IMPACT

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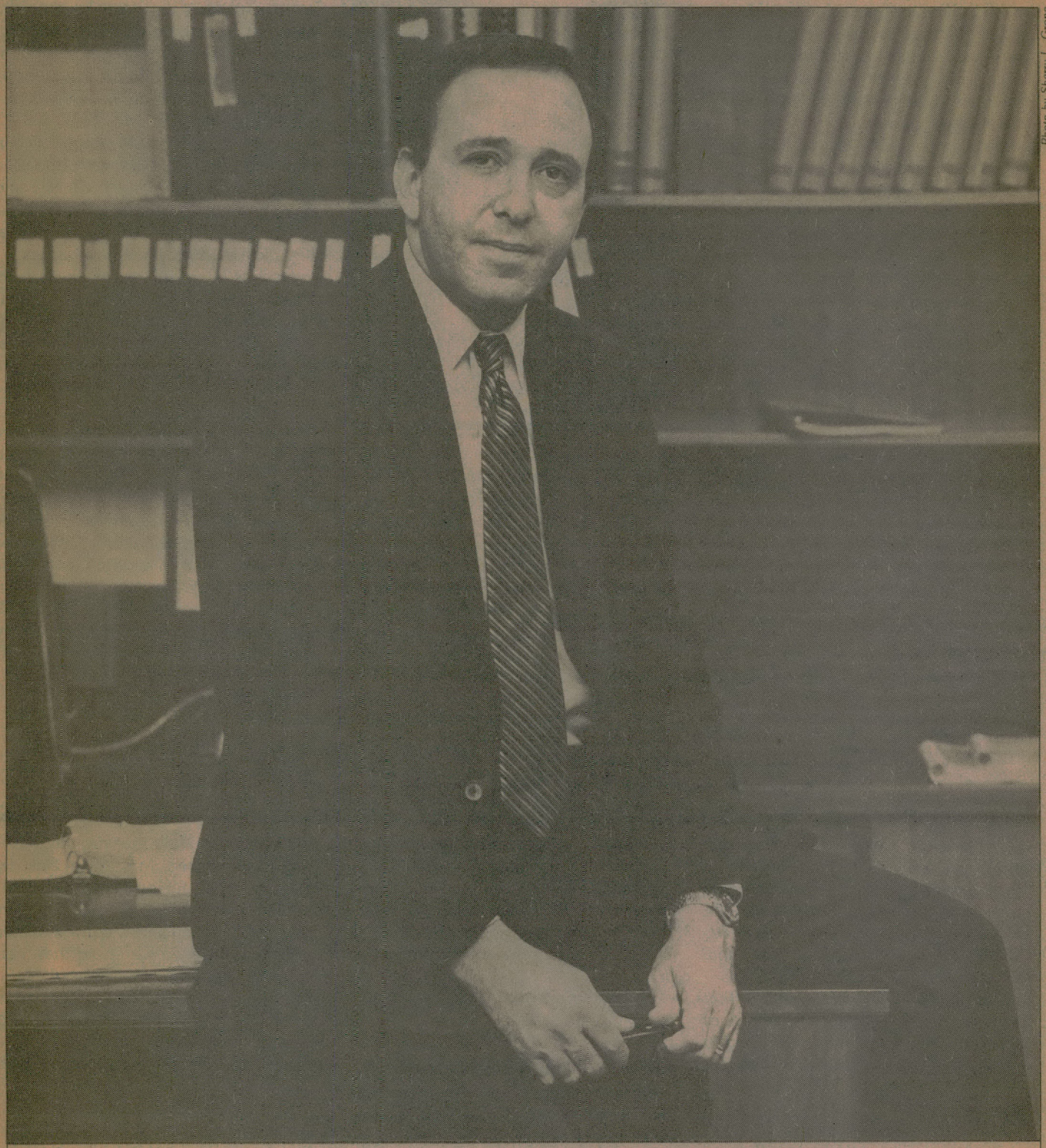


Photo by Sherry L. Grona

Texan returns home to head TDMHMR ►

Dr. Gary E. Miller Is New Commissioner

The new TDMHMR commissioner is Gary E. Miller, M.D. He was appointed to the post by the Texas Board of MHMR at its Dec. 14 meeting.

Dr. Miller, a psychiatrist certified by the American Board of Psychiatry and Neurology, presently is the director of the New Hampshire Mental Health and Developmental Services Agency.

He is expected to assume his duties in Texas in February.

"New Hampshire's loss is Texas' gain" seems to sum up the sentiment of those who have known and worked with Dr. Miller during the past five years in New Hampshire.

Gov. Hugh Gallen said, "Dr. Miller played an important role in New Hampshire's efforts to improve its services to the mentally disabled citizens of the state."

Robert B. Monier, N.H. Senate President, told Dr. Miller, "We are fortunate to have witnessed during your tenure a strengthening of the state's MH and developmental services systems."

Dr. Miller received similar praise in N.H. newspapers, including *Union Leader* and *Nashua Telegraph* editorials.

The 46-year-old Dr. Miller is a former TDMHMR deputy commissioner for MH services, serving in that capacity from 1967 to 1970. Previously, he was

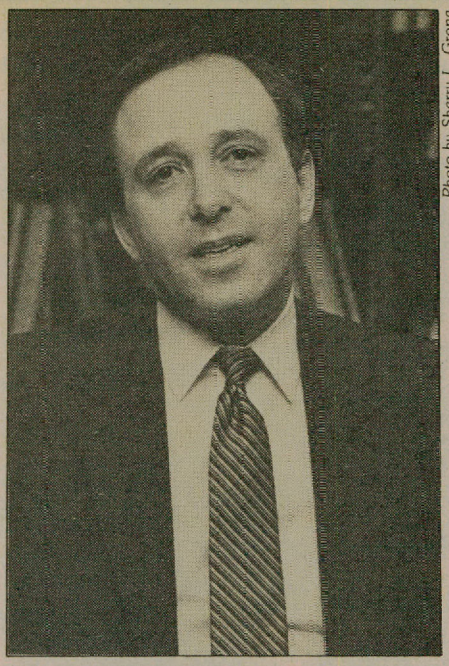


Photo by Sherry L. Grona

the director of what is now the Rio Grande State Center for MHMR in Harlingen, from 1966 to 1967.

Dr. Miller attended The University of Texas at Austin from 1953 to 1956 and received his doctor of medicine degree from The University of Texas Medical Branch at Galveston in 1960.

He served his residency in psychiatry at Western Reserve University Hospital in Cleveland, Ohio, and the Austin State Hospital.

After leaving the TDMHMR post in 1970, Dr. Miller joined the New York State Department of Mental Hygiene as a consultant and later became the assistant commissioner of that agency.

In 1972 he was appointed director of the Division of MH for the Georgia Department of Human Resources, serving in that post until 1974.

After two years of private practice in Atlanta, Ga., Dr. Miller was appointed director of New Hampshire's MH and developmental services.

Dr. Miller is the author of several technical study reports and papers.

He has been on the faculties of the Emory School of Medicine, Atlanta, Ga., the State University of New York at Buffalo, N.Y., the University of Rochester School of Medicine and Dentistry, Buffalo, N.Y., and the University of Maryland.

He and his wife, the former Karen Barrett of Buffalo, have two daughters, Anna Charis, 6, and Rebecca Elizabeth, 2.

James A. Adkins, assistant commissioner for administration, has served as acting commissioner since the resignation of former commissioner John J. Kavanagh, M.D., Sept. 30. Adkins was not considered as a candidate for commissioner since, by law, that position must be held by a medical doctor. ■

Interview: L. Gray Beck

For almost three years, L. Gray Beck has served as chairman of the Texas Board of MHMR, which sets goals and operating policies for the department. With his guidance, TDMHMR has assumed bold new directions in mental health in Texas.

Before his 1979 appointment to that position, Beck headed the board of trustees for what is now the Concho Valley Center for Human Advancement in San Angelo. He was one the founders of the Texas Council of Community MHMR Centers.

Beck was president of General Telephone of the Southwest from 1968 until his retirement in 1976. He has been active in numerous civic, research, social and educational organizations.

Recently Beck sat down with IMPACT editors to discuss his views of TDMHMR's present and future directions.

Following are the highlights of that interview.

IMPACT: The board recently appointed a new commissioner. What procedures did you follow and what steps were taken in making the selection?

BECK: When Dr. Kavanagh notified the board last July that he planned to retire, we asked Mrs. Ellie Selig of Seguin, chairperson of the board's personnel committee, to begin planning for selecting a new commissioner.

At that time we were told that there were 30 commissioner's jobs vacant in the 50 states. This fact gave us some concern when we first started the process of looking for someone to take over the job as commissioner of TDMHMR.

Our concern was whether we would get any applicants. Would you believe that we received 29 applications and only two of those came from Texas.

Think about this for a minute. There

are 30 vacancies in the 50 states for the position of commissioner, and Texas received applications from 29 people interested in our program. This certainly speaks highly for our program of care and treatment.

To go on with the process, the Central Office Personnel Section did considerable screening of those applications and the number came down to 12 or 13.

Mrs. Selig and other members of the personnel committee, A.L. Mangham, Jr., of Nacogdoches and David M. Shannon of Odessa, began the interview process. All board members were notified when candidates would be interviewed and many members participated in the interviews.

I personally missed some of them because I was out of the country but I did participate in the interviews of the top four candidates.

As you probably are aware, the board employed a clinical psychologist who interviewed each of the four top candidates, spending several hours with each in an attempt to measure the candidate's management skills and qualifications.

The psychologist made a report on his observations and analysis, giving a detailed evaluation of the various management characteristics of the four candidates. He unequivocally recommended Dr. Gary Miller as the top candidate.

He also said we were very fortunate to have this quality man apply for this job. It was the psychologist's opinion that Dr. Miller would do an exceptional job for the department.

IMPACT: Proposed reorganization of TDMHMR has been under study by the board and a special task force of Central Office executives for several months now. What do you perceive as the goals and objectives of reorganization?

BECK: The goals and objectives are the implementation of the mandate we have from the legislature and also the implementation of the goals and objectives the board has set up for our department.

I think a major objective relates to greater cohesiveness and teamwork in the entire gamut of services, and when I say gamut, I am talking about state schools, state hospitals, human development centers and community MHMR centers and, of course, the implementation of Senate Bill 791, the continuity of care measure.

In my opinion, the structure we now have does not promote this concept of teamwork and coordination, as I think the philosophical outline of Senate Bill 791 implies. I think reorganization is designed to promote this concept of teamwork in the continuity of care.

Photo by Sherry L. Grono

IMPACT: Now that the department has a new commissioner and he is not expected to assume his duties until late in February, will the implementation of a reorganization plan be delayed until his arrival?

BECK: Yes, it will. For practical reasons, we want Dr. Miller to review the work that has been done. And No. 2, House Bill 3 says that any organizational structure must be recommended by the commissioner and approved by the board.

I discussed this point with Dr. Miller when I called him to tell him he had been selected as commissioner. We are going to send him information on what has been going on in the reorganization study so that he will have time to study the proposal.

He plans to be in Texas at least two times before he assumes his duties, so we will have time to discuss these matters even before he begins his job as commissioner. Looking at the reorganization plan will be an ongoing process.

IMPACT: Some of the critics of the proposed reorganization effort have said that the plan under study by the board will produce "another layer of bureaucracy." What is your response to that allegation?

BECK: Actually, this does not occur. At the present time, the superintendents of the state facilities report to an assistant deputy commissioner who reports to the deputy commissioner who in turn reports to the commissioner.

Under the proposed reorganization plan, the superintendent reports to an area manager who reports to a deputy who in turn reports to the commissioner. So it is the same number of steps. There is no added layer of bureauracy.

IMPACT: What suggestions do you have for extending or improving our prevention efforts in the field of mental illness and mental retardation?

BECK: I feel very strongly about this, now that we have matured in a number of other areas. Basically, our facilities are JCAH- and ICFMR-approved. I think it was important to focus on these things.

Now I feel that two things are very important. No. 1 is prevention and No. 2 is planning for the next 15 or 20 years, because all the projections say Texas will continue to grow. Statistics say that a certain percentage of the population will continue to be afflicted with mental impairments.

In my opinion, there is no way we can cope with this situation in the future if we don't do two things. We have to let the legislature know of the statistical forecast situation. I think we have to propose to the legislature considerable expansion of prevention efforts. Part of that relates to what we can do internally in genetics screening. This is a big step forward.

I can't help but feel there are other avenues we have not addressed. I am particularly thinking of the educational system. If we can educate more of the potential parents as to what they can do to reduce the incidence of mental retardation and if we can educate them to cope better with the normal stress of everyday living, we will reduce the incidence of people requiring psychiatric help or having mental impairments. Now that is a nonprofessional opinion but I believe in it very strongly.

IMPACT: Much has been said and written about the high cost of providing services for the mentally ill and the mentally retarded and that community MHMR centers can provide those services at a rate far less costly than a state facility. Can the two service systems really be compared with each other? Isn't there a need for both services?

BECK: There is no question in my mind that there is a place for both services. I think the effort to provide better care in the community— the home environment—is being well implemented. The continuity of care legislation impacts immediately on that issue.

But from my observation there will always be a residue of people with mental impairments—the mentally retarded and the mentally ill—for whom institutionalization is the only answer. You just can't turn them out in the community and a home environment.

IMPACT: Do you think that in the long run we will see a decrease in the hospital and school populations?

BECK: I think we will see a percentage decrease but when you come to real numbers—with the population of the state increasing—I believe we have a problem that we will have to face up to and do some planning.

A couple of months ago I requested Mr. Adkins [Acting Commissioner James A. Adkins] to staff the question: what do we do in the next 15 to 20 years? In retrospect, the enactment of House Bill 3 in 1965 added impetus to a trend in MHMR care that already was under way—thanks to the success of psychotropic drugs for treating the mentally ill and improved techniques for helping the mentally retarded reach their full potential. This trend was the depopulation of hospitals and schools and greater emphasis on community care through community MHMR centers and outreach centers.

Unless adequate funds for treatment programs at the community level are provided, this trend will reverse itself. The population of our state institutions will increase and costs of care and treatment will also increase significantly.

It seems to me that we have an obligation to analyze what can happen if more funds and support are not forthcoming for community treatment, assuming that no new schools or hospitals are provided. For us to form recommendations, we need information and projections.

In my request to Mr. Adkins, I have asked him also to analyze the costs and treatment effectiveness of the operation of community MHMR centers, outreach centers and human development centers as compared to costs and treatment effectiveness of the hospitals and schools.

I believe we are at a major crossroad right now. We have done just about everything within the constraints of the legislature as far as community centers are concerned.

We have to get the story across to the legislature that, if we are going to continue this program, we've got to find more resources for the community centers.

Also, we need to look at the board's policy that some time ago said no more beds in schools and hospitals. I think that, at the time this policy was adopted, it was a very sound thing to do. Because of this population increase that we are experiencing in Texas—this movement to the Sun Belt—we are going to find, I believe, that we will have to take another look at this matter.

IMPACT: With the decrease in the federal budget and the loss of federal funds to the community centers, what, in your opinion, should the State of Texas do to provide the necessary money for the centers and what can be done to help educate the legislators about the need to supply ample resources to the community center programs?

BECK: This gets back to what I said previously about looking ahead to the next 15 or 20 years. I think some of the legislators are not taking a forward look. They think everything is going to stay the same. Well, it is not going to stay the same by any stretch of the imagination.

And so they have a couple of choices. One, they can decide to reduce the level of care this department provides. And I think this would be a mistake. I can't see that we have been exorbitant in the level of care we have been giving.

The other option is to recognize the situation that confronts us as we go into the future and provide some more dollars.

I am not one of those persons that moans and groans about the lack of federal support. Dollars all come from us as taxpayers. Whether it goes the federal route or goes in taxes we pay in the state, we will have to come out and decide what programs we are going to fund.

We, as an agency of the state, must point out what is being done and what we think needs to be done. Then the legislature has to decide whether we should continue these programs and, if we do, it will just take more state dollars to do it. And if they don't want to do it, that's for them to decide.

IMPACT: If you were to list TDMHMR's assets and liabilities, what would your list include?

BECK: I think our assets relate to the high level of care we give to the people we serve in our various facilities. I think the dedication of our staff throughout the department is very high.

On the liability side, I think sometimes our communications need to be improved throughout our entire operation. We need to improve on the teamwork concept and achieve more coordination.

Another liability that we now are turning into an asset is our data processing effort. We have been so far behind in our data processing and management information systems but this is being taken care of now.

IMPACT: When you hear people criticize the department and its facilities, what is your response?

BECK: First of all, I think that, with an operation as large as we have, affecting the lives of so many people regarding such a sensitive and personal matter with parents and those associated with people in our care, we are bound to be subjected to criticism.

My response is that, anytime I receive something in the way of criticism, I refer it to the staff to be sure we have looked at both sides of what has been alleged or what somebody has said.

Then, if some action is necessary, I expect the staff to take it and always respond whether it is to individuals or the media. I don't get upset, per se, when there is criticism. I think that is a natural, human thing that takes place. ■ *H.P.*

Pecan Valley MHMR Region

Where the emphasis is on independence

Nestled in a low farm valley is Stephenville, a picturesque, turn-of-the-century Texas hamlet whose red brick streets crisscross in a hopscotch pattern reminiscent of times gone by. Occasionally, a gray concrete patch divides the pattern.

Two blocks from town square is a white frame home converted years ago into hospital offices. It now houses the administrative offices of Pecan Valley MHMR Region (PVMHMR). Across the tree-lined street is Our Place, a cottage for clients of the PVMHMR Day Treatment Program.

"But community mental health does not exist in a building," says Theresa Mulloy, Ed.D., executive director of PVMHMR. "It exists in the community." Stephenville, like other towns in the PVMHMR service area, has a staff working daily with schools and organizations to bring better mental health to its citizens.

"We're not in the business of selling happiness," explains Dr. Mulloy, "but the quality of life can be enhanced. We want people to learn to handle their problems and to be effective American citizens."

Stephenville is a small community of proud people, a pull-yourself-up-by-your-own-bootstraps town of closely knit families. Sometimes this attitude is a hindrance in reaching people, says Dulaney Barrett, D.Min., PVMHMR's director of consultation and education.

"Values here are relatively well defined," adds Dr. Mulloy. "For that reason, it is easier for mentally ill people to live here. For instance, we can tell them 'If you dress this way, you will be accepted' or 'If you behave this way, you will be included.' It is not so easy in a large city where there is a diversity of people and cultures."

"We try to keep a balanced staff as far as professionals are concerned," explains Roy Alexander, director of client services. "In addition, because our regional centers are far from one another, we travel constantly and use the telephone a great deal. We have a traveling psychologist and a consulting staff psychologist."

PVMHMR, only four years old, has centers in Granbury, Mineral Wells, Stephenville, Glen Rose and Weatherford serving Erath, Hood, Palo Pinto, Parker and Somervell Counties.

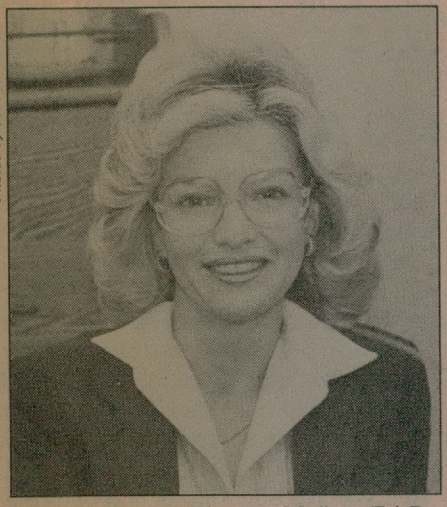
These centers offer a range of services including drug and alcohol abuse counseling; infant stimulation for developmentally delayed children; a 24-hour crisis intervention and suicide prevention emergency telephone service; and an alternate residential care unit that provides overnight care on a short-term basis for persons returning from or in transit to state hospitalization. Alternate residential care is also available to abused spouses.

Texas Highway Project

"We believe in paying your own way," says Dr. Mulloy. "The purpose is to instill pride—that's the American way."

With this emphasis, the Texas

Photos by Julie Lira-Powell



Shown above is Theresa Mulloy, Ed.D., PVMHMR executive director. In the group photo, Judy Rex, LVN (seated), shares a light moment with Betty Kirkham (left), Jan Bridges (center) and Jay Yates, alternative residential care employees.

Highway Beautification Project started a year ago. This project enables 32 handicapped persons to earn money, many of them for the first time in their lives. Thought to be the first of its kind at an MHMR facility, the project involves workers cleaning litter from state highways and maintaining two county roadside parks. Some clients earn up to $400 a month.

"It is a program that provides real employment, meaning and salaries," Dr. Mulloy says.

To win the beautification contract, PVMHMR had to enter competitive bidding. But since the mentally retarded clients proved efficient and caring workers, the state has set aside the programs for MHMR centers that may apply.

"Not only are they doing the job, they're doing it better than it has been done before," says Claude Milton, PVMHMR's coordinator of the highway project.

Work Activity Center-Sheltered Workshop

Lena Ellichman sits at her mechanical workshop table removing erector screws the size of match heads from small metal frames that are parts of a gun scope. "They are little and it is slow," she explains, "but the job's pretty good."

The next step in her job is to paint the indicators on the adjustment screws and the numbers on the cams and calibration rings.

Ellichman, 37, is one of three mentally retarded clients living independently and working at the Erath County Sheltered Workshop, located within walking distance of her apartment. On weekends, she earns extra money cleaning and maintaining a roadside stop for the Texas Highway Department.

"I love living alone. Only thing is it gets lonesome. But then I call momma or friends or play some records," Ellichman says.

Ellichman and eight other clients now are working on a Leatherwood Industries contract which involves making gun scopes for the U.S. Army. Workshop clients do the simple assembly of the scopes, then return them to the contractor for final assembly. Because of the clients' quality workmanship, Leatherwood, which has contracted with the workshop for the last five years, is planning to increase its orders.

PVMHMR also has a sheltered workshop program at the Hood County Work Activity Center in Granbury.

"They are little and it is slow, but the job is pretty good," says Lena Ellichman, a client of the Erath County Sheltered Workshop, as she removes tiny erector screws from metal plates, one step in the assembly of gun scopes.

Infant Stimulation

An important breakthrough in the field of MHMR care has been the early detection of developmentally delayed children.

Experts have found that the earlier these children receive special care, the greater their chances of achieving normal growth. The first three years of life are the most crucial because children in that age group have the greatest learning potential.

In a combined effort with pediatricians and local clinics, the PVMHMR Infant Stimulation Program staff has launched an all-out effort to encourage the parents of developmentally delayed children to seek help. Staff members often give talks and conduct special screenings of infants.

"Children who have problems developing speech or eating skills are sometimes ignored or it is thought that they will 'outgrow it,'" says Dale Warren, PVMHMR's director of developmental disabilities services. "These signs and perhaps slowly developing motor skills such as crawling, sitting, rolling or using hands may indicate developmental delay. Early assistance is important," he stresses.

Infant stimulation teachers Dee Wise and Cindy Worden drill children in such exercises as rolling over, raising the head, feeding, dressing, stacking blocks and talking. For rewards they lavish the children with lots of hugs, kisses and praise. Parents are taught how to provide continuous stimulation necessary to improve the child's skills.

Wise talks enthusiastically about Johnnie (not his real name), a 2½-year-old boy who came to the program with gross motor development problems. He had a severe limp when he walked, characteristic of a cerebral palsy child. He had great difficulty keeping his balance and he awkwardly used his whole hand for picking up small objects.

By practicing different sitting positions and doing a variety of special exercises, his limp has been considerably reduced. He now uses his fingers and thumb for picking up small objects and he goes about his play chattering contentedly like any normal two-year-old.

"Some parents have a real problem accepting their child's handicaps," says Kay Roubah, social services coordinator. "Our job as therapists is to help deal with those feelings and the rights of the child."

"It is an expensive program in terms

of time and money but it would be more expensive not to do it," Dr. Mulloy says. "No child, however, is denied therapy because a family is unable to pay."

All agreed that the impact of infant stimulation will be seen in a reduction in the number of adult clients within the next 10 to 15 years.

School Dropout Program

In keeping with its philosophy of prevention and community cooperation, PVMHMR's center in Weatherford is conducting a program to help high-risk junior high school students stay in school.

Because dropping out of school is a sign of underlying problems within the family, the center tries to treat the family as a whole.

Families are taken on week-end outings where they can enjoy themselves and learn how other families maintain discipline, manage financial matters and interact with each other. Children share in activities while learning to solve their problems more effectively and enjoy their family.

"Many times it is too late to keep the older kids from leaving school, but we try to help the younger children," says Dr. Barrett.

A unique aspect of this program is a linkage friendship system between high school and middle school youth. In a spirit of camaraderie, the older students help the younger ones find solutions to problems that confront them during difficult adolescent years. Students participate in many activities, including bowling, attending ball games, watching television or just sitting around talking.

The Key Link Program, as it is called, involves the cooperative efforts of the Weatherford Police Department and the public schools. Counseling through PVMHMR is available for any family member desiring it.

Day Treatment Program: Our Place

Our Place, a frame home with cheery yellow curtains, sits across the street from PVMHMR's administrative offices. The unit temporarily houses mentally ill day treatment clients who have been hospitalized and are easing back into family and community life. Also participating are clients who would otherwise be hospitalized away from their homes.

The program is based on the concept that each individual has a potential for improvement.

In addition to working on a news bulletin, clients participate in a variety of activities such as ceramics and needlework. They may take field trips that draw them into community events and group activities. Those who like competition can choose from a variety of games and sports.

At Our Place clients are learning to develop personal and social skills so that they can function as effectively as possible.

"What clients really like about the Day Treatment Program is that they can walk to town since it is only two or three blocks away," says Dr. Mulloy.

PVMHMR has similar day treatment programs in Glen Rose, Weatherford and Mineral Wells.

Work adjustment counselor Gretchen Walker (left) describes the gun scope assembly procedure to Dulaney Barrett, D.Min., director of consultation and education, as client Dora Estrada works on one of the assembly parts.

Learning About Substance Abuse

In Stephenville, legally a "dry town," alcohol abuse ironically is a real problem, according to Dr. Mulloy. For that reason, the PVMHMR staff devotes extensive effort to reversing this trend.

Recognizing that alcohol and drug abuse often start at an early age, the staff has approached the schools to help tackle the problem before it begins.

A special task group of school administrators, teachers, students and parents worked together, in consultation with Dr. Barrett, over the course of a year to develop a substance abuse prevention program the Stephenville School District is adding to its curriculum. Children from kindergarten through grade 12 will learn daily the responsible use of drugs and their effects on the human body.

The program pays particular attention to developing a positive self-image in students, since alcohol abuse among children and teenagers is often a result of peer pressure.

There are a few dark clouds on the horizon threatening some PVMHMR services. A change in the federal government grant program to the states may mean less money for social services.

The operating budget for PVMHMR in 1980 was approximately $828,000. Federal grants made up almost 38 percent of this amount or more than $311,000. Future loss of federal funds is estimated at between 25 and 40 percent, says Alexander.

"Hard dollars will be hard to come by," he adds. "Instead we will seek other kinds of resources."

He is hoping local citizens will respond to PVMHMR's need to stretch services by volunteering to help.

"When we started with Pecan Valley, the idea was that we were going to do away with the grant money in time. We are just going to have to be more creative in making these changes sooner," Dr. Mulloy says.

"Our emphasis is on getting patients out of the hospital," she says. If the Day Treatment Program were to close, the clients would be forced to remain in the hospital longer or stay there indefinitely.

Despite the uncertain future, PVMHMR staff members are optimistic as they go about making plans for the future. ■ *J.L.P.*

FAIR

New support for ex-patients, families

Mental illness may be one of the best-kept secrets in American society.

One out of four American families experience emotional disorder, according to estimates of the President's Commission on Mental Health, yet few dare to discuss it outside the privacy of their own homes. Embarrassment, shame and fear of nonacceptance further complicate the lives of those affected.

Because of the stigma of mental illness, recovering patients ready to return to society are met with a new set of obstacles. They face readjustment in an environment rife with hostility toward and ignorance of the sickness they have overcome. Giving up becomes a very real consideration.

Family and Individual Reliance (FAIR) is a statewide project of the Mental Health Association (MHA) that recognizes the dilemma of families and individuals affected by mental illness and gives them new hope and encouragement. Its program is based on self help through peer support.

FAIR aims to help provide support and understanding to clients' families; advocate for consumers' mental health services needs; and bring together individuals who have been hospitalized to share in readjustment to the community.

The project was begun and is funded currently by a National Institute of Mental Health (NIMH) grant to TDMHMR for developing support services for long-term chronically mentally ill persons.

Removing the stigma

Destigmatizing mental illness has to start with clients and their families, says Dian Cox, FAIR director. "If we are ashamed of being mentally ill, we can't really blame others for feeling the way they do. Society does a good enough job of stigmatizing us without our adding to it."

Practicing what she preaches, Cox matter-of-factly introduces herself as an ex-mental patient. Being an ex-patient is one of the requirements of her job.

Photos by Jackie Stilwell Neuman

Dian Cox, director, Family and Individual Reliance

Seven years ago, after a 10-year career in broadcasting, she began a descent into severe emotional difficulties that swept her from reality into three mental hospital commitments.

For four years, she lived in a world of irrational fears, too frightened to talk on the telephone or to write her own name in public.

"There was a real reason in my life for that paranoia, but when I couldn't face that real fear, I developed all the irrational ones," she says.

Cox's paranoia brought chaos into her mother's home also, since the young woman, unable to work to support herself, had no place else to live.

"So many doctors encouraged my mother to give up on me," Cox says. "'Put her away in an institution,' they told her. 'She's not going to get well. Don't let her continue to ruin your life.'"

But Cox's mother persevered—on her own. Between help from her, the right doctors and mutual support groups, Cox has put those days of terror behind her. She has been on her own and doing well for three years.

Knowing how lonely and difficult her mother's battle was a few years ago when there was no family support group to share the burden seems to have sharpened Cox's determination to spread the word about FAIR.

She is committed to further developing the network throughout the state. Since FAIR's inception a year ago, 22 groups have been established within MHA chapters, with locations in: Austin, Beaumont, Dallas, El Paso, Galveston, Houston and San Antonio, as well as in the areas surrounding Kerrville and New Braunfels. In Edinburg and the Freeport/Lake Jackson area, where currently there are no MHA chapters, groups have been established under the auspices of the state MHA division in Austin.

Originators of FAIR believe it to be the nation's first group that brings the client and family components together under one administrative umbrella, fusing their efforts toward legislative goals, yet calling for the groups' distinctive identities and separate meetings.

After observing that clashes between extremist family and client groups have threatened the efforts of both in some parts of the country, FAIR planners hit upon the idea of combining their forces.

"Even friends don't want to listen to you when you have mental illness in the family."

Their approach is aimed at creating a reasonable platform that is likely to win wider support for legislative programs. Currently, one of the group's main objectives is to obtain state support in establishing in the community more living alternatives for recovering patients.

Family groups

FAIR family meetings are designed to aid family members, especially parents, in understanding mental illness so that they can help speed the recovery of their loved ones and learn to cope with the concomitant stresses upon their own lives.

Linda Donelson, TDMHMR director of special programs and project director of the Community Support Program grant that funds FAIR, was instrumental in establishing the group and charting its course. Her 20 years of working as a mental health nurse specialist in California, Massachusetts and Florida gave her insights into the needs of family members as well as the needs of clients.

"When you work with the chronically mentally ill over a long period of time, you hear a lot of blaming of families," Donelson says. "And you hear massive amounts of guilt coming from parents.

"'What did I do wrong?' is the general feeling. They have the impression that the mental health system is saying 'You produced this sickness.' And they're right. The system traditionally *has* blamed them."

Severe restrictions in hospitals on families visiting patients and the use of the label "schizophrenogenic mothers" (those who produce schizophrenic children) are only a couple of the indicators, she says. "It's difficult for family members to be saddled with that guilt feeling and still be able to maintain a typical household."

Donelson points out that recent research is showing that chronic schizophrenia could be biological and that it is likely, instead of chaotic families producing schizophrenic offspring, that schizophrenic offspring are producing chaotic families.

Whatever the case, FAIR family meetings concentrate on educating and strengthening the families of the mentally ill, boosting their resolve and helping them overcome their guilt through mutual support. In essence, they are helping each other learn to maintain their own mental health.

Most parents agree that one of the greatest benefits of FAIR membership is contact with other parents of manic-depressive and schizophrenic children.

One mother, new to Austin, calls FAIR a "gift of God."

"It is extraordinary," she says, "to know that you can talk about this without being stigmatized and looked upon as being strange.

"My experience with FAIR has helped me to better understand mental illness and has given me hope, to know that I am not alone in the world, to know that there are ways and means of helping each other."

The father of a mentally disturbed child says, "They are people who listen and sympathize. Even friends don't want to listen to you when you have mental illness in your family. If it's heart trouble, they'll listen and sympathize, but they don't understand mental illness. They cannot really grasp what kind of thing it is and how hard it is to deal with."

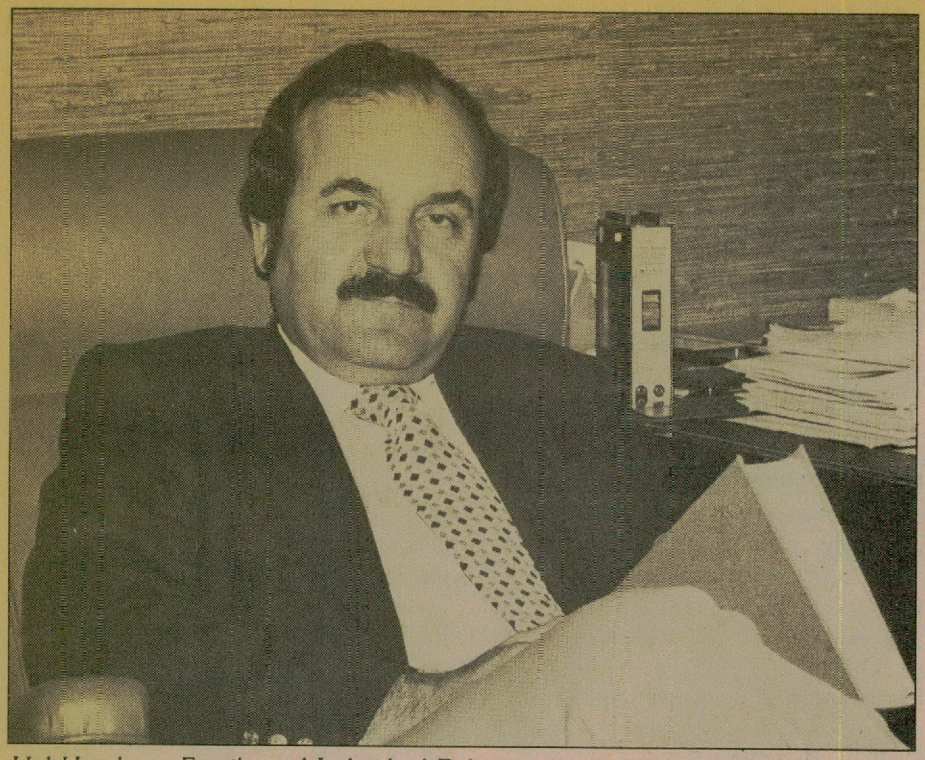
Client groups

Society hasn't given ex-patients a chance to learn to live with mental illness and still function, Donelson says. "The stigma forces them to feel isolated, lonely and different; then self-confidence goes down.

"Peer support groups are a place to begin to relate and to say 'I'm okay.' All of us need to know we belong to other people."

Cox believes that mutual support groups help clients regain their dignity. "My doctors were amazed at how [the] group speeded my recovery," she says. "Doctors would tell me what to do and [the] group would show me how."

At FAIR meetings clients learn from each other. They discuss their concerns, ask questions and listen to how others have handled similar problems.



Hal Haralson, Family and Individual Reliance steering committee chairman and Mental Health Association board member

In Austin, meetings consist of a general session for exchange of community services information followed by small-group discussions. Occasionally, there is a guest speaker.

At a recent client meeting, Hal Haralson, a successful Austin attorney, spoke of his own fight against mental illness. Today Haralson is chairman of the FAIR steering committee and a member of the MHA board of directors. Recently he was honored by Reclamation Inc., a former mental patients group, for his outstanding contribution toward reclaiming the human dignity destroyed by mental illness.

"I am one of you," Haralson said as he began to unfold the story of his life and illness.

Twenty years ago, after a long-term manic-depressive illness and a suicide attempt, Haralson found himself in a padded room at San Antonio State Hospital (SASH). He spent only one night in that room but remained at SASH for the next three months receiving therapy that he says helped turn his life around.

Though Haralson's words placed his crisis in an early 1960s setting, the vividness of his recollections said it was only yesterday. He hadn't forgotten the despair that caused his suicide attempt, the frustration he felt during his two months of job-hunting after he was released from the hospital, the strain his illness placed on his family life or that he came close to losing his wife and children.

Haralson and his wife Judy recently celebrated their 25th wedding anniversary, and he hasn't been a patient in a mental institution since 1974. Since his recovery, he has earned a law degree (entering law school at the age of 33), established his own law firm in Austin and lent moral support to Judy while she returned to school to earn a master's degree in counseling.

Haralson expressed high regard for the mental health professionals he encountered during his illness and gives them much credit for his recovery.

After his talk, listeners questioned Haralson about various phases of his transition to "normal" life.

One concern shared by everyone in the room was how an ex-patient can find employment when the inevitable question is asked: *Do you have a history of mental illness?*

Anyone who's experienced it knows that an affirmative answer to that query can be the death knell of an otherwise promising interview.

What, then, should ex-patients do? Does it pay to be honest with prospective employers?

"I can't tell you what to do. I can only tell you what worked for me," Haralson began.

"If I lie, then I have something I am concerned about others finding out about, and that is one hell of a burden. What we are talking about here is being mentally healthy."

One client said, "Sometimes it is smarter to lie."

Then another interjected, "Trying to be secretive about it can be devastating in itself. If you are going to remain straight with some kind of moral power, you must quit pretending that you have not been labelled 'mentally ill.'"

Another said, "I think it is a matter of privacy. It's none of their business."

Haralson said he has no argument with those who feel that they must keep their problem a secret in order to find or keep a job. "But," he added, "I am sure that there are people out there who are willing to give us a chance if we are open and honest about where we have been.

"I think I was eventually hired because a man was impressed that I was honest about my past," Haralson said, referring to his eight-hour-a-day, two-month search for employment during a period when mental illness was even more stigmatic than it is now. "I think that is one of the most important reasons why I am where I am today."

Unstructured approach

The FAIR program is unstructured in comparison to some mutual support groups, Cox says. "We have no rigid rules, but we do have a few guidelines."

FAIR support supplements, not supplants, the work of mental health professionals. Meetings never involve therapy and are conducted by non-professionals (usually clients or family members). Members share experiences and suggestions; no one gives or gets advice.

The future looks promising for FAIR, and Cox sees limitless opportunities for the groups to play a vital role in improving mental health services in Texas.

Though FAIR's current funding from NIMH will cease after May 1982, the project will continue with a matching grant recently awarded to the MHA from the Hogg Foundation for Mental Health in Austin.

Anyone interested in joining FAIR, forming a new group or making referrals may contact a local MHA chapter or Dian Cox, FAIR Director, c/o Mental Health Association, 4600 Burnet Road, Austin, Texas 78756. ■ *J.S.N.*

ECT: Then and Now

"No genuine discourse can be redundant when the truth about a treatment method is obscured by the righteous indignation of many who never use it and by the unquestioning faith of those who do."

—Milton Greenblatt, M.D.
Former Commissioner of Mental Health, Massachusetts

The mere mention of electroconvulsive therapy (ECT), more commonly known as electroshock therapy, evokes negative feelings in many people.

Somewhere in a magazine or comic book, they remember reading about inhuman doctors using electric shocks to punish powerless victims in the shadows of some musty and forgotten institution.

ECT, a method for treating severely depressed or suicidal clients via medically controlled convulsive seizures, was first used in Rome in 1938 by Ugo Cerletti and Lucio Bini. It was introduced in the United States in 1939.

Revolutionizing mental health treatment methods in the 1940s, ECT became one of the major physical methods psychiatrists used to treat the mentally ill until antidepressants became widely available in the 1960s.

Unfortunately, because ECT was so easy to administer, inexpensive to use and achieved immediate results, it became overused and thus, to some degree, fell into disrepute. Since then, ECT and the procedures involved in its use have improved considerably.

The way it was

Long gone are the days when clients lined hospital halls while waiting their turn on the ECT machine. In those days, ECT was performed without muscle relaxant or local anesthesia. Because of a shortage of personnel, clients themselves were asked to hold down the ECT recipient to prevent bone-breakage during the shocks.

The procedure was frightening to clients who watched as well as to other nonmedical observers who later described the treatment in movies, books and magazines.

The 1950s brought about better treatment for ECT clients with the introduction of a muscle relaxant that prevented bone-breakage, but until the practice of administering anesthesia along with ECT came into use in the late 1960s, the procedure was still traumatic. Anesthetizing the client helped to lessen the smothering feeling caused by the muscle relaxant.

"When I was a resident in the late 1960s, 30 or 40 clients [awaiting ECT] would be placed in a holding area reminiscent of a cattle pen," remembers Albert Gallo, M.D., clinical director of Austin State Hospital (ASH). "It was a morbid process for a sensitive human being."

Hal Haralson, an Austin lawyer, recounts his experiences with ECT in the 1960s:

"They got us together in the morning, usually without breakfast. I was in my pajamas. One at a time, they would wheel us out on a rolling stretcher to the room where they would perform ECT. When it was my turn, they put me upon a table and strapped me down. They put electrodes on my head. I remember the lights shining above.

"They gave me a muscle relaxant with a syringe and asked me to inhale and hold my breath and count as long as I could so that the muscle relaxant would work. The sensation was that of smothering to death. At this point, they gave me the shock.

"I remember screaming but I don't know if it was audible or just within my brain. After what seemed three minutes or three hours, I awoke.

"The experience was very frightening and painful but I decided I would do whatever was needed to reverse my depression." Haralson's deep depression had driven him to attempt suicide.

How it is today

With new antidepressant drugs now on the market, doctors have decreased their reliance on ECT. Still, for some clients, drugs are not the answer.

Antidepressants like imipramine may take up to two weeks before they give any therapeutic effect. For suicidal clients, those two weeks can mean the difference between life and death.

Other instances in which ECT may be considered are: (1) when large doses of medication and psychotherapy are ineffective and (2) when an individual is allergic to the necessary medications.

Today's ECT treatments are administered with muscle relaxant, general anesthesia and are "essentially painless," according to Dr. Gallo.

In Texas state hospitals, only qualified or training psychiatrists may give ECT treatments. They do so taking every possible precaution, aided by a variety of emergency equipment, including cardiac arrest and respiratory support units. The client is given multiple health examinations to ensure a successful operation.

Recent ECT study

Early in 1981, TDMHMR conducted a study to learn about current ECT use in Texas state hospitals. The study, entitled *Using Electroconvulsive Therapy in State Mental Hospitals: Is it Dangerous, Defunct or Too Demanding?* revealed, among other things, that out of 20,825 clients served in state hospitals in 1980, only 26 had received ECT for the first time. Figures also showed a 60 percent decrease in ECT use in Texas state hospitals between 1976 and 1980.

The survey, conducted by researchers Vijay K. Ganju, Ph.D., and Mark

Mason, of TDMHMR's Program Analysis, Planning and Resource Development Section, also revealed that, overall, physicians' attitudes were favorable toward the use of ECT.

Approximately 80 percent said that it remained the safest, least expensive and most effective form of treatment for severely depressed clients and some types of schizophrenics.

More than half of the doctors who responded to the survey said there were clients in state hospitals who should be receiving ECT but were not.

Some of the reasons they gave for this situation were doctors' fears of being sued, strictness of the Commissioner's Rule on ECT (which governs use of ECT in Texas state hospitals) and the difficulty in obtaining informed consent from the clients.

The question arose whether clients actually were being denied the most effective treatment for their problems.

Proposed rule change

Having seen a steady decline in ECT use in the last seven years, J.R. Clemons, M.D., superintendent of Terrell State Hospital (TSH) and the former deputy commissioner for MH Services, in March 1981 proposed a clarification of the Commissioner's Rule on ECT.

The proposed change emphasizes that "ECT is a valid treatment modality, and is, at times, the treatment of choice," phrasing already contained within the rule but repositioned in the prosposal for clarity.

The proposal formally states the requirement for giving a cardiovascular examination to clients prior to ECT treatments, a procedure already being practiced in most state hospitals in Texas. And it makes additional specifications as to cases in which ECT should be considered for use.

"ECT does have to be used with some precautions, but you should not waste a great deal of time on other treatments when the condition is so serious that you need to use ECT," he adds.

In the 1970s, ECT was used as a last resort to treat severely depressed or suicidal clients who were not responding to antidepressants or therapy. The proposed change in the Commissioner's Rule is intended to assure that ECT is not ignored as a treatment option.

"The fear of litigation within the medical profession in TDMHMR may be reflective of the overall medical profession," says Harold K. Dudley, Jr., acting deputy commissioner for MH services. "I don't know whether this fear is real or imagined."

W. Kent Johnson, TDMHMR chief of legal services, says that he is not aware of any case law dealing specifically with the issue of ECT in Texas but that such cases have been reported in other states.

ECT use in other hospitals

Although the previously mentioned study did not poll mental hospitals outside the TDMHMR system regarding ECT use, other research shows a greater use of this treatment in private hospitals and in public hospitals in other states.

All the reasons for TDMHMR's limited use of ECT in comparison to private hospitals' more frequent use of the same treatment are not completely clear. Some physicians answering the survey, however, did point out that clients' illnesses are appreciably different in the two settings and that informed consent is easier to obtain in the private sector.

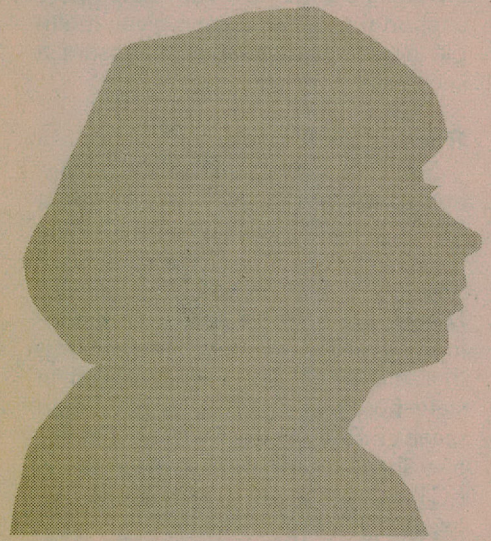
Other studies reveal a tendency for clients of private hospitals to be admitted voluntarily, to have higher income and education and to be insured.

Some doctors think that part of the reason ECT is given more often in private hospitals is that clients of these institutions are usually better able to afford the three-month hospital stay required for ECT. A series of ECT treatments usually involves a 10-week period plus about two weeks for recuperation. With drug treatments, a client can leave the institution within two to three weeks and continue to receive therapy as an outpatient.

Another possible factor limiting the use of ECT in state hospitals, according to some psychiatrists, is that state procedures and regulations, under constant scrutiny of taxpayers and legislators, are more rigid than those of private hospitals. Dr. Gallo thinks that this rigidity guarantees the client quality care.

Consenting to ECT

The rigid system followed by TDMHMR psychiatrists involves a consent form that must be signed by either the client or his or her legal guardian before ECT can be administered. In case of an emergency, ECT



"It may not be so bad forgetting certain things. Since I was very sick, I'm not so sure I want to remember that much detail," says one woman, referring to her loss of memory after ECT treatments.

may be administered without a consent form but with approval of proper authorities within the system.

This signed consent form verifies that the client has been given a verbal explanation by the attending psychiatrist in simple nontechnical language detailing medical procedures to be followed. By signing the consent form, the client states that the physician also has explained any discomforts, risks and benefits connected with ECT treatments.

Additionally, the psychiatrist discusses with both the client and legal guardian psychotherapy and antidepressant drugs, answers their questions and informs them that the consent may be withdrawn at any time.

Answering some crucial questions

Despite all the precautions, some critics think ECT is still not safe. They say that ECT causes permanent memory loss. While doctors do warn that a certain memory loss does result from the treatments, they say that loss involves only the six months prior to the treatments and that memory returns within a year.

Dr. Clemons compares loss of memory resulting from ECT to forms of memory loss that result from diseases such as meningitis. Major surgery can have similar effects on memory, he says.

"I have treated professional people who depend on their stored knowledge for their livelihood," says Dr. Clemons. "They have gone back to their work and have functioned well."

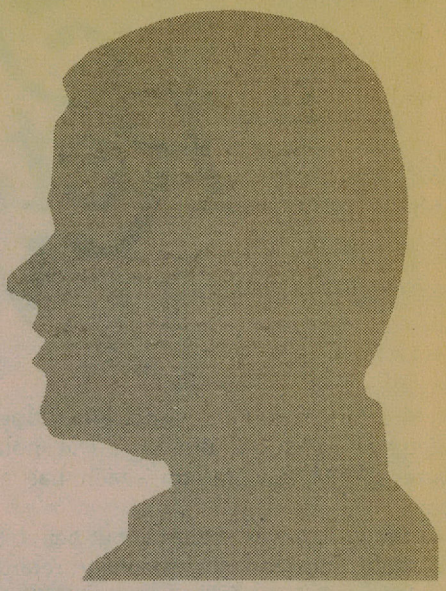
Charlotte Douglas, a past ECT client, seems to bear this out (see IMPACT, March/April 1980). Douglas, a high school teacher, was given ECT treatments for depression after other methods had failed. In less than a year, she was back in the classroom.

Still, some ex-clients point to the risks of using ECT. They tell of experiencing headaches, nausea and confusion. They talk of not remembering past friends, places or things from before the treatments.

"I've lost a year of my life because of ECT," says Alice (not her real name). "When I go to a store, it feels like a new store to me. I need a map to get to places in Austin and I've been here over five years."

Another past client tells about finding clothes in her closet that she did not know she had. "I held a jacket trying to remember how I had gotten it. I eventually remembered bits and pieces of a past Christmas," says Dana (not her real name). "However, it may not be so bad forgetting certain things," she adds. "Since I was very sick, I'm not so sure I want to remember that much detail."

"I have no more right to stop you from having ECT than you have to stop me, if I desire it."



Another claim critics make is that ECT damages the brain. It is no secret that ECT treatment over a period of many months does alter parts of the brain.

Coleman C. de Chenar, M.D., a pathologist at ASH, says he has found "noticeable changes in the brains of ECT clients where treatments had continued on a regular basis over many months."

"ECT causes a reaction like an epileptic seizure; if epileptic seizures continue over long periods, structural changes in certain parts of the brain occur," says Dr. de Chenar. "These changes also occur after several months of intensive electric shock treatments."

Critics also say that no one knows how or why ECT works. In the past, doctors believed it worked psychologically, as an incentive for clients to get well because they feared the treatment or because they experienced memory loss. These reasons have not been supported by research.

According to Dr. Clemons, however, there have been recent discoveries. Researchers, he points out, have found that certain physiological and hormonal changes occur during the convulsive seizure to make it work.

"Until recently, we didn't know how aspirin worked either," adds Dr. Gallo, "but that didn't stop us from using it. So much is serendipity. Thorazine was originally an antihistamine until we found out it could be used as an antipsychotic."

Although views greatly differ about the effectiveness of ECT, many ex-mental clients agree it should be available to persons needing it, but only as a last resort and after clients have received alternative treatments and warnings about ECT's possible side effects.

"I have no more right to stop you from having ECT than you have to stop me, if I desire it," Haralson says.

Dr. Gallo and Dr. Clemons agree that ECT's real problems lie, not in its side effects or in the elaborate requirements to implement it, but in the public's perception of it.

"The only time we get any publicity is when something goes wrong. We seldom receive credit for our achievements," says Dr. Gallo. "We need to educate the judiciary, the legislature and the public so that we can get a greater level of public confidence."

Despite their differing opinions, physicians are striving daily to find better ways to help people suffering from mental illness. They share the common goal of seeing clients recover as soon as possible. For some like Haralson or Douglas, ECT may have been the only answer. For others, only time will tell.

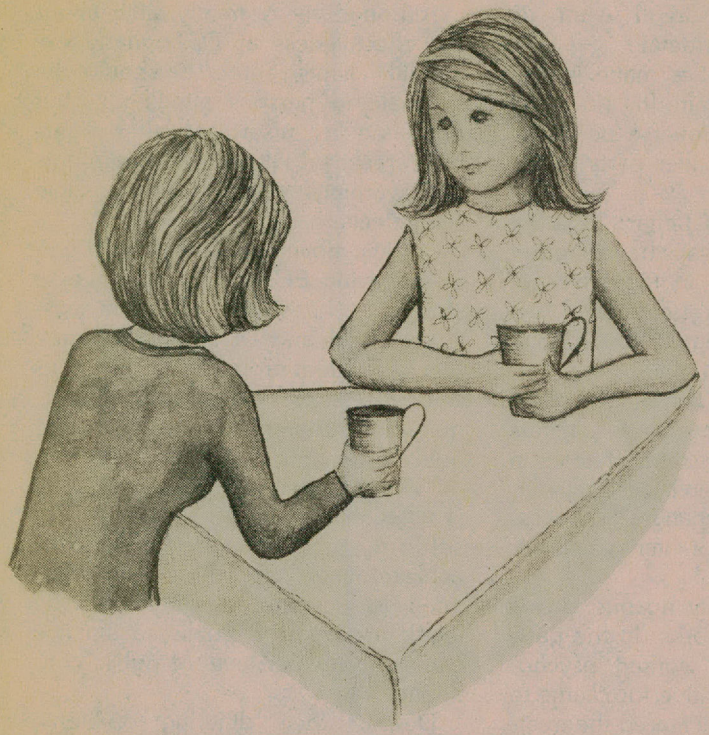
"You do for humanity whatever, whenever and however you can," says Dr. Gallo. ■ *J.L.P.*

Mental Retardation... What is that?

By Janet James McKee

Mrs. Green and her friend, Mrs. Lopez, were talking over a cup of coffee one morning. The mothers had something very special in common—each has a mentally retarded child.

Mrs. Green was talking about her child, John. "The doctor told me John is mentally retarded. I never have understood that. John is not so different from my other children. Now, he's been slower than my other children to do a lot of things. It took him longer to learn to feed himself and to dress himself. But mentally retarded? He's never been sick a day of his life! I don't know why the doctor said he is retarded. I thought those kids couldn't learn anything."



"My girl, Cynthia, is sixteen, and she's been real slow to learn things, too," said Mrs. Lopez. "The doctor said she is retarded because she's a mongoloid. But I really don't know what he means. She does learn things. She's just real slow."

"Isn't it odd," said Mrs. Green, "how our children are so different but they're both called mentally retarded? I wish I knew more about it. Are there different kinds of retardation? What causes it? What did I do to make John retarded? Or did I do anything? What can I do now? I know John is different but there is so much I don't understand."

Mrs. Lopez had an idea. "Why don't we go visit a psychologist? A psychologist once gave my Cynthia some tests. Those tests told us how retarded Cynthia was and how much we could expect her to learn. I bet the psychologist would explain some things about mental retardation."

So Mrs. Green and Mrs. Lopez called the psychologist and arranged for a meeting.

One afternoon the psychologist called together a group of mothers who all had a retarded child for a long talk about their children. They soon learned that each child was very different from the others and very special in his own way.

The psychologist started talking about retarded children. "Retarded children are more like your other children than they are different," he explained.

"We say retarded children have a learning handicap—they are slower to learn how to do things. For example, your other children may have started walking when they were about one year old. And a retarded child may not walk until he's three or four, or even much older. If a child can't do the things most other children his age can do, we might suspect he is retarded. A psychologist can give him certain tests to tell for sure.

"But don't confuse mental retardation with mental illness, or with being sick," cautioned the psychologist. "Your retarded child is not sick, nor is he 'strange.' He's a slow learner, and there are some things he may never learn. But he can learn!"

Mrs. Green spoke up. "I can understand that my John is a slow learner but tell me why he's retarded. What causes retardation? Does John have the same thing Mrs. Lopez's daughter has?"

"Retardation," answered the psychologist, "is caused by anything that happens in a person's life that prevents, reduces or delays learning."

"Well, what does that mean?" asked Mrs. Green. "Tell us what can cause this learning problem?"

The psychologist explained, "Mental retardation can start when a child is very young, at birth, or even before birth—when the mother is still pregnant.

"Let's begin there, before a child is even born. Do you know what genes or chromosomes are? Genes are very small parts, so small you can't even see them. They determine all sorts of things: what color eyes a child will have, what color hair.

"These genes are located on something called a chromosome and there usually are 46 chromosomes. A baby gets 23 chromosomes from the father and 23 from the mother.

"But a baby may somehow end up with 47. This is what happened to your daughter, Mrs. Lopez. For some reason,

Cynthia has an extra chromosome and we call this Down's Syndrome, or mongolism. And all this happened before she was even born.

"But other things can happen before birth to cause retardation. The mother may not eat all the right foods, so the baby doesn't get all the nutrition it needs.

"Or, the mother may have some illness, such as German measles, while she is pregnant. In some cases, this could cause the baby to be retarded. Other things can also cause retardation when the mother is pregnant. These are only a few."

Another member of the group spoke up. "My doctor said my child is retarded because she didn't have enough air to breathe when she was first born. Can you explain that?"

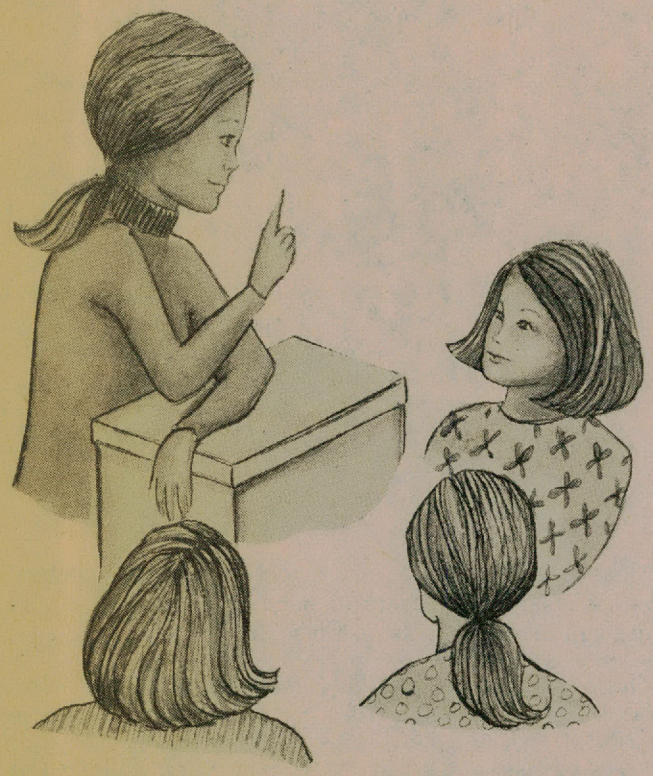
"Sure," said the psychologist, "that's something called anoxia, when a baby doesn't get enough oxygen during birth. Perhaps his nose and lungs got stopped up with fluids or mucus. Or the umbilical cord, the cord between a mother and baby, may be squeezed or pinched for so long that the baby's oxygen supply is cut off.

"Another thing can happen during birth. A mother may have had such a long and difficult labor that the baby's head could be injured. This could result in brain damage."

One of the mothers spoke up. "My child was normal until he had something called encephalitis. He had a high fever for long time. After he got well he was retarded."

"Yes," answered the psychologist. "Things can happen after a baby is born—early in his life—that may cause retardation. You just mentioned encephalitis. What happened is, the high fever caused brain damage, leaving him retarded.

"Another disease called meningitis might possibly do the same thing. Or, a young child may receive a serious blow on the head, damaging the brain, and causing him to be retarded.



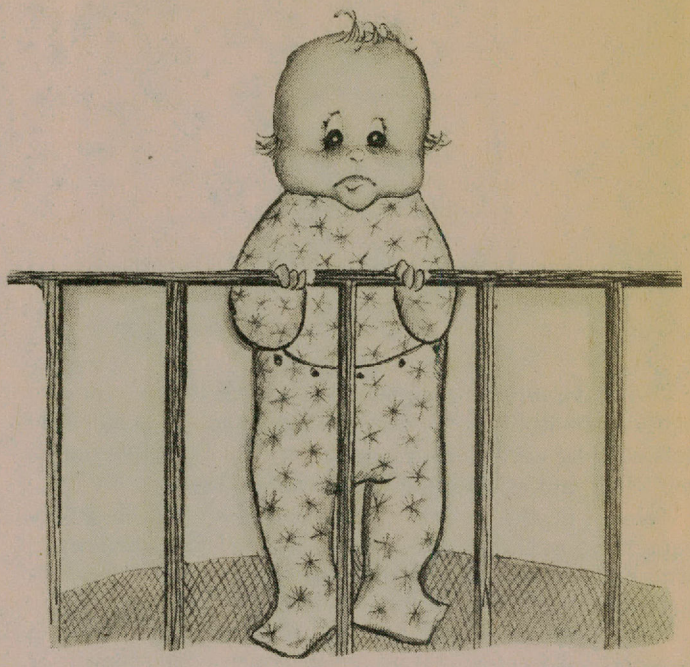
"Are these all the causes of retardation?" asked Mrs. Green.

"Oh, no!" answered the psychologist. "There are many more things that could cause retardation. And we haven't discovered all the reasons yet.

"You are very important to your child. And you can do much to help him learn all he is able to learn. You can help him reach his fullest potential."

"What does that mean?" asked Mrs. Lopez. "What can we do?"

"Let's talk about the mother of a young baby," responded the psychologist. "She may feed the baby when he's hungry, change his diapers when he's wet but the rest of the time, the baby just stays in his crib.



"The mother never talks to her baby. She never picks him up. The baby doesn't have any toys to play with. The mother thinks her baby can't learn anything so she never tries to teach him. What do you think would happen?"

"I don't think that baby would learn very much," answered Mrs. Lopez.

"Exactly," said the psychologist. "If a child never has anyone to talk to him, he won't learn to play with toys. And if a mother thinks her child can't learn to do anything—and does everything for her child—the child won't learn to help himself."

"What exactly are you saying?" asked Mrs. Green.

"All of us are made up of what we are when we are born. We call this our biological makeup. We are also made up of what goes on around us after birth, our family, our home, our neighborhood, our school, our friends. We call this the environment.

"A child may be retarded because of a physical or biological reason. If his environment is poor or dull, too, this will contribute a great deal to the child's not learning. For example, if you hang a bright mobile over his crib, he will enjoy watching it move. Moving colors are much more fun than a plain ceiling."

Mrs. Green had never thought that improving the environment could help her child learn more. She and the other ladies asked the psychologist to explain more about environment.

"In order to learn, a child needs an opportunity and a reason," the psychologist said. "Let's say your child has heard you say 'ma-ma' all the time. One day, he says 'mama' and you get all excited, pick him up and kiss him. He

soon learns that whenever he says 'ma-ma' you are going to come to him. And he likes that.

"Now, it may take him a while to learn. But if you are sure to reward him with a hug or kiss, maybe even with a cookie or favorite food each time he says 'ma-ma,' he'll learn to say the word all the time.

"What if every time he says 'wa-wa' for water, you give him water and a hug? He has no reason to say 'water.' He gets what he wants just by saying 'wa-wa.' Try to get him to say water and reward him every time he tries."

"Well, I have a question," said one of the mothers. "My daughter sometimes acts a little strange. She shakes her arms and acts silly. People have told me that it's just because she's retarded. Could she have learned to act this way?"

"Oh, yes," answered the psychologist. "Too often a retarded child acts badly because people expect him to or because they never expect him to act nicely. These children can and should be expected to behave like your other children.

"You see, if a retarded child is around people who think he is very different from normal children, they may treat him differently. Or they may feel sorry for him and pay attention to him when he's very bad. They actually 'teach' him to be different.

"A retarded child is slower to learn things. There are some things he may never learn. It is different for each child. You mustn't expect too much or too little from your child, any more than you do from your other children. The more you treat him like your other children, the more normal he will act. He should be treated as normally as possible."

The psychologist continued. "As your child learns a new task, he also is learning how to learn. If you pay lots of attention to him when he is learning to talk, you will be helping him to try more and more words—and later phrases and then sentences.

"You may have other problems in your family. Maybe someone is very ill or you don't seem to have enough money, or you have a lot of other children who demand your time. It may seem you just don't have enough time to work with him. Or you figure he'll learn on his own as he gets older.

"Remember, the more you teach your child when he is very young, the more he'll learn and the happier both of you will be when he's older. What may seem cute when he's three or four is not so cute when he's older.

"He needs to be with people who will talk to him and spend time with him. He needs to be around interesting things and he needs to go to different places—to the park, to the store, to the zoo. And don't treat him like he's strange or sick. He is not. He's a special child, just like your other children. He needs and deserves to learn as much as he can."

One of the ladies spoke up. "I think I understand. I help my son a lot more than I help my other children. I dress him. I feed him. He doesn't have many toys. Maybe if I tried to teach him these things, he would learn. I guess I feel guilty because he's retarded. So I try to help him more."

"Do you think he could learn to do more for himself?" asked the psychologist.

"I think so," she answered. "You've said today that so many things can cause retardation. My child was retarded when he was born. I never thought I could help him by changing this thing you call environment. But I understand now. What we all need to do is teach our children whatever they can learn."

"Let's review what we learned today," said the psychologist. "There are many different causes of retardation. Some things can happen before a baby is born, while it is being born, or early in its life.

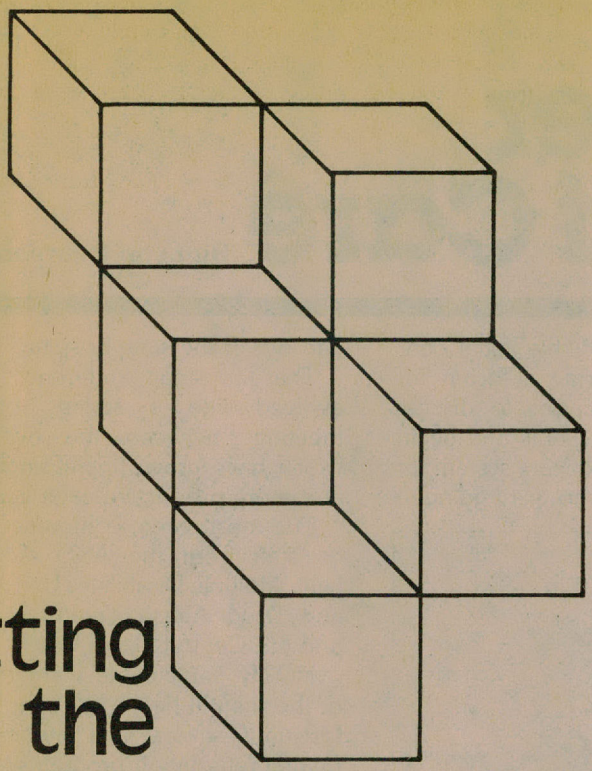
"Mental retardation means the child is slower to learn and he may never learn some things. But he can learn.

"We can help our children learn by talking to them, taking them to different places, giving them toys to play with—by making their environment interesting.

"Just as other children are taught to behave, mentally retarded children can learn to behave nicely. We should treat them as normally as possible." ■

This material is available as a brochure in limited quantities. It may be ordered from the information director at local TDMHMR facilities or from Harley Pershing, Director, Public Information Services, TDMHMR, P.O. Box 12668, Austin, TX 78711.

The author Janet James McKee and illustrator Lindy Robinson are former TDMHMR employees.



Fitting the block grant puzzle

Christmas week, John (not his real name), a handsome man in his thirties with a history of manic-depressive illness, was rushed to a Denton general hospital. John was suffering extreme depression, causing him to quarrel and abuse his co-workers to the point of being dangerous.

While in the hospital, he received therapy and medication from North Central Texas MHMR Center (NCTMHMR) in McKinney through a special inpatient program cooperatively sponsored by the Denton hospital and the center.

Within a few days, John was back at his job and was able to enjoy New Year's Eve with his wife and children. Fortunately for him, NCTMHMR's inpatient program, designed to help people without insurance or money and funded by a federal grant, was there to help him.

In June this service and others in 15 Texas community MHMR centers either will be eliminated or reduced because of a 26 percent reduction in federal grant money. The cutbacks are being ushered in along with a new method of administering these funds which employs block grants.

In the past, federal funds for health and human services have been administered directly to the receiving state agencies through 25 separate, categorical grants. Under the new system, those 25 grants will be compacted into 7 state block grants: preventive health; maternal and child health; alcohol, drug abuse and mental health; primary care; social services; community services; and energy assistance.

Federal funds for mental health now will be combined with alcohol and drug abuse funds in one grant referred to as the ADM (Alcohol, Drug Abuse and Mental Health) block grant.

The ADM grant to Texas totaling $17 million will be shared by TDMHMR for mental health, the Texas Department of Community Affairs for drug abuse prevention and the Texas Commission on Alcoholism for alcoholism-related services.

TDMHMR's portion of the grant will amount to about $6.8 million, with the remaining $10.2 million going for alcohol and drug abuse services.

"The reality is that TDMHMR has almost $2.5 million less to work with," says James King, TDMHMR acting deputy commissioner for community services. Last year, Texas mental health programs received .$9,188,000 in federal funds.

"We like the block grant concept," says King, "but we would have preferred a block grant without a decrease in funding."

Most mental health grants originally were issued for an eight-year period after which the programs were supposed to continue with local funding. Since 10 of these programs are in their eighth year, they will not be as severely affected as those in centers which are just beginning their grant cycle. King points out, however, that the cuts will indirectly affect the whole mental health field.

Buddy Matthijetz, TDMHMR director of program analysis, planning and resource development, is chairman of a task force charged with administering the ADM block grant to the receiving agencies and implementing distribution of TDMHMR's portion under policies to be set by the Texas Board of MHMR.

He says the task force will probably reduce each center's funds by the same percentage that the total funds are reduced.

"There are so many variables that can turn this into a complete nightmare," says Matthijetz, explaining that the grant amount will be subject to change until Congress passes a final appropriations bill.

Gary Smith, NCTMHMR executive director, says the block grant system is intended to reduce bureaucracy and paperwork. So far, however, federal grants have been complicated to administer, he adds, and have cut into staff time.

TDMHMR officials agree that at this point it is difficult to predict the ultimate effects of the funding cuts and the changeover to the block grant system.

"MHMR centers may have to become more aggressive in charging patient fees," King says. "They may ask local government for more money or they may use traditional ways of fund raising through their own efforts."

He cites a recent campaign in Giddings in which the community residents raised $200,000 to keep the town's only hospital from closing its doors.

King says a one-time fund raising campaign may be an answer to a specific problem. "But it is not the best way to fund ongoing mental health programs," he adds. "You can't keep going to the people over and over for the same program."

Samuel Brito, mental health consultant for the Region VI alcohol, drug abuse and mental health division of the U.S. Department of Health and Human Services in Dallas, says that only time will tell how successful the block grant system will be.

"It will depend on how well organized communities are in dictating their needs to their local authorities," he says.

"They are going to need someone who will identify sources of revenue and an advocate to appeal to the Texas Legislature for those sources if they want the services that are being lost."■ *J.L.P.*

Toward Better Continuity of Care

By Lynn Pearson

Five years ago a small group of staff from Austin State Hospital (ASH) and the Heart of Texas Region MHMR Center (HOTR) in Waco met together for the first time to share information and ideas on joint clients.

The major goal of this initial conference was to provide a forum for staff of the two facilities to discuss problems in serving clients and begin creating a continuity of care system for HOTR area clients who were going in and out of the state hospital.

That first small conference in 1976 evolved into a series of annual meetings between the two staffs, which have grown increasingly larger and more productive each year.

The most recent conference included staff from the ASH Adolescent Unit, Multiple Disabilities Unit, Alcohol and Drug Abuse Treatment Center and the Central Texas Unit.

HOTR participants were members of the mental health staff and, for the first time, several staff members from mental retardation programs.

A broader staff participation this year from both facilities helped to sharpen the general understanding of goals, problems and concerns inherent in their mutual commitment to providing appropriate, effective psychiatric care for the HOTR area residents.

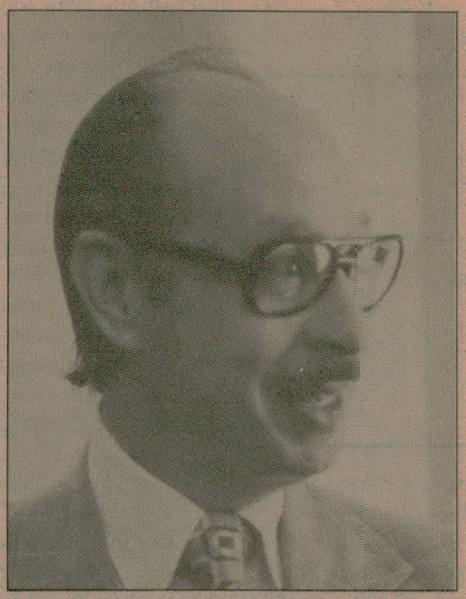
Without the continued support and encouragement of Luis Laosa, M.D., ASH superintendent, the development of a working continuity of care system between the hospital and the center would have been slower in coming and much more difficult to maintain.

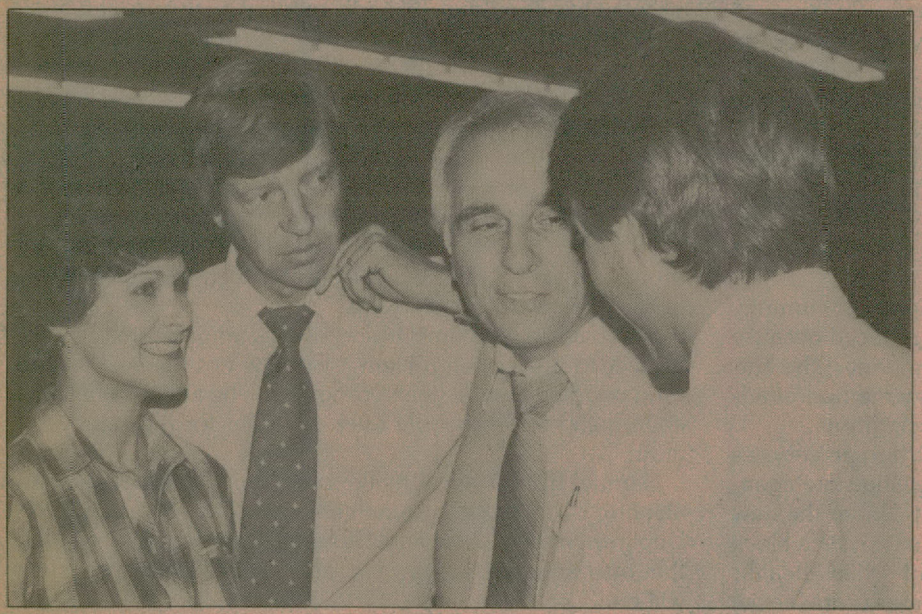
Continuity of care begins with the center screening persons who have psychiatric problems to determine whether they need the long-term treatment available at ASH. If the persons can be treated effectively in the community, then the center offers that treatment.

The screening helps assure that only those persons who are experiencing severe psychiatric problems are referred to the state hospital where they can receive intensive therapy in a 24-hour structured environment.

While HOTR clients are in the state hospital, center staff travel regularly to Austin and are kept informed of the clients' progress. When the time for discharge approaches, ASH and center staff sit down with the client and prepare a joint treatment plan, which the client signs before leaving the hospital.

Photos by Lynn Pearson





Austin State Hospital (ASH) and Heart of Texas Region MHMR Center (HOTR) staff members meet annually to exchange ideas and information on joint clients. In the top row are Kathryn Lynn, HOTR aftercare director, and Luis Laosa, M.D., ASH superintendent. In the group photo (left to right) are Mrs. Albert Gallo; Jim Newkham, HOTR outpatient director; Albert Gallo, M.D., ASH medical director; and Lee Wallace, Ph.D., ASH clinical psychologist.

According to Dean Maberry, executive director of HOTR, the annual joint conferences between the staffs of the two facilities have provided the time and the cooperative atmosphere necessary to produce a well-oiled screening system, which he said has played a vital role in reducing the number of persons admitted to ASH from the MHMR center.

"The total number of admissions to ASH from our region continues to decrease on a year-to-year basis," he said. "However, while the total is decreasing, the number of severely disturbed admitted has increased by 30 percent since 1979. This has meant that, even though the hospital is serving fewer people, it is providing almost the same number of bed days annually for the harder-to-treat patient."

Maberry said one of the reasons for these statistics is that the center is doing a better job of screening clients referred to ASH and that ASH is providing increasingly more effective response in treating these clients.

"We feel that the quality of care for our clients at ASH is excellent," he continued. "The net result is an effective continuity of care network between the two agencies."

Because the core group of staff attending the joint conference has remained essentially the same for the four annual meetings, the relationship among this group has grown closer, smoother and more informal over the years.

The addition of new staff with different training and experiences has created an even larger reservoir of skills and insights which helps to create fresh approaches to treating the most difficult of the facilities' shared clientele.

According to Dee Blinka, program director of HOTR, the fourth annual conference "cemented the strong team spirit and solidarity of the two agencies' working together, an approach long ago advocated by Dr. Laosa and supported admirably by his staff through the years."

She said that staff now know each other as persons rather than just voices on the telephone, something that helps considerably in fostering cooperation. One aspect of the conference Blinka found particularly beneficial was the inclusion of staff who work with emotionally disturbed mentally retarded persons.

"I think our staff has a much clearer understanding now of the difficulties experienced in placing emotionally disturbed mentally retarded than we did before the joint conference," she said.

"It was especially helpful for all the participants to address the needs of this client group instead of relegating the discussion to a small group of specialized staff, as has been done in the past."

The solid working relationship between the local MHMR center and ASH has resulted in a much more coordinated approach to client care in the HOTR area.

Center staff are careful to make sure persons returning home from the state hospital keep their appointments at HOTR during their critical adjustment period.

That's what continuity of care is all about: staff coordinating and communicating with each other to benefit the clients, making it more difficult for them to find themselves alone and helpless, prime candidates for a return trip to the state hospital. ■

This article originally appeared in MHMR, *the newsletter of the Heart of Texas Region MHMR Center. Lynn Pearson is the center's information director.*

DRUG DIALOGUE

By L. R. Dillon, R.Ph. • Edited by Michael W. Jann, Pharm. D.

The inability to sit still in class, poor performance in school despite average or above average intelligence, coordination problems, poor memory and a short attention span are traits that may be attributed to as many as 10 percent of all school-age children.

Some of these children might be diagnosed as having minimal brain dysfunction (MBD), a disorder in which certain areas of the brain are slow to develop.

Such "problem" children, once simply thought to lack proper discipline, can often benefit from a combination of counseling and therapy with stimulant drugs. The most popular and one of the most effective drugs for this purpose is methylphenidate, sold under the the trade . name Ritalin, which seems to act by stimulating certain slowly developing areas of the brain.

Because methylphenidate can cause in normal individuals some of the symptoms it helps control in cases of MBD, great care must be taken in diagnosing the malady and monitoring the effects of the drug.

In normal individuals methylphenidate can cause restlessness, insomnia and, in high enough doses, a drug-induced psychosis almost identical to paranoid schizophrenia. Higher doses can overload the nervous system and lead to seizures and death.

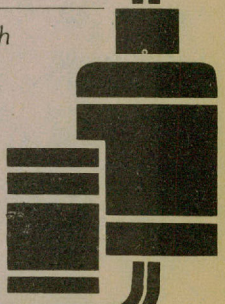
Side effects which can be caused by methylphenidate include rapid heartbeat, nausea, decreased appetite and a resultant weight loss. Caution should be used in taking other drugs along with methylphenidate, since it interacts with many prescriptions and over-the-counter preparations.

Methylphenidate is available in 5-, 10- and 20-milligram tablets and is usually prescribed in daily doses of 10 to 40 milligrams.

If you have any questions concerning the use of methylphenidate, ask your pharmacist or physician. ■

L.R. Dillon is a contract pharmacist with the Bexar County MHMR Center. Dr. Jann is San Antonio State Hospital's chief of pharmacy services.

Pharmacists working with TDMHMR are invited to contribute to this column. For guidelines, contact IMPACT editor at the address shown on the back cover.



EXPANDING HORIZONS

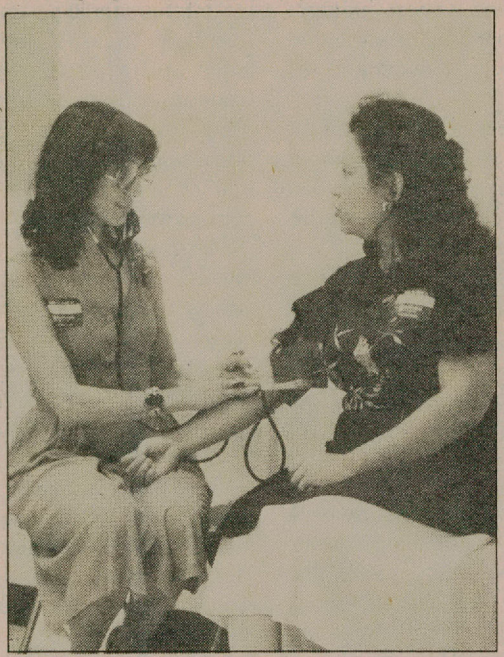
By Cheryl Callicott

It sounded like a good idea—let the employees know what kinds of jobs are available and the qualifications needed to apply for them. Thus began the first annual Career Day at Corpus Christi State School (CCSS).

Career Day was a recent project of the Employment Advancement Committee, a group of employees who volunteered to work with Supt. James Armstrong, Ph.D., to facilitate upward mobility and career advancement for CCSS employees.

The theme of the day was "Expand Your Horizons" and 22 departments set out to do just that. Using job descriptions, posters, photographs, slide shows, printed materials and lots of salesmanship, department staffers discussed career opportunities with more than 300 employees who reviewed the displays during the day.

Photo by Linda Roehl



At Corpus Christi State School's first annual Career Day, Anne Saenz, director of nursing, checks the blood pressure of insurance coordinator Janie Martinez.

Displays included the Rehabilitation Department's handcrafted items; Occupational/Physical Therapy's adaptive equipment for feeding; and Housekeeping's cleaning aids and tips.

Medical Services handed out grab bags, offered blood pressure checks and brought scales for the weight conscious. Volunteer Services displayed scrapbooks chronicling the school's 10-year history.

Photo by Cheryl Callicott

Staffing a Career Day information booth are Barbara Alvarez, director of the Foster Grandparent Program, and Manuel Barrera, staff development trainer.

Other departments attracted attention with helium-filled balloons, apple trees and displays of special equipment.

Since the focus of the project was to acquaint employees with advancement opportunities within the school, much attention was directed toward job descriptions and discussions of training needed to compete when openings occur.

Follow-up to Career Day will include employment interviews and opportunities for staff members to spend a day working in a different department to find out what it would be like.

Members of the Employment Advancement Committee say that, although Career Day was a tremendous success in terms of quality of displays and numbers of staff members involved, its real effectiveness will be measured by the number of internal promotions that occur. ■

Cheryl Callicott, director of staff services at CCSS, serves as liaison to the Employment Advancement Committee.

DSM-III TRAINING GUIDE - AN AID TO MH PROFESSIONALS

By Lore Feldman

TRIMS team produces best-seller

The *DSM-III Training Guide* is selling beyond the wildest expectations of its editors at the Texas Research Institute of Mental Sciences (TRIMS) in Houston and even its sedate New York publisher Brunner/Mazel.

With a record 32,000 copies sold in the first two months, the book is far and away the best-seller at Brunner/ Mazel, a leading publisher of psychiatric literature. A psychiatric text book is thought to be doing extremely well if it reaches a sale of 5,000.

The guide to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (Third Edition)* consists of training materials tested in workshops throughout the state and written and edited by TRIMS faculty members. Editors are Linda J. Webb, Dr. P.H., TRIMS continuing education chief; Carlo C. DiClemente, Ph.D.; Edwin E. Johnstone, M.D.; Joyce L. Sanders, R.N.; and Robin A. Perley.

An audiovisual package of 140 slides and a 60-minute videotape which presents five cases was prepared by former TRIMS audiovisual chief Mike McGuyer. These are available as a separate package from Brunner/Mazel.

The guide is designed to be used both for self-instruction and as a text in continuing education programs in which the *DSM-III* classification system is taught. It covers the basic concepts and applications of the *DSM-III* diagnostic system. As a companion to *DSM-III*, it offers systematic coverage of the major classifications, as well as illustrative tables and case examples.

Comments about the guide's quality, timeliness and usefulness are coming in from leaders of the psychiatric profession. It is a "clear and succinct adjunct to *DSM-III*," wrote Jerry M. Lewis, M.D., psychiatrist-in-chief of Timberlawn Psychiatric Hospital in Dallas, while social worker Ellen Rosenthal of The Guidance Center, New Rochelle, N.Y., called it an "absolutely indispensable tool for intelligent understanding and accurate use of *DSM-III*."

Authors of chapters include James L. Claghorn, M.D.; Jaime Ganc, M.D.; Mary Beth Holley; Mohsen Mirabi, M.D.; Joseph C. Schoolar, Ph.D., M.D.; Kenneth S. Solway, Ph.D.; and the editors.

The *DSM-III Training Guide* is $10.95 paperbound, $15 clothbound and going fast. ■

Continuing education series based on DSM-III begins via COMNET

TDMHMR's new statewide teleconference network, COMNET, began operation in January with a continuing education series from the Texas Research Institute of Mental Sciences (TRIMS) in Houston (see related story, p. 23).

The purpose of the series, offered by the TRIMS office of continuing education, is to train TDMHMR staff members in the use of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (Third Edition)*.

Sessions will be transmitted monthly from TRIMS to all state hospitals, state schools, human development centers and Central Office.

The conferences take place on the first Wednesday of each month from 3 to 4 or 4:30 p.m. in classrooms set aside by each facility. The series ends Sept. 1.

Using *DSM-III* and the *DSM-III Training Guide* published by the office of continuing education, the conferences will be led by TRIMS faculty members. Each location has identical equipment consisting of voice amplifiers, speakers, and microphones. The *DSM-III Training Guide* and slides will be mailed in advance of the conferences.

The series began with a general overview of *DSM-III*, followed Feb. 3 by a discussion of basic concepts and the major classifications.

The seven remaining programs will provide a thorough review of each major *DSM-III* classification:

March 3 — disorders first evident in infancy, childhood and adolescence

April 7 — psychosexual disorders, factitious disorders, disorders of impulse control and adjustment

May 5 — substance abuse and organic mental disorders

June 2 — personality disorders

July 7 — schizophrenic, psychotic and paranoid disorders

Aug. 4 — affective disorders

Sept. 1 — anxiety, somatoform and dissociative disorders

Serving on the faculty are Joseph C. Schoolar, Ph.D, M.D., TRIMS director; James L. Claghorn, M.D., assistant director; Carlo C. DiClemente, Ph.D., alcoholism treatment clinic; Mary Beth Holley, assistant chief, family therapy training program, and training coordinator, child and family section; Edwin E. Johnstone, M.D., director, psychiatric residency training program; Steve McColley, Ph.D., clinical psychologist, inpatient service; Timothy Sharma, M.D., chief, substance abuse section; and Kenneth S. Solway, Ph.D., chief, clinical psychology and social services training section.

The teleconferences carry continuing education credits. For more information, contact the TRIMS office of continuing education, STS 859-9204 or 859-9205. ■

The articles were adapted from The Emissary, *the newsletter of TRIMS, where Lore Feldman is information director.*

★ PEOPLE & PLACES ★

Resources

Do You Know Where to Go for Health Information?

Many people have health questions but do not know where to go for the information they need. For example, a person may want to know more about high blood pressure, physical fitness or particular medications, or a health educator may need materials for teaching about alcohol or nutrition.

There is now a central source of information and referral for health questions. The National Health Information Clearinghouse (NHIC), a service of the Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine, U.S. Department of Health and Human Services, is available to find an answer to your health question.

The NHIC has identified many groups and organizations that provide health information to the public. When you contact the NHIC with your question, the information services staff determines which organization can best provide an answer. A staff member contacts the organization and requests a response be sent directly to you.

To obtain health information from the NHIC, call 800-336-4797 (toll-free), or write P.O. Box 1133, Washington, DC 20013.

Rarity

In these days of rapid turnover, **Olga Johnson Wages** is a rarity. She will retire in February after 38 years of service at **Terrell State Hospital** (TSH), where she was one of the facility's longest term employees.

Wages, who joined the TSH staff in 1941, has worked "nearly every place in the hospital but the barn and the dairy," including two wards, the switchboard, the doctors' dining room and the laundry. Meanwhile, she found time to attend school and complete a licensed vocational nurse's degree.

In 1951 Wages earned a cosmetology license to qualify as manager of the TSH beauty shop, a post she has held since that time. Under her supervision, the operation expanded from what was then an informal back-porch shop to its present four modern salons.

Working at the hospital in the forties, Wages says, was like being part of a big family. "You knew everyone, and the patients' families became friends also." In fact, it was on the job in 1946 that she met Dale Wages, whom she later married and who has worked at the hospital almost as long as she has. He is currently a member of the Maintenance Department staff.

Mrs. Wages, who brought an added touch of beauty to the lives of thousands of TSH patients, undoubtedly will be missed.

This article was adapted from a story by Mary Whitt, a free-lance writer and former Terrell State Hospital employee.

Conference Calendar

Feb. 18-19
Perspectives for the 80s
Sixth annual conference on alcoholism
Held in El Paso
Contact: Rita Chrane
Office of Continuing Medical Education
or
Rudy Arredondo, Ed.D
Department of Psychiatry
Texas Tech University Health Sciences Center
Lubbock, TX 79430
806-743-2804 or 743-2929

Feb. 24-25
Adult Neuropsychology: Current Status and Applications
March 10-11
Basic Techniques of Group Therapy
March 31-April 1
The Crisis: From Assessment to Intervention
Faculty Resource Program
Held in Houston
Contact: Office of Continuing Education
Texas Research Institute of Mental Sciences
1300 Moursund
Houston, TX 77030
713-797-1976, ext. 204 or STS 859-9204

Feb. 27
Effective Antimicrobial Therapy and Its Economic Impact in the 1980s
Infection control seminar recommended for TDMHMR pharmacists and physicians
Sponsored by Austin Area Society of Hospital Pharmacists
Held in Austin
Contact: Earl Matthew, M.D.
Brackenridge Hospital
1500 East Ave.
Austin, TX 78701
512-476-6461, ext. 5204

April 15-16
The Dual-Earner Family
Annual conference
Sponsored by the Texas Council on Family Relations
Held in San Antonio
Contact: John Touliatos, Ph.D.
Program Chairman
4221 Capilla
Fort Worth, TX 76133
817-921-7309

Newsmakers

★Five Central Texas outreach centers are among an elite group of

about 50 U.S. facilities that have earned the stamp of approval of ACMRDD (Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons).

Recently accredited or reaccredited by ACMRDD are the following centers, all of which are mutually operated by **Austin State School** and local community boards of directors: Scheib Opportunity Center, San Marcos; Comal County MHMR Center, New Braunfels; Guadalupe County MHMR Agency, Seguin; Special Opportunity Center, Kerrville; and Llano County Special Opportunity School and Activity Center, Llano.

★**San Antonio State Hospital and San Antonio State School** recently received an award from the Beautify San Antonio Association, a division of the Greater San Antonio Chamber of Commerce, for their meticulously landscaped 535 acres.

Harry Stewart, plant engineer and landscapist, and **Vernon Price,** greenhouse supervisor, are responsible for care of the lush green grasses, the many leafy trees and the never-ending seasonal bursts of colorful plantings at the facilities.

★Gov. William P. Clements, Jr., has appointed **Rush H. Record** of Houston to the Texas Board of MHMR, replacing William B. Schnapp of Houston, who recently resigned.

Record is an attorney with the law firm of Vinson and Elkins.

★**Joseph H. Emerson,** former chief of personnel and training for TDMHMR is the new superintendent of **Richmond State School.**

Emerson's appointment, approved by the Texas Board of MHMR in November, became effective Jan. 1. The superintendent's post has been vacant since last August.

The 48-year-old Emerson has been with TDMHMR since 1979, serving as director of Austin State School's vocational education unit and director of staff services at that facility before becoming chief of personnel and training on May 31, 1980.

★**Mohsen Mirabi, M.D.,** a psychiatrist and chief of adult outpatient services at Houston's **Texas Research Institute of Mental Sciences,** recently became second chairperson-elect of Region V of the American Association on Mental Deficiency (AAMD).

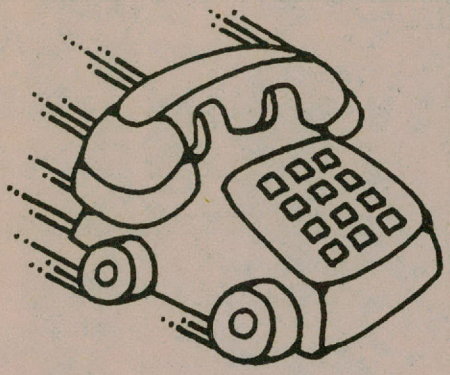
Having chaired the board of the AAMD Region V Medical Division for three years, Mirabi will head the organization from October 1983 to October 1984. AAMD Region V, covering Texas, Arkansas, Louisiana, Oklahoma, Kansas and Missouri, includes physicians and other professionals concerned with the welfare of mentally retarded persons. AAMD is the only interdisciplinary organization in the field of mental retardation in this country.

★**Jon D. Hannum, Ph.D.,** recently announced his resignation as TDMHMR deputy commissioner for community services.

His resignation, submitted to Acting Commissioner James A. Adkins, was effective Jan. 4.

Dr. Hannum, 43, a clinical psychologist, has been the deputy commissioner for community services since 1976, supervising 30 community MHMR centers, four state centers for human development and the Rio Grande State Center for MHMR.

He said he plans to enter the management field in private business.



Off the Road, On the Line

A new era in communications began last month for TDMHMR facilities with the inauguration of COMNET, a telephone system that links Central Office (CO) to all facilities and all facilities to each other (see related story, p. 21).

COMNET provides a means of instant communication between and among all TDMHMR facilities and a method for conducting conferences, training sessions and seminars through use of the telephone instead of face-to-face meetings.

Here's how COMNET works: Special equipment has been installed in a designated meeting room at each facility. This equipment is linked to CO which is the control center, administered by Mike Laritz of Management Information Systems Division.

Should John W. Carley III, Ph.D., deputy commissioner for MR services, want to confer with state school superintendents, he would notify Laritz of his plans. Laritz would call each school COMNET operator, informing that person of the date and time Dr. Carley had designated for the conference.

At the appointed hour, a call would go out from Laritz's special phone to the school operators. When all operators respond to Laritz's call, a switch is flicked, activating communications in the facilities' COMNET conference room, and the meeting would begin. Dr. Carley would conduct the meeting, ask questions, receive answers and hear discussions from each superintendent. When the conference is ended, the communications link is switched off and everybody goes about their business.

Had the meeting been held in Austin, it would have entailed travel time for each superintendent plus per diem and mileage allowances.

With COMNET in operation, the meeting could be conducted in a few hours at no additional cost to the facilities.

"We believe COMNET will bring about substantial savings throughout the department," says Laritz. "Approximately 30 percent of the face-to-face meetings now being held could be conducted on the COMNET system, and with the department's total travel budget at more than $2 million a year, the potential savings is tremendous."

"COMNET is a modern tool that when used fully will help the facilities realize more benefit from their travel dollar."

SEND TO: IMPACT, P.O. Box 12668, Austin, TX 78711

____ Add my name to the IMPACT* mailing list.

Send me these publications:

____ **1982 Directory of Services***
Just published, this directory describes each service location of TDMHMR facilities and community MHMR centers. Included are current TDMHMR service area maps, a list of private mental hospitals licensed by TDMHMR and a list of certified diagnostic and evaluation centers.

____ **New Directions 1981***
This is TDMHMR's annual report, highlighting the department's progress since 1965 when it was created by the Texas Legislature's passage of House Bill 3 and emphasizing its services during the past year.

____ **Mental Retardation . . . What is that?***
This general information brochure appears in this issue of IMPACT, page 14.

____ **Infant Stimulation Programs List***
Recently updated, this is a listing of TDMHMR-related programs designed to meet the needs of children ages 0-3 who are developing slowly and may be at risk for mental retardation. (These programs, which are also included in the *1982 Directory of Services*, are made available in this form for easy reference.)

____ **Supplement to Texas Laws Relating to Mental Health and Mental Retardation, Third Edition** (Price $2 plus tax)
Another new publication, this supplement is a compilation of MHMR-related legislation adopted by the 67th Texas Legislature in 1981. It contains new statutes, amendments to existing statutes and corrections to the *Third Edition*.

*Single copies free

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IMPACT

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