Can urban models of service be utilized for rural areas? These and other questions are now being asked and answers explored.

A national rural mental health conference has been inaugurated at the University of Wisconsin. President Carter's Commission on Mental Health included a task panel on rural mental health which found rural areas consistently underserved. A number of national organizations concerned with rural mental health issues have been organized during the past 10 years, including the National Association for Rural Mental Health, the National Rural Primary Care Association and Rural America, Inc. Professional associations such as the National Association of Social Work, the American Psychological Association and the National Council of Community Mental Health Centers have become more oriented toward rural concerns. A number of rural journals and newsletters are now being published.

Changes are coming. For those who have long contended with too much geography and too few resources, it is exciting to be a part of this process. ■

L. Brent Walker, ACSW, is the assistant outreach coordinator at Terrell State Hospital. W.R. McAlpin is the coordinator of Outreach Alcoholism Services at Terrell State Hospital.

Photos by Sherry L. Grona

Interview: Mary Ellen Nudd

Mary Ellen Nudd is executive director of the Mental Health Association in Texas.

IMPACT: What is the Mental Health Association?

NUDD: We're a voluntary citizens' advocacy organization with a three-fold mission: to promote mental health, to prevent mental illness and to work on behalf of mentally ill persons.

Our major activities are in education and advocacy. Our chapters do seminars and workshops, but we don't provide direct treatment services. Locally, our members serve on HSA [Health Systems Agency] boards, on PRCs [Public Responsibility Committees], on boards of trustees for mental health centers. At the state level we monitor state agencies and try to educate lawmakers regarding services. We also provide free information about mental health topics.

IMPACT: What are your specific objectives?

NUDD: This year our objectives are primarily in the legislative arena, and in establishing mutual support groups for former mental health clients, and for families of mentally ill persons.

The Mental Health Association put together a legislative platform this year covering four major topics: community services, guardianship, commitment and rights of mentally ill persons.

IMPACT: What legislation are you supporting?

NUDD: Continuity of care legislation. I think Mr. [L. Gray] Beck, chairman of the Board [the Texas Board of MHMR], the board members themselves, and Commissioner Kavanagh have made a real effort to put in place a continuum of services. I think that's evidenced by legislative proposals they put together this year.

There are several continuity of care bills which would help greatly in the development of a real "system" of care in Texas. We're never going to have a true system of mental health care unless every type of service is funded. The continuity of care bills focus on screening patients in communities, to decide whether a state hospital or a local facility is the most appropriate kind of treatment for the individual. The bills also call for aftercare, if needed, at community centers, or elsewhere, once a person is released from a state hospital.

What the association wants to see is the availability of appropriate care—least restrictive care. Right now we have islands of services. Sometimes you're lucky and get the right kind of treatment; sometimes you're not. You can still be put in a mental hospital, because nothing else is available, when all you really need is some good community treatment where you can stay in your own home and maybe keep your job. Of course, some people do need to be hospitalized, and that's okay if it's what they really need.

You can't have a choice unless a continuum of care is available. That means more community services than we now have. The Mental Health Association would like to see, as a start, that 25 percent of the department's budget be allocated for community alternatives. We need to be creative in some reallocation of resources. But we're a long way from that. As it has been, about 90 percent

of the state money has gone to the state institutions; 10 percent has gone to the communities. Yet communities serve about 60 percent of all the people served by the department.

To its credit, the department put communities as their top priority for construction. The first 30 items in the department's construction budget request to the legislature were for community facilities. We support that. First, though, we have to change the law so that community centers can own and purchase property. We are supporting a couple of bills that should accomplish this, as well as the department being able to provide construction money for centers. If that happens, it would be legal to provide funds from the State of Texas to build those facilities.

IMPACT: Are there any other changes you would like to see made by the state legislature?

NUDD: Oh, yes. Flexibility in funding is another important issue. A 15 percent flexibility of funds across line items was requested by the department. This makes a great deal of sense. As needs change, the department should have the authority to transfer funds where they're needed. Otherwise, funds not needed in a program could lapse, and another area that needs funding goes without. The department is supposed to manage mental health care, so they ought to have some flexible funds available to manage.

There are a couple of other legislative items we are also interested in. One is funding for the department's management information system. When I began working for the Mental Health Association eight years ago, one of the first criticisms I heard was about the lack of data available. Everybody agreed it was terrible. It's my understanding that virtually every group studying the department in the past decade—and there have been plenty—has recommended that the information system be revamped.

What else? House Bill 3—the bill that established TDMHMR in 1965—needs to be amended to include mental health centers in the system of care. Right now they're not even mentioned, and that's caused problems. The role of centers in the whole system of care, if we ever get a total system, needs to be more clearly defined.

IMPACT: What things do you want to see the department do?

NUDD: Revision of the Mental Health Code, but they're already paying attention to that.

At the recommendation of the Special Senate Committee on Delivery of Human Services the department set up a fairly broad-based task force this year to attempt to revise the code. Everybody on the task force had at least 10 different things they felt were wrong with it. So it became apparent that a patch-up wouldn't do, and there wasn't time for all of them to agree on what should be in a full rewrite.

Because of the task force's work, there are a couple of good drafts for a new code, but much more needs to be ironed out. The new strategy is to try to get a special legislative interim committee to rewrite the code—with citizen input, of course—and have it ready to go for the 1983 session.

IMPACT: What other changes would you like to see?

NUDD: I'd like to see a lot more services for children. The available services don't begin to touch what we need. Take Houston, for example—no public beds separately and specifically for children. The situation was so bad that a judge refused to allow children to be sent to their public holding facility. The current arrangement is for two public psychiatric observation beds for children at a different hospital. Harris County doesn't operate a single bed for psychiatric treatment of children under 12 years old. This is unbelievable to me.

The report from the President's Commission on Mental Health [in 1978] said that the most effective means of prevention is to help children during their formative years. Texas has a lot of smart people. I bet we would figure out how to improve greatly on what we're doing for children if we really wanted to.

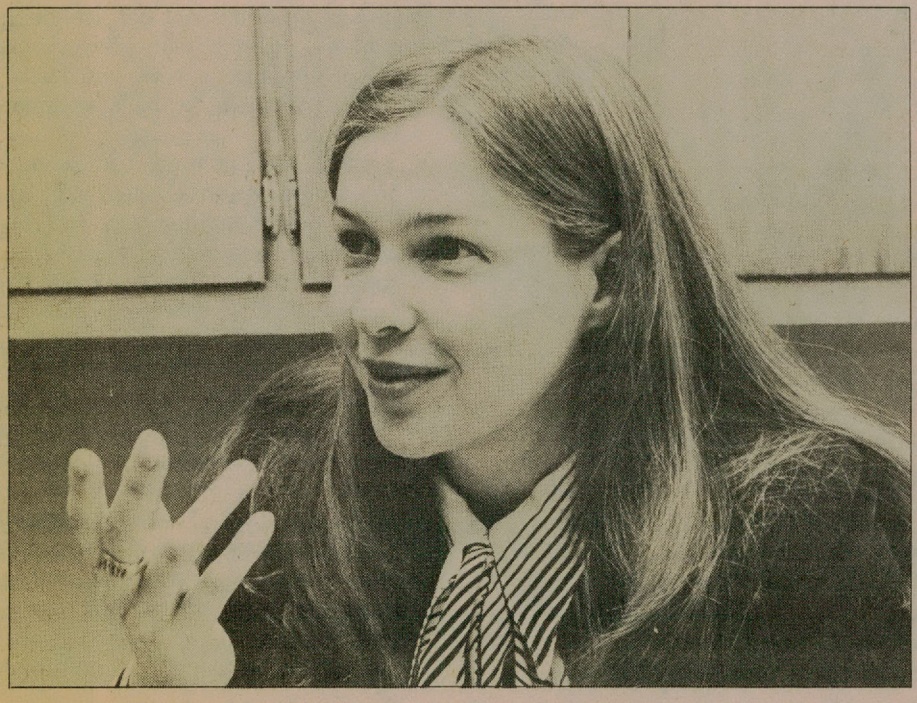
IMPACT: What about the legal rights of mental patients?

NUDD: You have fewer rights as a mental patient than anywhere else in our society. There's a gentleman from Fort Worth who likes to point out that a mental patient really ought to have as many rights as an accused rapist.

Commitment procedures, guardianship, what constitutes "treatment"—these all need to be considered. A new Mental Health Code could go a long way toward assuring and defining rights.

There is one bill now being considered, however, which would help. It's for an internal advocacy system for the department, which we support. It won't solve everything, but it'll help.

If the bill passes, there will be a paid person in each state school and state hospital who would be an advocate on behalf of the clients. This person would not work for the superintendent, but directly for the commissioner. They would talk to new clients, give them a book about their rights and tell them to come back if they have any problems. And they would hold classes for the personnel. I know the institutions do have Public Responsibility Committees [composed



of nonemployee volunteers], but they aren't there every day. When you're having a mental breakdown, it's a very vulnerable time in your life. I think we should do anything we can to help protect these people.

Some are worried it would reduce morale, but I think if it does, it's probably only going to reduce morale of people who are abusing patients. If you're not doing anything wrong, it's not going to be a problem. Nobody on earth can deny there's client abuse in the mental health system. And it's really cheaper and more humane to prevent the kinds of problems that are now coming to court.

IMPACT: In what ways do you cooperate with TDMHMR?

NUDD: One way is in the establishment of peer support groups. Once people get out of the hospitals and return to their communities they sometimes have a hard time adjusting and staying out of the hospital. And their families have a hard time, too. We often get calls from former clients, or family members, who want to meet with other people with the same problems.

We've had no place to tell them to go for mutual support. We checked with the community centers and found no family groups at all, and there were no client groups other than Recovery, Inc., though we have done referrals to them.

The Mental Health Association recognized a real gap, and we set as one of our objectives last year that we would try to promote the establishment of self-help groups.

This is something we discussed with people in the Community Support Program of the mental health section [of TDMHMR], and with their assistance we ended up getting a grant for the project. So last December we hired a coordinator, Dian Cox, to put together self-help groups for families and former patients.

Self-help groups are really popular—to lose weight, to not drink, to not smoke—so this is just another kind of self-help group. Our program is called project FAIR—Family And Individual Reliance. Dian is a former patient herself; she's been hospitalized privately and also at Austin State Hospital. Peer support was very helpful for her, so she is an ideal person to coordinate this project.

You know, if you're a patient sitting in a hospital, you may feel nobody ever makes it out of there, or if they do they're not doing anything productive. There's a woman in Minnesota who works with Project Overcome; she once asked, "Would you ever go to a college that didn't have graduates?" Of course not. People who are having mental problems need to meet others who have made it, who are functioning successfully in society.

IMPACT: That was funded by a grant. But aren't most of your activities funded by contributions?

NUDD: Yes. Everything else is private contributions. We have 17 local affiliates, and these chapters have a dues structure. They support our state operation, and we support our national organization. The rest comes strictly from contributions, fundraising campaigns—dances, "-athons," house-to-house drives—and memberships in the organization. We have a big one coming up—our Galaxy Ball in Fort Worth on April 24. We'll be happy to sell anyone a ticket.

I think just about all the charitable organizations are really having a rough time. Inflation has hit us all pretty hard.

IMPACT: Besides administrative overhead, where does the rest of your money go?

NUDD: To educational materials that we give away. Any time anyone asks for information in a particular area—such as depression, childhood mental health problems, schizophrenia, family problems—we give them individual copies or small quantities. If someone asks for a topic we don't have, we try to order what they need.

IMPACT: Do you do any information and referral?

NUDD: Yes, particularly since our Austin chapter now shares our office. We also have a free Enterprise number into Temple-Killeen and some other areas where we don't have chapters. Some of the calls we get are heartbreaking—suicidal, wife abuse, child abuse. We try to get the callers through the maze to the appropriate service agency.

I recall one phone call from a woman who was an abused wife. She felt like her daughter was suffering emotionally because of it and needed some counseling. It was a complicated family situation. The woman had contacted the mental health center, but she was so upset that she had never really explained her problem correctly. It took us four hours that day of calling back and forth to agencies to find her the help she needed. But we did it.

IMPACT: The Mental Health Association keeps an eye out on what the department is doing. What do you think it's doing right?

NUDD: It's making an effort to

establish community alternatives, in lieu of institutions, if it's appropriate. Guess my record is broken on that subject.

IMPACT: Do you think there's any less stigma associated with people who have used mental health services?

NUDD: Your very own annual report cites some comments by community mental health centers that people are using their services more and credit that to the fact that the stigma is a bit less.

But President Carter's report from the Commission on Mental Health said stigma still was one of the major problems in mental health. It's a terrible problem.

Most people stereotype a person with mental problems as acting in a bizarre or violent manner. Not true. But the media helps to perpetuate this myth.

Stigma is still rampant. Former mental health clients sometimes even stigmatize themselves. About two weeks ago a woman who had been in a mental hospital called us. She wanted to know if she could vote and own property since she was once a mental patient.

In the response we've had to the self-help groups, we've found even doctors stigmatize former patients. Some doctors were very skeptical about former patients or clients getting together and supporting each other, as though they didn't have the ability. For the record though, most doctors are very supportive of the program, and are even recommending it.

IMPACT: It's been said yours is an organization representing a group with no alumni. Families of mentally retarded persons often band together but family members of a mentally ill person will not.

NUDD: To a large degree I think that's right. We have former clients, and people who have had mental illness in their family, on our board of directors—but not enough.

One of the things I like about the self-help group is that we are getting more people involved in the Mental Health Association, either those who have been mentally ill themselves, or family members. This is a great strength for the organization because they speak from the heart, and it helps to keep the organization on target with what the needs really are. ■ *J.O.*

Mental Health Association Directory

National Mental Health Association
1800 N. Kent St.
Arlington, VA 22209
703-528-6405

Mental Health Association in Texas
103 Lantern Ln.
Austin, TX 78731
512-459-6584

Texas Affiliates

Mental Health Association in Abilene
201 Fannin
Abilene, 79603
915-677-2428

Mental Health Association in Austin
2825 Hancock, #103
Austin, 78701
512-459-6585

Mental Health Association in Bexar County
1405 N. Main Ave., Suite 237
San Antonio, 78212
512-222-1571

Mental Health Association in Center
501 Pine St.
Center, 75935
713-598-3092

Mental Health Association in the Coastal Bend
505 S. Water, Suite 537
Corpus Christi, 78401
512-884-1746

Mental Health Association of Dallas County
2500 Maple Ave.
Dallas, 75201
214-748-7825

Mental Health Association of El Paso
5959 Gateway W., Suite 320
El Paso, 79925
915-778-1859

Mental Health Association in Galveston County
1814 - 45th St., Suite 103
Galveston, 77550
713-762-1250

Mental Health Association of Gregg County
325 Bramlette Bldg.
Longview, 75601
214-758-6871

Mental Health Association of Houston & Harris Co.
3208 Austin
Houston, 77004
713-522-5161

Mental Health Association in Jefferson County
447 Orleans St., Suite 316
Beaumont, 77701
713-833-8636

Mental Health Association of McLennan County
579 Westview Village, #14
Waco, 76710
817-776-8081

Mental Health Association in Nacogdoches
P.O. Box 13046, SFA Station
Nacogdoches, 75962

Mental Health Association in Orange County
P.O. Box 891
Orange, 77630
713-886-3899

Mental Health Association of Tarrant County
804 W. 7th St.
Fort Worth, 76102
817-335-5405

Mental Health Association of Tyler
1324 S. Beckham, Suite 112
Tyler, 75701
214-592-0582

Wichita Mental Health Association
1511-D Beverly Dr.
Wichita Falls, 76309
817-723-6312

Helping People Help Themselves ... in the Oil-Rich Permian Basin

Jutting high into the vast West Texas sky is a cluster of tall, sparkling buildings that stand in striking contrast to the miles and miles of empty flatlands surrounding them.

The buildings are downtown Midland, sometimes called "The Tall City" because of its uniqueness in having a skyline in this region of blink-and-you-miss-them towns, tumbleweed and cacti. Most of the downtown office space in Midland is occupied by businesses connected with the oil industry.

From the 24th floor of the tallest skyscraper in the heart of this booming oil town, the headquarters of the Permian Basin Community Centers for Mental Health and Mental Retardation (PBCCs) is visible on the northern edge of town. It is a one-story building occupied by people who are working to help others cope with mental and emotional problems.

Robert Dickson, executive director of the centers since their inception in 1969, says he believes the only real security in life is a person's ability to produce. Consistent with his philosophy, the centers aim to give clients just enough support so they can take over for themselves and either become or remain functional members of the community.

"We are encouraged to see our clients go from being taxtakers to taxpayers," says James Bolgiano, who, as program director for special services, heads the centers' sheltered workshops.

The Permian Basin centers, located in Midland, Odessa and Fort Stockton, serve three counties: Midland, Ector and Pecos.

The Midland and Odessa branches offer a broad range of services to people of all ages, from infant stimulation for developmentally disabled children to 24-hour crisis intervention and suicide prevention/emergency telephone service. Other services include a comprehensive alcohol and drug detoxification program which was among the first established in the state; inpatient, outpatient and partial care for the mentally ill; and diagnosis and evaluation and sheltered workshop training for the mentally retarded.

Since the Fort Stockton branch opened a year ago, it has grown from a one-person operation to a center with a staff of seven that provides outpatient services, sheltered workshop training and infant stimulation.

Located in the oil-rich Permian Basin, an area that supplies 25 percent of the domestic crude oil used in the United States, the PBCCs serve an unusually well-educated population that has one of the highest levels of income in the country.

It is a population that is aware of the quality services offered at the centers and takes advantage of them. In 1980 the PBCCs served nearly 22 people per 1,000, a rate of service greater than that of any community MHMR center in the state.

Of course, not everyone living in the

Permian Basin reaps big profits from the oil business. "Over one-half of our clientele make less than $100 per week," says Dickson. "Despite what people may think, we do have indigent folks and this center serves them."

SCREENING

The PBCCs have long been committed to treating clients within the community whenever possible instead of referring them to state institutions. To prevent unnecessary institutionalization, the centers began a screening and aftercare program in 1974, a practice that TDMHMR Commissioner John J. Kavanagh, M.D., recently ruled all Texas community MHMR centers must adopt by September 1981.

The PBCCs instituted their screening program in cooperation with Big Spring State Hospital (BSSH) which was then under the direction of the late Preston Harrison, M.D., who played a major role in bringing about the innovation.

Since the inception of their intensive screening program, the centers have become known locally as likely alternatives to state institutions for mentally ill and mentally retarded residents.

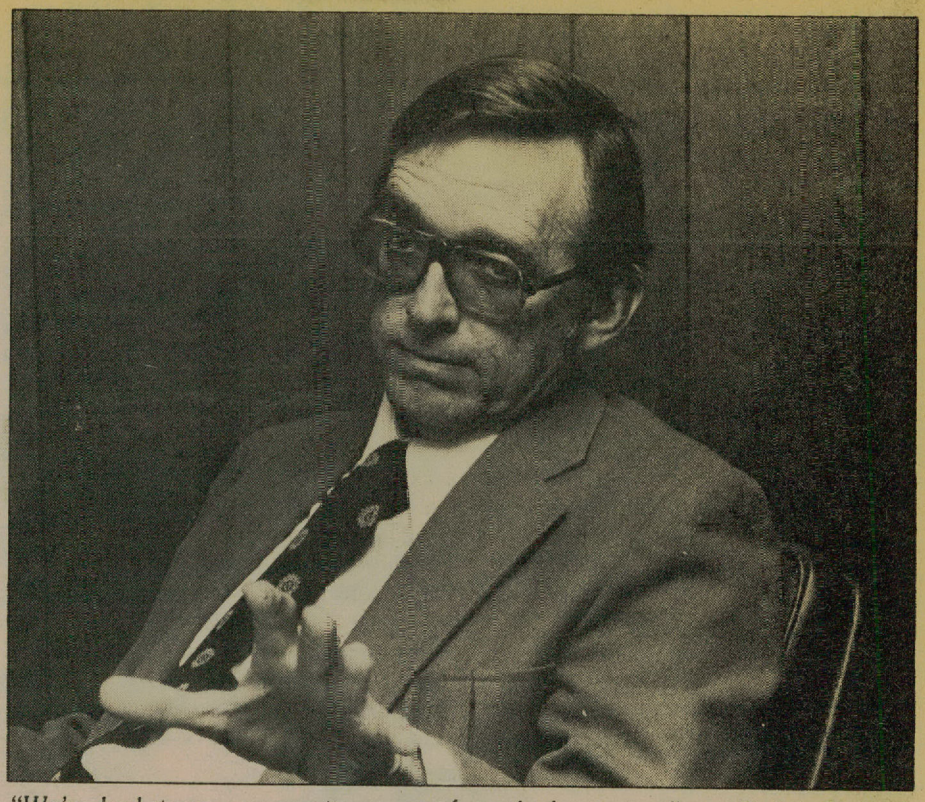
Ken Wolf, Midland County program director, recalls the beginning of the program in Midland and Odessa. (The Fort Stockton branch was not yet in existence.)

"We would screen for appropriateness all potential admissions who came from our catchment area. Anyone who went to the state hospital and reported a Midland or Odessa address would be referred to us, at which time we would have the opportunity to assist the person and then provide local care. That one maneuver quickly cut the admissions rate from our two counties by at least 50 percent.

"We were also fortunate to get the county courts to cooperate by turning screening of involuntary commitments over to us. So, in one fell swoop, we were screening everyone, both potential voluntary and involuntary clients."

Today in Midland County only one out of every thousand residents is admitted annually to BSSH. Before screening, admissions were three times greater.

The program has given would-be hospital patients the opportunity to recover from mental and emotional problems while remaining in their own homes in the community and receiving outpatient treatment, partial care or drug therapy at the center.



"We've had strong community support from the beginning," says Robert Dickson, PBCCs' executive director. "West Texas towns are very community-minded in that when they decide to do something, they want it to be the best, whether it's a theatre, a museum or an MHMR center."

Wolf recalls the case of one woman who came to the center, grief-stricken and deeply depressed after her husband's death:

"He had been everything to her; he had managed everything, made every decision, solved every problem. Now she was alone. She thought life was not worth living without her mate, and, even if it were, she had little practical experience living it. She believed that, without experience in her own affairs, she should go to the state hospital where she would be taken care of.

"Through outpatient treatment, consisting of two or three hours' counseling each week, she has gradually gotten back on her feet. She has traveled miles compared to where she was when she came in. If she had persisted in the belief that she needed someone to run things for her and had gone to the state hospital, it could have incapacitated her for life. That was the last thing she needed," Wolf continues.

"Either inpatient or partial care would have increased her dependence, whereas outpatient care gave her just enough support to take over for herself.

"We have to walk a fine line between doing too much for the client and doing too little," he concludes.

Chronically and emotionally disturbed individuals may benefit from partial care which involves therapeutic activities designed to help clients adjust to life in the community, whether they are just learning to cope with emotional problems or are returning home after hospitalization.

Clients receiving partial care report to their center daily or a few times weekly where they participate in structured activities such as relaxation therapy, arts, crafts, film-viewing, music appreciation and current events.

By working closely with county officials, center personnel have been able to "get a handle on people who might otherwise slip through the cracks" and unnecessarily go on to a hospital on an involuntary commitment, according to Natalie Rothstein, emergency services coordinator for the Ector County branch of the PBCCs.

"If they can't come to us, then we go to them," says Rothstein, who makes frequent visits to the county and city jails to screen individuals who

have been arrested and might be in need of center services.

"We do all the legal paperwork that would normally be done by the county, whatever is required for involuntary hospitalization. This gives us an opportunity to plug a client into the program that is most appropriate for him," she says.

"We consider the least restrictive possibilities before recommending an individual be committed to a state hospital. We look at outpatient treatment, partial care and a two-week stay at a local hospital under an order of protective custody. If these services don't work, then our psychiatrists look at the 90-day commitment."

SUBSTANCE ABUSE RECOVERY PROGRAM

One option available to individuals who have been arrested for public intoxication in Ector County is participation in the Substance Abuse Recovery Program (SARP).

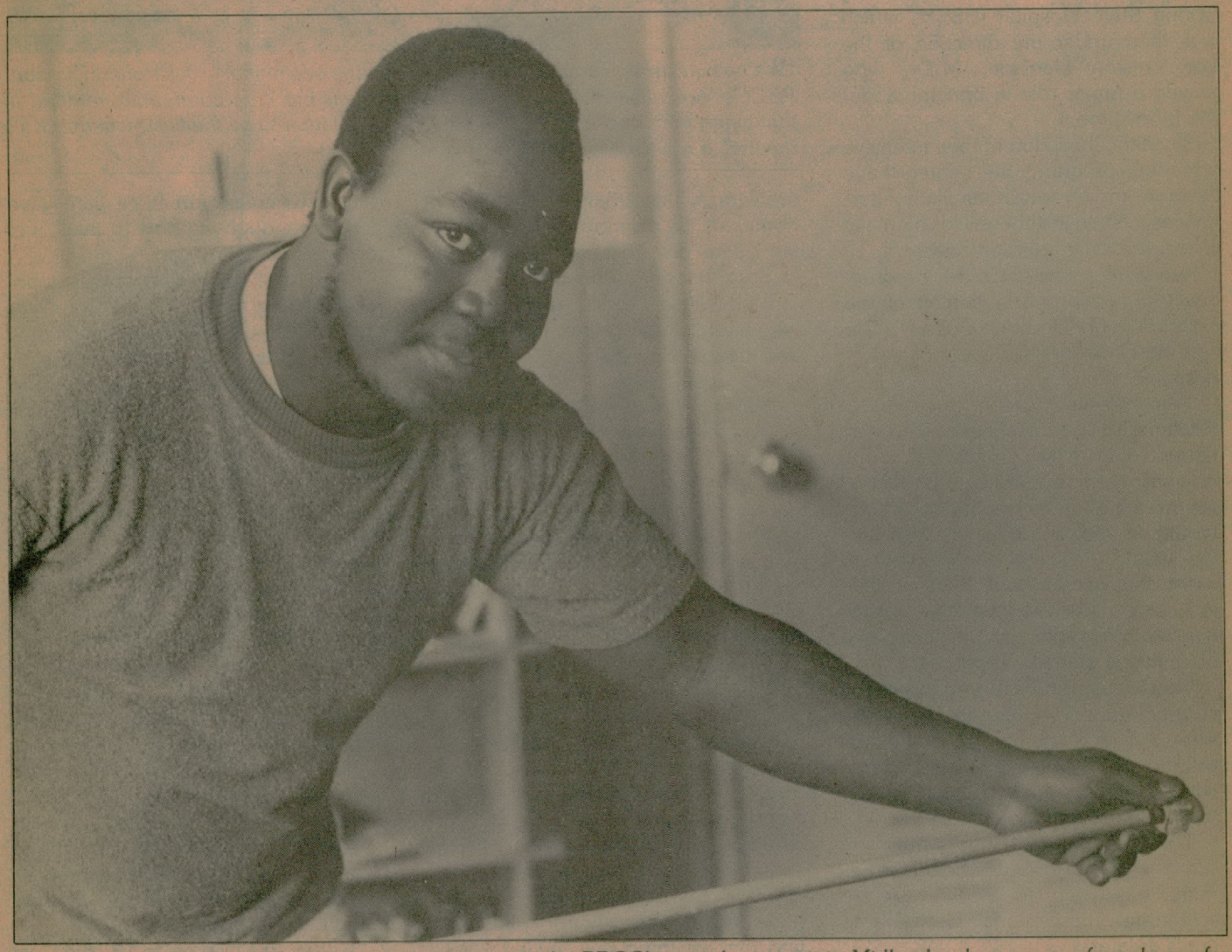
The SARP involves a 3- to 21-day stay at the Mullins Center detoxification unit in Odessa, with the length of stay depending upon staff recommendations. While at the detox unit, clients attend nightly Alcoholics Anonymous meetings. They receive 24-hour care, including three meals daily, and may choose from a variety of recreational and current events activities for entertainment.

SHELTERED WORKSHOPS

The majority of the centers' sheltered workshop clients would be in state schools if it weren't for the shelter program, according to Bolgiano who coordinates it. His staff conducted a study in recent years which showed that 85 percent of the parents of workshop clients were not able to care for their children throughout the day because of other responsibilities. Consequently, they rely heavily upon the workshop as a place where their children can spend a structured, productive day under the supervision of MR professionals.

Sheltered workshop training is designed to allow each individual to achieve maximum vocational potential. The shelter can be a workplace, a training place or a place for both, depending upon the needs of the individual client. Clients are paid for the work they do based on minimum wage, and some are paid more, depending upon the nature of their work. Bolgiano says that one client earns $8 per hour as a forklift operator.

The Midland-Odessa Community Living Enrichment through Working program, referred to as CLEW,



Howard Cooks chalks his cue during a pool game at the PBCC's partial care unit in Midland, a home away from home for people who need help. Approximately 15 clients participate daily in the Midland center's partial care services which include a full range of recreational, therapeutic and educational activities.

represents an important sector of the labor market in the Permian Basin. Many businesses supporting the oil industry depend upon the in-shop production capabilities of clients who, though they are not prepared to enter the competitive employment market, are dependable workers in the sheltered atmosphere of the workshop. In such cases, the work is brought to the shop, and it is completed under the supervision of center staff. Current contracts include packaging nuts and bolts and assembling a tool for sharpening welding torches. Sorting, salvaging, cleaning, collating, stapling and stuffing envelopes are other jobs CLEW can do.

Clients who are capable of competitive employment with training are given instruction in service-oriented areas such as custodial work, housekeeping, grounds maintenance or food service.

"We geared in on service-oriented jobs, because they bring clients higher incomes. Besides that, with this type of job clients are in a realistic situation. They actually go to the job site, they have a real supervisor, and they are learning skills they can use on other jobs," says Bolgiano.

"Ninety percent of the mentally retarded who lose their jobs do so because of poor work and job habits—not because of poor skills," he continues. "So we also teach Work Adjustment and Personal Social Adjustment (PSA)."

In Work Adjustment clients learn appropriate job habits such as responding to supervision, being on time, hygiene factors and working with fellow employees. PSA is a highly individualized program designed to aid clients in developing skills necessary for daily living like looking for an apartment or learning to shop in a grocery store.

Once the clients' skills, Work Adjustment and PSA habits are up to par, they train in job readiness. This involves lessons in interviewing, filling out job applications and understanding Social Security and income taxes.

"We have just about placed ourselves out of business," Bolgiano smiles. "In five years, we served 150 clients and of them we have placed 60 in competitive employment.

"All they need is someone believing in them, giving them responsibilities and opportunities. You cannot believe how quickly they will blossom and grow.

"We have one extremely low-level client who has learned custodial skills. He is now running a (professional) buffing machine—expertly! During the six or seven years he has been in the program, he has gone from being a nonproducer to a functional member of the CLEW cleaning crew.

"He got one contract he could do, he got his confidence and he started growing. He may never go out in the competitive market entirely, but he is now a fine employee in the sheltered environment.

"Clients like him prove that our greatest limitation in working with the mentally handicapped is that we don't set high enough expectations of them," Bolgiano says. ■ *J.S.N.*

Debbie Stephens is one of PBCCs' many sheltered workshop clients who have become proficient in using a professional buffing machine and other custodial equipment. She puts her newly acquired skills to good use as a member of the CLEW custodial crew at work in Odessa.

The screening process begins when a client comes to the outpatient clinic seeking help. During the initial interview, Terry Clemmer (left), caseworker at the PBCCs' headquarters in Midland, assesses client needs and refers the individual to a staff psychologist, psychiatrist, alcoholism counselor, drug abuse counselor or other appropriate professional. Photos by Jackie Stilwell Neuman.

Commissioner's Column

By John J. Kavanagh, M.D.

The commissioner meets each month with employees at Central Office to bring them up to date on administrative news. Here are excerpts from recent meetings.

Number of Employees

As far as the five percent reduction [in the number of state employees], there has been no further action. However, the governor in his budget proposal (which is about $200 million less than the Legislative Budget Board proposal) does include a ceiling for personnel for each type of facility—not by institution, but separate ceilings for schools, for hospitals and for human development centers. If these ceilings are enacted into law, they essentially mean reductions.

Speaker Clayton has introduced his own budget because he took exception with the LBB budget. As far as we are concerned, it's not much different from the LBB budget. However, there is a rider in it that staffing levels would be frozen at the number of employees on board as of November 1980. This means we not only couldn't fill what vacant positions we had at that time, but we would lose any positions the LBB had recommended in their proposal. In February we had 27,243 authorized positions and 25,482 assigned.

Regarding the governor's ceiling, it has been interpreted that you can exceed that temporarily as long as you end up below the ceiling at the end of the year. So we can't tell what the final authorized strength of the department will be.

Sick Leave and Merit Raises

My proposed policy on merit raises and misuse of sick leave has caused some problems, so Joe Emerson [chief of Personnel and Training] and I are studying that. My reason for the policy to begin with is this: If you have ever worked at a facility and you are on, say, a weekend night, a holiday night or a payday night, look over your building and you'll find that where six people are supposed to be, there are two.

The poor supervising nurse for that shift goes into orbit trying to provide coverage, and it's largely due to people who call in sick. They report in sick at very convenient times, and you can correlate it with payday, holidays and stretching a weekend.

We have increased our merit program awards. We've been able to give merit raises to about 37 percent of those eligible last fiscal year. But to make the program meaningful, we are trying to get criteria (performance evaluation and other factors) so that people who earn them get them. Otherwise, the program loses its value. We'll see if we can effect a compromise in this policy.

Maximum Security Unit

The Maximum Security Unit at Rusk [State Hospital] has been a recurring problem. We are reorganizing the Maximum Security Unit and putting an assistant superintendent in charge. The goal is to have the unit run more efficiently and effectively.

Affirmative Action

We had a request from a legislator recently for a run-down on our affirmative action—how many employees we have, how many are women, how many are Hispanics, how many are blacks, and a distribution according to grade level.

In gross overall figures we do very well, because 70 percent of our employees are women. And we do well in the minority representation.

Where we fall down is in middle and upper management. We have one black director of a human development center. We have several Hispanic directors. But we need to get more women in leadership positions. This is something I think all supervisors who are interviewing and hiring should bear in mind as an affirmative action goal.

Commissioner's Review

Several months ago I instituted the Commissioner's Annual Program and Administrative Review [see IMPACT story on next page]. This is an annual overview of each institution. I did this for several reasons: one, because of my military background I'm used to that sort of thing; and second, it was my feeling that I never had a comprehensive overview of how an institution was doing.

So we instituted this team; and as you would suspect, the response on the part of the directors and superintendents of the facilities was mixed. Those who were polite were complimentary and those who weren't, were otherwise. I feel it has achieved and is achieving the objective for which it was devised.

Board Action

The board recently discussed the cost to TDMHMR of Hurricane Allen [in August 1980]. Modest estimates run around $140,000. We are in the process now of rewriting the evacuation plans both of Central Office and the facilities in the path of hurricanes.

Three Volunteer Services Council projects were approved. One was the therapeutic park at San Antonio State Hospital-State School. That's a rather heroic project, involving a cost of around $1 million. Next was the chapel on the campus of Brenham State School and the third was a multipurpose recreational complex on the grounds of San Angelo Center.

We had an appointment for a superintendent at Big Spring State Hospital but the board did not approve it. So probably, for the first time in the history of the department, we will go for a nonphysician superintendent in a state hospital.

It's very difficult to get physicians interested in being superintendents of state institutions when you're constantly sued, and getting your name in the paper, and having all sorts of pressures. Private practice is a lot more enticing, and there are few Joan of Arcs out there who are willing to become martyrs to the cause.

The terms of three board members expired Jan. 31, and I have no good rumors about who has been appointed. The present members whose terms have expired will serve until the new members have been named and confirmed by the senate.

The proposed legislation for the revision of the Mental Health Code has been something similar to the United Nations in one's inability to get a consensus about anything. So rather than passing or running, we punted, and the board proposed an interim committee involving the legislature to take two years to revise the code.

It was obvious the revision we had proposed was too radical for some groups, too conservative for others, and it would not be politic or appropriate to go down to the legislature with a revision that is highly controversial and expect the legislature to take any definitive action on it. ■ *J.O.*

TDMHMR Client Care— It's Quality Checked

You aren't serving your pizza hot enough. Repair those cracks and potholes in campus roads. Put a new roof on your program building. And develop and implement a management by objectives program.

These are just a few recommendations that may be made to a TDMHMR facility during the course of the Commissioner's Annual Program and Administrative Review (CAPAR). The review gives the department a way of keeping abreast of operations at schools, hospitals and human development centers while ensuring that they are in compliance with both departmental and external standards—right down to the temperature of the pizza.

The CAPAR, which was begun a year ago, represents a comprehensive approach to the decade-old internal review process, and it requires more of facilities than ever before. The scope of the CAPAR goes far beyond that of earlier reviews which were intended primarily to prepare facilities for annual audits performed by external certifying agencies. The standards that facilities now must prepare to meet are more numerous, more rigorous and more strictly monitored.

Aside from checking to ensure that facilities meet the standards of certifying agencies, reviewers are now checking for compliance with more than 30 volumes of Commissioner's Rules that are ever more demanding in terms of client care, safety and environment; the Texas Mental Health Code; the Mentally Retarded Persons Act; the Life Safety Code (National Fire Protection Association regulations which apply to

Austin State School pharmacist Jan Delk, a member of the SCQA review team, and Brenham State School pharmacist Joe Williams verify the expiration date of medication during a recent departmental review of the school. The pharmacy check also involves reviewing the drug distribution system, medication storage and administrative areas such as participation in continuing education programs and drug information services.

all public buildings); and the rules of a host of other national, state and local groups.

During the CAPAR, no aspect of client care goes unobserved. Even seemingly trivial matters such as where the toothpicks are placed in the cafeteria concern food service reviewers, who recommend for hygienic reasons keeping them in the dining room rather than in the serving line.

Sounds nitpicky? "It sure does," says Sue Dillard, director of Standards Compliance and Quality Assurance (SCQA), "that is, it does unless you realize that the best way to prevent the spread of infection is to stop it before it starts." Dillard's section serves as the commissioner's agent in planning and coordinating the annual reviews.

The primary purpose of the detailed reviews is to help ensure that facilities operate at a high level of client care and efficiency. Client care is guided by myriad rules that run the gamut from requiring that the facility maintain an appropriate student-teacher ratio in the classroom to demanding that smoke detectors, sprinkler systems and smoke-stop doors be installed in campus buildings.

The reviews also serve as a management tool for the commissioner and facility administrators in telling them exactly where the facility stands at the time of the review. To provide a basis for administrative evaluation, deputy commissioners examine such things as fiscal management patterns, appropriations versus actual expenditures and staff utilization.

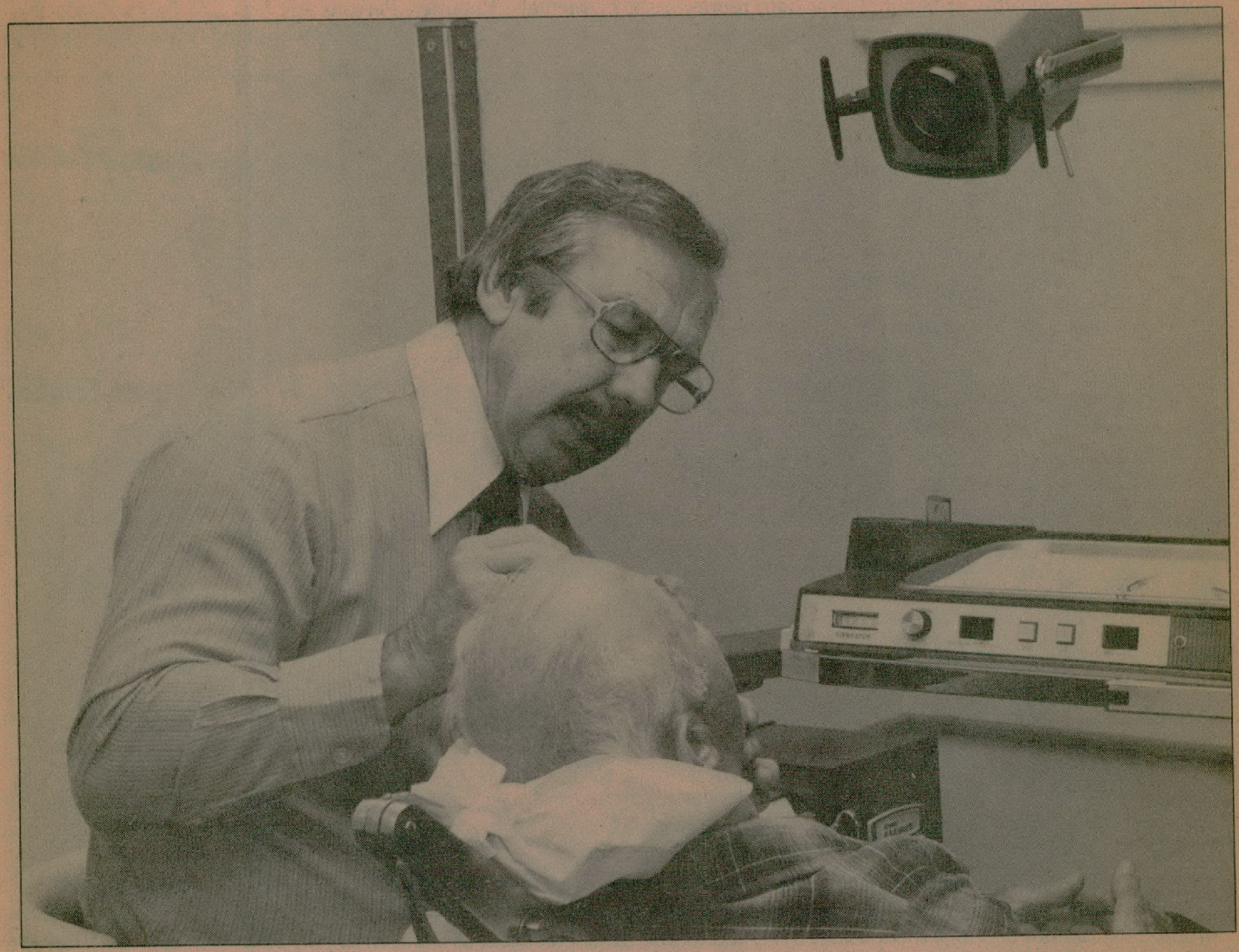
Working through a commissioner's review makes the next hurdle the facility faces less formidable. It helps to prepare facility administrators for the annual audit by national standards groups such as Medicare, Intermediate Care Facilities for the Mentally Retarded (ICF-MR), Joint Commission on Accreditation of Hospitals (JCAH) and Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (ACMRDD).

Failure to meet the standards of these groups and to thereby maintain certification can result in loss of federal funds and third-party reimbursements that would otherwise be returned to the state General Revenue Fund.

Though the stakes are high in the external audit system, the chances of failure are slim if the facility has prepared well for the CAPAR.

"Facilities that comply with the Commissioner's Rules are almost certain to meet the standards of outside groups, since the rules not only are patterned after these standards but are even more exacting," says Dillard.

"If a floor isn't clean, the internal review explores reasons



TDMHMR director of dental services, George Jurek, D.D.S., M.P.H., examines the teeth of a client during a recent review at Austin State Hospital. "Proper dental care is reflected in the appearance, speech and health of an individual," Dr. Jurek says. "We strive to see that clients are provided with care at least equivalent to what you might find in the private sector."

why it is not clean," she says. "It aims to eliminate the cause as well as the result. If the equipment is faulty or the staff is not well-trained, then recommendations are made for improved equipment or staff training. The external audit is concerned only with the result."

"We have so many high-quality internal rules of our own, particularly in relation to client care, that some of the outside standards seem minimal and not so demanding in comparison," says Dee Frerick, SCQA program consultant for MR services. "One example is that ICF-MR standards require that medicine be administered by a medication aide, while our rules go a step further in requiring, with certain exceptions, that it be done by a licensed nurse."

SCQA reviewers strive for consistency throughout the review process. Because of the particularly subjective nature of programming, it is observed by at least two reviewers who attend different sessions of the same program and later compare notes. If their viewpoints differ, they do further review until agreement is reached.

"Probably the most common deficiency is lack of consistency in documentation," says Marge Avera, SCQA program consultant for MH services. And that very consistency is the key to continuity of care.

The importance of continuity of care could hardly be overemphasized, yet it is "the hardest thing a hospital staff must do," according to Avera, and it can only be maintained by extensive recordkeeping systems.

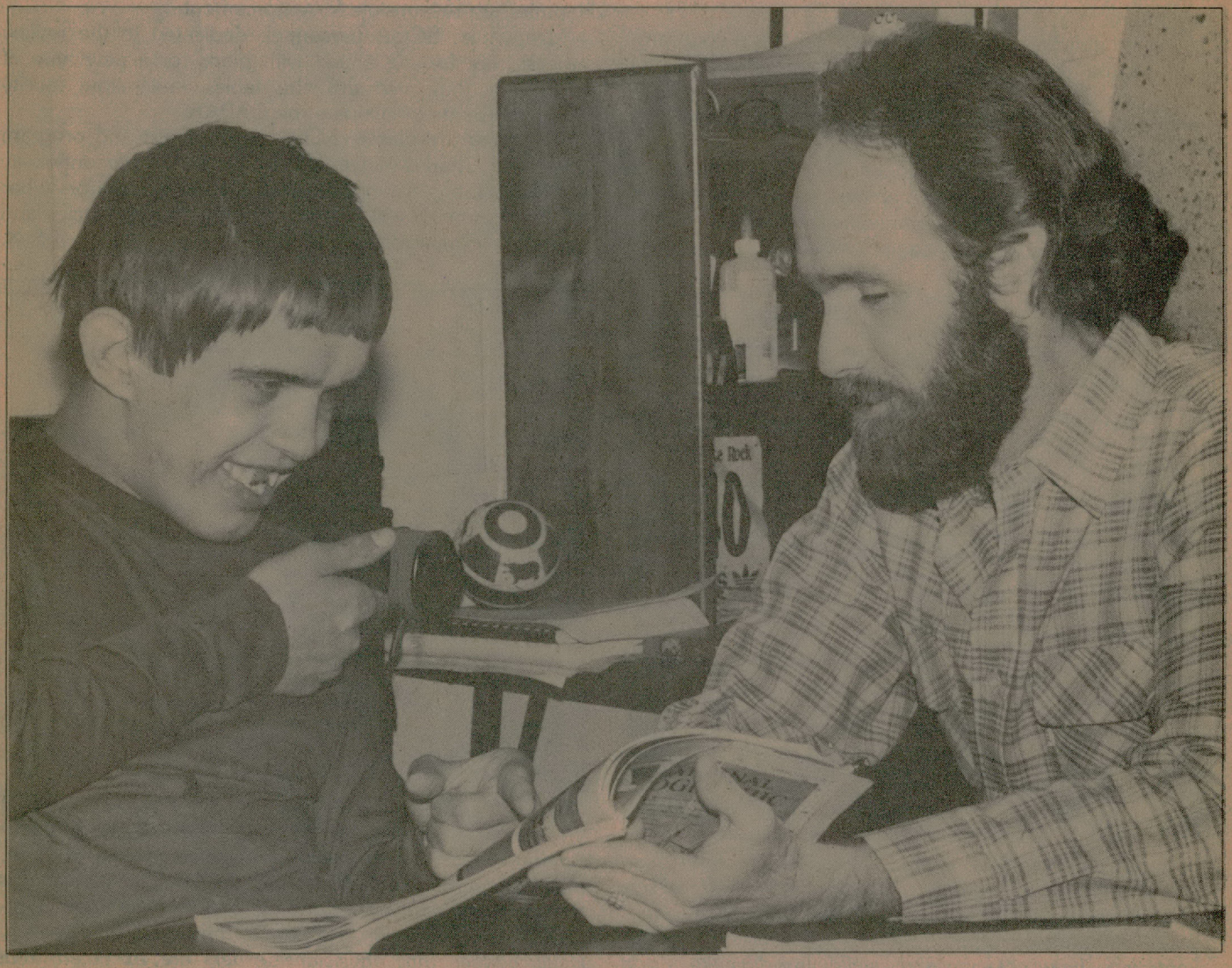
"With three employee shifts daily, if there were no written record, then you would never know if a person got a correct diet, medication, therapy or anything else," says Avera. For that reason, SCQA team members comb through detailed client records comparing scheduled and actual feeding, medication and activities.

In addition to identifying areas that need improvement, the review gives SCQA an opportunity to discover exceptional programs being used in individual facilities so they may be shared with the rest of the system.

"We found that Terrell State Hospital has the best medical and surgical unit in the system and that Abilene State School excels in food service," says Dillard. "So we recommend that other facilities follow their example."

Planning for a review begins at Central Office (CO) at least a month in advance. Once the commissioner has notified the superintendent of the impending review, SCQA goes into action.

SCQA is authorized to review the operations of facilities,



SCQA reviewers observe educational programming with an eye to student-teacher ratio. During a one-to-one classroom session at Brenham State School, teacher Rick Carroll (right) helps client Tommy Smith with a counting lesson.

report on them to the commissioner and make recommendations for improvement.

They coordinate the schedules of CO review team members and their facility counterparts. Included in the scheduling are personnel from SCQA, Nutrition and Food Service, Laundry Service, Design and Construction, Plant Maintenance, Staff Development, Personnel and Mental Health or Mental Retardation Services, depending upon the facility being reviewed.

The team is looking at these areas and many more, including pharmacy, medical and nursing services, educational and recreational activities, occupational and physical therapy, behavior modification, dental service, client records, housekeeping and the chaplaincy.

Once on campus, reviewers systematically and thoroughly delve into their assigned areas. TDMHMR director of dental services, George Jurek, D.D.S., M.P.H., for example, examines 10 percent of the client population of a facility, checking each individual for unmet dental needs.

Dr. Jurek's examination is concerned not only with the condition of clients' teeth. Broad in its scope, the exam involves a check of the tongue, floor of the mouth, tonsillar area, palates, cheeks and gums, as well as inspection of the face and neck for soft tissue lesions, swollen glands and asymmetry.

"We are determining whether the facility has a good program by the quality and extent of care being provided clients. At the same time, I'm looking at the cost-effectiveness of staffing patterns as well as clinical space and equipment," Dr. Jurek says.

Depending upon the size of the facility, the team varies in number from seven to fifteen members and may spend between two and seven days completing the job.

During the entry conference, SCQA team members and key facility personnel discuss the new review system and how it will be carried out. Interim conferences are scheduled so that urgent corrective measures may be implemented during the review period while CO personnel are still on campus to assist. A malfunctioning smoke detector at one school, for instance, was quickly repaired with the help of the CO electrical engineer on the review team.

At the end of the review period, the team and facility administrators meet once again to capsulize major findings. Each reviewer's written report is included in a comprehensive report that later is sent back to the facility along with a letter from the appropriate deputy summarizing and setting priorities for items that require attention.

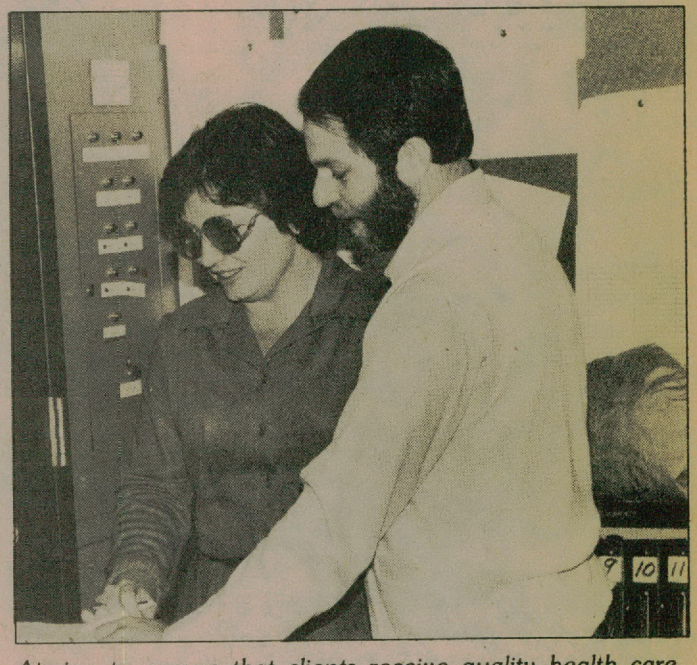
The facility must submit to the deputy's office a written plan of correction for all deficient areas cited by the team approximately six weeks after receipt of the SCQA report. The time allowed for actual correction depends upon the magnitude of the deficiency. Roofing a building, for example, would require long-range budget planning, while taking steps to ensure that all campus vehicles are kept locked when not in use could be done immediately.

Generally SCQA's written recommendations are sufficient to correct deficiencies, says Dillard. In rare cases of noncompliance, however, the commissioner and his deputies are responsible for enforcement.

Meanwhile, SCQA personnel, dedicated to the review process, are forging ahead with plans for a new type of evaluation that will turn the tables and allow facility superintendents to evaluate the CAPAR.

Designing the plan is SCQA psychologist and program consultant Charles McDonald, Ph.D. SCQA personnel say they're counting on input from facility administrators who, this time around, will be the ones noting deficiencies and making recommendations. ■ *J.S.N.*

During inspection of the central kitchen at Brenham State School, James Walker (right), the school's chief of food service, shows regional nutritionist Vemuganti P.R. Rao, Ph.D., blending equipment used to break down food for clients who have chewing and swallowing difficulty. Food textures range from regular to ground to blended, depending upon individual client needs.



Aiming to ensure that clients receive quality health care, SCQA program consultant Roberta Davis, RN, reviews client records with Brenham State School health care coordinator Mikel Redman. As part of the health care review, Davis verifies that physicians' orders are executed, that delivered care is documented and that prescribed medication is on hand. Photos by Jackie Stilwell Neuman.

★PEOPLE & PLACES★

Newsmakers

★**James T. Moore,** director of Nutrition and Food Service, has won the 1981 Silver Plate Award for excellence in hospital and health care feeding.

The International Food Service Manufacturers Association makes the award annually to the top person in each of eight categories of food service operations. One of the eight, which include Moore, will be selected to receive the Gold Plate Award at the National Restaurant Association's annual meeting in May.

★**Gene Graham** of **Austin State School** has been named Trainer of the Year by the U.S. Office of Personnel Management, Southwest Region.

Graham's competition included personnel and training specialists from federal, state and local governments.

Board Notes

Meeting in Kerrville in February, the Texas Board of MHMR authorized the commissioner to seek a legislative sponsor for a resolution that would lead to revision of the Mental Health Code.

The resolution calls for a committee comprised of four senators and four representatives who would be required to appoint a citizens' advisory group. If adopted, the resolution would make it possible for a comprehensive revision of the code to be ready for submission to the 68th legislative session meeting in 1983.

A TDMHMR task force assembled in 1980 attempted revision of the code but found the complexity and number of issues could not be resolved in time for submission to the current legislative session.

While meeting in Kerrville, board members attended dedication ceremonies for **Kerrville State Hospital's** new physical therapy building. The building was named in honor of David Wade, M.D., who was TDMHMR commissioner from 1970 to 1974.

Community Support

To encourage states to improve opportunities and supportive services to the severely mentally disabled, the National Institute of Mental Health (NIMH) sponsors a pilot project program called Community Support Systems. Texas was selected for one of 19 pilot programs, and a contract with NIMH enables TDMHMR to test innovative ideas in developing supportive community services for the severely mentally disabled.

The Texas Community Support Program produces a newsletter to communicate about statewide efforts and share resources. To receive the newsletter or to contribute to it, write Michael Carter, TDMHMR, P.O. Box 12668, Austin, TX 78711.

Rights and More Rights

With proper help, retarded persons can greatly increase their capacities. And access to help—including public education, treatment, equal protection under the law, employment opportunities—has become a legal right.

In *The Legal Rights of Retarded Persons,* a new Public Affairs pamphlet, Elizabeth Ogg explains a variety of rights, notes shortcomings and discusses issues such as sterilization, guardianship, involuntary institutionalization, marriage and community-based care. The 28-page booklet is available for 50 cents from the nonprofit Public Affairs Committee, 381 Park Avenue S., New York, NY 10016.

Also available for 50 cents from the Public Affairs Committee is a new booklet titled *The Right to Die With Dignity,* dealing with difficult issues concerning treatment of terminally ill people, including changing attitudes toward death and dying, how hospices work, the right to refuse treatment and right-to-die laws.

A catalog of other available titles is free on request.

Conference Calendar

May 17-19
Stations of the Mind: New Directions for Reality Therapy for the Family and for Adolescents
Annual regional staff institute
Sponsored by the Southwestern Regional Council of the Family Service Assn. of America
Held in San Antonio
Contact: Richard Ney
Jewish Family Service
8438 Ahern Dr.
San Antonio, TX 78216

July 5-10
International Efforts in Meeting the Needs of the Severely Disabled
25th national conference
Sponsored by the Assn. of Medical Rehabilitation Directors and Coordinators and the American Assn. for Rehabilitation Therapy
Held in Hollywood, Fla.
Contact: Dr. Syd Rudman, chairman
4801 Madison St.
Hollywood, FL 33021

Ten Years Ago...

IMPACT was born. It appeared in April 1971 (although the masthead mistakenly labelled the year "1970").

Then Commissioner David Wade, M.D., wrote in that first issue: "It is intended to be for and about you, the Texas Department of Mental Health and Mental Retardation employees, your accomplishments, your jobs, your interests and your contributions to the care and well being of the patients and retardates we serve."

The language has evolved since then (with terms like "clients" or "residents" replacing "retardates"), and the mission has expanded beyond being just an employee newsletter. The current circulation is 32,000 with the bulk of the copies going to employees. Items about employees still are important but there's been increasing emphasis on sharing innovative program ideas and discussing current issues.

As publication and mailing costs rose, IMPACT switched from a monthly publication to 24 pages produced five times a year. Newsprint replaced standard white text-weight paper.

Gleaned from the IMPACTs produced during 1971 are these excerpts:

"U.S. Sen. Hubert Humphrey was the featured speaker at the Denton State School Eleventh Annual Volunteer Council Awards Banquet. The former U.S. vice-president and now senator from Minnesota was joined by Gov. Preston Smith in addressing a capacity audience at the October event."

"A little known side to TDMHMR history is the fact that the Mexia State School site was a prisoner of war camp from 1943 to 1945. It was called the Mexia Internment Camp and housed 2,000 German prisoners who were brought to Texas from Boston by train. This fall, three of the former prisoners made a sentimental journey to see where they had lived in captivity for almost three years."

"This is one Department. Our single job is offering service to those in need.

If you haven't joined the team, then you should make a determined effort to sign up and get in the game. Think TDMHMR; not TDMH/MR or TDMH-MR. In other words, get the hyphens and slash marks out of your thinking."*

"One of the Department's typical ice cream factories is located at Wichita Falls State Hospital where spotlessly clean equipment is put to work twice weekly to provide dessert for the patients."

"San Angelo Center is the first facility for the retarded to receive accreditation from the Joint Commission on Accreditation of Hospitals for its hospital unit."

"State grants-in-aid to provide a major source of financing for 24 community mental health and mental retardation centers have been approved by the Texas Board of Mental Health and Mental Retardation.

The grants-in-aid, totaling $5,425,581, will be awarded on the basis of budget and program plans submitted by each Board of Trustees for fiscal year 1972."**

* *From the Commissioner's Corner*

** *In contrast, grants-in-aid totaled $48,570,141 for 30 centers in fiscal year 1981.*

IMPACT

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