impact

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Sherry L. Grona

More than child's play

page 14

Austin State School

**Where the staff are devoted,
the facilities are up-to-date
and all the clients are encouraged toward self-reliance**

"When I first came here eight years ago, Austin State School was a quiet place on 35th Street," says Rose Rossman, the school's program auditor. "Now it's very much part of the community. We interact a lot with other agencies around town."

The school continues to blend into one of the fastest growing cities in the United States. Its clients learn to live productively on the two campuses, and they receive training to build skills for living in and near the Austin community.

In concert with the effort to create community living arrangements, the school's staff also offer training and opportunities to clients for whom the school may always be home.

"Our clients live in a million dollar neighborhood," says Karen Hardwick, director of habilitation services. "We're within walking distance of almost anything they want, on a bus line, in a safe community that is regularly patrolled by police, with no walls and with no doors to those who are able and willing to use community resources."

The school is in the process of placing 80 clients in the community, as required by the *Lelsz v. Kavanagh* settlement agreement. Seventeen of those are deaf clients who will live among three houses with 24-hour supervision. All the clients will work in the community and receive additional programming through Austin-Travis County MHMR Center, with which the school works cooperatively.

And work cooperatively it must. The liaison between state facilities and community MHMR centers has been underscored with the passage of Senate Bill 633 (see story on page 20). Yet Austin's service providers also must link arms for reasons peculiar to their location. They serve an ever-growing population lured to the Sunbelt, specifically to Austin. And Austin State School is thus no longer a quiet, cloistered campus.

"The biggest changes we've experienced relate to Austin's growth," says David Rollins, director of community services. "More people are moving here, and they wonder what services we have for people with mental retardation. Sometimes people make their home-community decision based upon services that are available."

Not only do people seeking services eye Austin State School. It is constantly scrutinized as one of the three state schools named in the *Lelsz* settlement. It has had its share of front page news.

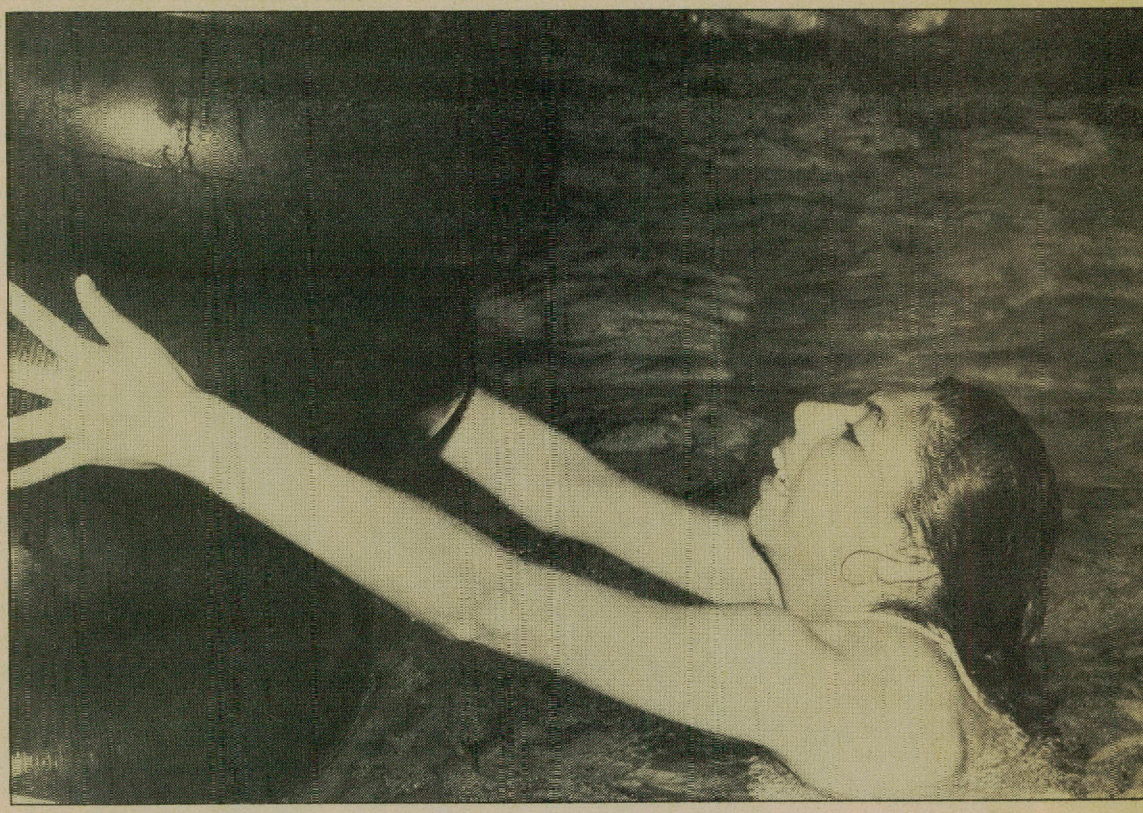
"The lawsuit has had a lot to do with all the activity on campus," says B.R. Walker, Ph.D., the school's superintendent since 1970. "The changes we are seeing are for the good. But sometimes the time frame is a little difficult for us, especially in such a large facility. The school is comparable to a big corporation. If it were a mom-and-pop shop, you could make changes like *that*," he says, snapping his fingers. "We meet the deadlines. Sometimes we extend ourselves to do so."

Dr. Walker says the ICF-MR program also causes change. ICF-MR—Intermediate Care Facilities for the Mentally Retarded—standards are met by the school to ensure proper care and Medicaid and other funding. ICF-MR compliance also is required by the *Lelsz* settlement. ICF-MR regulations demand, for example, that the school maintains standards of sanitation and provides adequate client programming.

Austin State School recently passed its ICF-MR review. In preparation for the audit, school staff often worked seven days a week, and Dr. Walker attended to such details as repairing damaged furniture.

The challenge in maintaining ICF-MR standards is to keep up with new rulings. For example, the standards now state that clients must be able to let themselves out of their dormitories. The school will have to change locks on doors that originally were meant to be secured for clients' safety, says Dr. Walker.

Other than changing locks on doors, the most notable area that will be strengthened is structured programming for older clients.



Dana Scragg

Tina Altamarino reaches for inner tubes while enjoying recreation time in Austin State School's Aquadome.

Five hours a day

"Each client who is physically able is involved daily in five hours of structured behavioral program activity, whether it be school, work or play," says Rossman, who audits programming for compliance with ICF-MR standards.

The clients participate in a variety of activities that range from workshops to Jane Fonda's workout. And they are consulted about their programming through "consumer interviews" and recreation interest surveys, for instance.

The recreation interest survey is required by ICF-MR. Recreation staff and the clients discover likes, dislikes, talents and strengths, which are discussed by professionals at the clients' annual staffings. Rossman says that even the most severely disabled clients have strong preferences. "Although they may not respond much, they react to certain music because they grew up listening to it," she says.

She also conducts "consumer interviews" with verbal clients during their socialization classes, when they tend to be more gregarious and the conversation snowballs. These interviews also are discussed at staffings, along with other professional evaluations, such as medical and educational.

"The majority of our clients need training in structured leisure activities," says Rossman. Through socialization training, they learn to get along with their peers and interact with one another rather than only with staff. As clients mature, training helps them develop the skills of cooperation, sharing and mutual support. "These are skills we may take for granted," says Rossman, "but clients need them in the community. They also need them here at school."

Other leisure training includes grooming, academics, arts and crafts, gardening, music and exercise. At Holly training center, for instance, women older than school age attend six 50-minute classes a day. Most clients have become independent enough to move from one activity to another.

They also swim in the Aquadome, which offers advantages beyond exercise. "Some clients don't interact much, but when they get in the water, they take on a different personality," says Rossman. "They play games with each other and splash around."

Less mobile clients receive gentle physical therapy in the pool. The buoyancy offers clients in wheelchairs the chance to be upright and to strengthen their functional muscles.

Many clients, such as those with multiple disabilities and medical complications, may never leave the school. But they still receive training that improves their independence skills. This is a practice the school has always employed.

Moving off campus

"We've consistently trained and placed clients in the community since before I came to work here in 1972," says David Rollins. "We locate alternate living arrangements and match them to clients based upon their abilities and their family's preference. Our stance has always been to involve families in the community placement. Some parents are resistant, and in some cases there are no parents. Most folks are pretty involved in what goes on with their relatives."

For example, the mother of a ten-year-old with emotional disturbances and behavior deficits requested that her child be placed in a smaller facility when he left the school. Rollins says this private program outside Sugarland has staff who are well-trained to deal with emotional problems. The program was exactly what this parent wanted for her child.

Other clients may no longer have family to advocate for them, like the three women who have begun their 30-day evaluation in a core and cluster program in San Marcos. The staff work with them to evaluate their needs and then design a living situation suited to them. This core and cluster arrangement is funded through the home and community care waiver, which allows the community program to receive Medicaid payment for services without maintaining an institutional standard of care. Austin State School is one of five service providers to receive waiver funds.

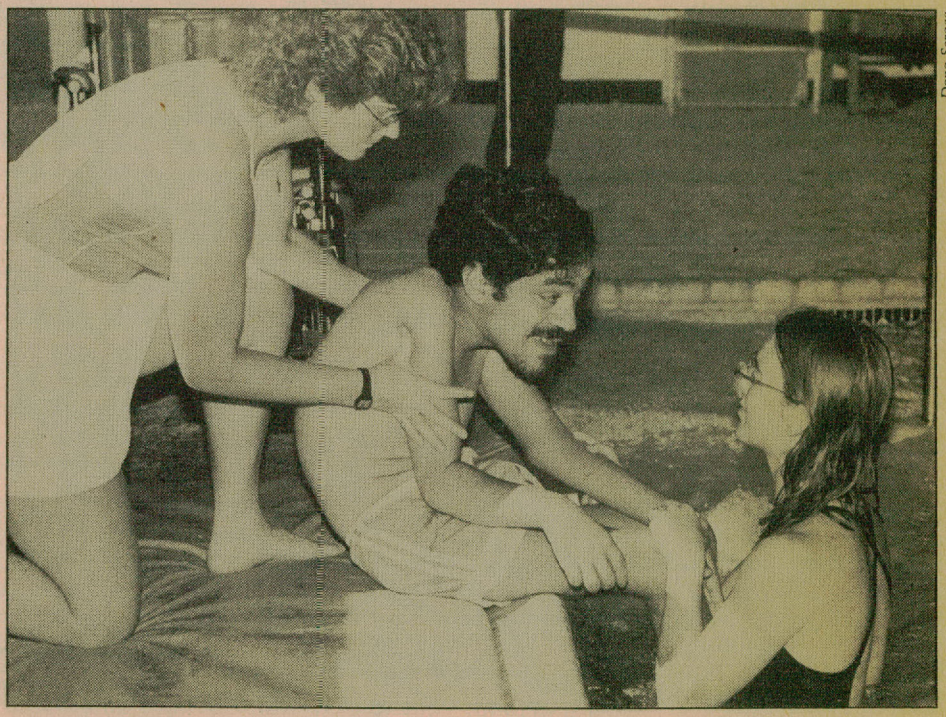
"After the evaluation, we probably will arrange for a house in New Braunfels with live-in or shift staff," says Rollins. "The women will participate in day programs at Comal County Developmental Training Center."

The school already has residential alternatives for 14 people scattered throughout its service area that are funded through the waiver. Rollins says 30 more beds are yet to be added.

"Residential services are developed around existing day services so we can tie them together," says Rollins. "The legislature has always been good about funding day services, and the communities where we operate day services are supportive and active. Local folks who want these services for people with mental retardation help develop community support for creating residences."

Rollins says the day services sites were donated by the communities in Seguin, San Marcos, Kerrville, New Braunfels and Llano. "We don't pay utilities or local phone bills," he says. The services include academics and vocational and prevocational training that is provided through partnership with local independent school districts. Crisis intervention and follow-along for clients who were once in the programs are also provided since many families want their child to live with them at home.

"Austin State School must show that its community placements are equal to or better than the living arrangement the client is leaving in order to comply with the *Lelsz* settlement," Rollins says. So, staff are meticulous in evaluating clients who may fare better in the community than at the school.



Dana Scragg

Victor Ramirez (center) receives gentle therapy in warm water from recreation director Pat Spencer (left) and occupational therapist Demetra Rodriguez.

Dana Scragg

Madge Porter collates pamphlets as part of her five hours of programming at Holly training center.

To leave or not to leave

Karen Hardwick's habilitative services staff are developing a geriatric evaluation form to better assess elderly clients' self-care skills and determine if they could be placed appropriately in the community. The clients to be involved in this evaluation all have good motor skills and are able to take care of themselves. After they are evaluated, the clients will embark on training programs that are age-appropriate and interesting and useful to them. Even clients who are not projected for community placement will be able to apply the training to their lives on campus, where many live in cottages.

The skills clients will learn include shopping, money management and food preparation. Clients need to learn what Hardwick calls "the philosophy of eating," especially the idea that one doesn't spend every cent on food. "Because of rules and health cards, a lot of these people have never been involved in the preparation of food," says Hardwick. "It's been provided for them within a rigid dietary system. But we're working with some of the units on this training."

Hardwick also is interested in preventive aspects of therapy for people with multiple disabilities and medical complications. An ongoing project is to train staff in such areas as positioning to avoid clients' pressure spots. "We want to make the entire day, even nap time, therapeutic," says Hardwick, who is focusing on the multihandicapped in working toward her doctorate in special education.

Reduction of the Austin State School population works well on paper, but staff must thoroughly evaluate each candidate for community placement to ensure it also works well in practice. "We must take into consideration clients' needs and staffing and money problems in Texas," says Hardwick. "The least restrictive environment as defined by the judicial system will not necessarily offer the most freedom for all clients."

"Clients have complete freedom of campus here," says Gene Benjamin, the school's coordinator of volunteer services . "This freedom doesn't necessarily translate to a neighborhood since many of these people are not capable of exercising good judgment."

While Austin grows, Austin State School becomes more enmeshed with the community. The population growth and the *Lelsz* settlement will continue to affect the pace at which people are admitted to the school and served by its community programs.

"The school has even become smaller," says Rossman. "We've placed in the community 400 clients since I've been here, and we've closed down two buildings because they didn't meet ICF-MR standards."

There is no doubt MHMR services are in transition, says Dr. Walker. Austin State School staff strive to offer clients and their families in the Austin area the options that are right for them.□*D.S.*

TWENTY YEARS LATER

By Nadine M. Jay

How many times have you heard the saying, "Time heals all wounds"? As I recall, it was always a favorite of my mother's. She was convinced that any hurt could be healed in time.

For the most part, my experience in life proved her to be right. I, like most people, suffered the loss of loved ones and have been hurt by people in various ways. While I thought at the time I would never get over the losses, or that my hurt was too deep to forget, time did ease the pain.

One significant event in my life 20 years ago still remains vivid in my mind. I feel it with almost the same intensity today as when it happened. That event was in October 1966, when I was driven to the state hospital in Larned, Kansas, where I stayed for the next few months.

The events leading to my hospitalization are in my memory like bits and pieces of a movie that have been cut and spliced without organization. Exactly when it all began, I have no idea. In 1966, I didn't even know what mental illness was, let alone suspect I was heading toward an abyss of confusion and terror.

I remember being terrorized all the time. I remember being in a furniture store, not knowing how I got there or what I was there for. I remember thinking someone was after me, and not knowing who or why. I remember sitting on the floor in my bedroom at night, alone, curled up in a little ball.

Walking around, in my home, at my job, I was so depersonalized, I was convinced that I was outside of myself. I would be taunting myself from my outside perch, making fun, cussing that person walking around and accusing her of all sorts of wrongdoing.

Suddenly, I saw her lying in the bed with her hands and feet tied down, screaming at the top of her lungs, banging her head on the bars, and I laughed at this pitiful sight until someone came and put us both to sleep.

For six years I was in and out of the hospital. Actually, *in* more than *out*. I spent four months in the state hospital and was admitted at least 16 times to a community mental health center's inpatient unit. Four North was the name and location of that inpatient unit. I have since become aware of how many psychiatric inpatient units are on the fourth floor—usually the top floor. Seems like a social statement to me!

All of this took place in Kansas, which at the time was heralded as one of the most progressive states in mental health care. Undoubtedly, this reputation was because of the presence of the Menninger Foundation, a psychiatric complex, and the community center where I received my care, which was one of the original centers funded by the Community Mental Health Centers Act. Of course, progressiveness in mental health care is, like everything else, relative. Some would say some care is better than none. Many would take issue with that.

During the course of my illness, I believe I received the best care offered at the time. I know, however, the care I received had little to do with my getting well. Being placed within a state hospital is probably the most devastating experience an individual can have, regardless of the conditions within that setting. It is an experience that after almost 20 years has left a scar of doubt that I will live with the rest of my life.

Unfortunately, things haven't changed much since then. The most accepted method of assisting an individual through a psychotic episode is hospitalization and medication. Hospital staff are not always willing to accept the fact that individuals have the right to be treated with respect and dignity.

Standing in line was part of the state hospital routine. We stood in line for medication, for our personal belongings, for cigarettes, to eat, to get in the door, to get out the door.

There was always the medication; for me it was Thorazine—400 milligrams each day. Take it or it will be given to you, one way or another. After I returned to my hometown, when I was driving with all of that medication in me, I would come to a stop sign and look both ways. Before my foot would move from the brake to the gas pedal, I would forget and have to go through the whole ritual again.

A couple of things contributed significantly to my recovery. The first began when the president of the local Mental Health Association told me about a talk she had with her husband, who happened to be my therapist. "Who is the most difficult patient you have right now?" she asked him. Without hesitation, he answered "Nadine."

My friend was interested because she had heard of a self-help group named Recovery Inc. developed by Abraham Low, M.D. She came to me after I was discharged from the hospital and asked me if I would be interested in starting a Recovery group in our town. I said yes, not because I was interested, not because I felt I could do it. I did it because I was asked.

The local Mental Health Association chapter sent me to Denver for

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Nadine M. Jay

the training necessary to begin a group. I practiced the recovery method in a vacuum, never believing for one minute that what I did would be of the least help. Somewhere, somehow, the principles began to stick and I began to feel better about what I was doing. I kept doing it because I felt like I was doing something for others—and I could see them improving. I felt useful.

The second thing that contributed to my recovery was school. Instead of finishing high school at 17 years of age, I married and became the mother of my oldest child. During treatment, one of my therapists suggested that I go back to school. I assumed I was too dumb to go to college. After much haranguing by this man, I agreed to take the GED, just to prove I would fail.

I started out in college taking art and a few required courses. Much of my college years is a blur to me also. I cannot explain the driving force. For the first couple of years, I felt like I was putting one foot in front of the other. The only thing I knew for sure was that I was not in the hospital when I was at school.

I wanted to be a psychologist. I felt I surely must be too crazy. I would never make it through and, worse yet, if I did, no one would hire me. So I avoided making that decision. Along the way, I snuck in a few psychology courses and found myself absolutely fascinated by what I was learning.

At some point, I became aware of a world outside that was far different than anything I had imagined or could have believed existed. I found I couldn't make bad grades despite the fact that practically every semester of my first three years I was in the hospital at least once. Part of my treatment several times was to sleep at the hospital and go to school during the day.

I will never forget the day a social worker said to me "Oh, Na, don't tell me! You want to be a psychologist just like everyone else who has been in treatment." I was crushed. The tone of her voice implied that it was a worthless endeavor. My lack of feelings of self-worth contributed to my interpreting her remark to mean that I could never do it.

I did go on to college and pursue a graduate degree in clinical psychology. I was able to do my internship at the state hospital where I had been a patient. It was a heart-rending experience to come back to the same ward and see the seclusion room where I had spent my share of time for not wanting to wear state clothes and for rebelling against being bathed by someone else. It was heart-rending to see the same persons shuffling around in circles in the dayroom. It filled my heart with grief to hear that Rachel committed suicide in that very seclusion room which was intended to be a place for her protection.

After graduate school, I was able to obtain employment at the community mental health center where I had been an inpatient nearly 20 times throughout the years. I felt good that I had come so far after having been so sick. I was greatly concerned at the time whether I would be hired with my history. The administrative director took a chance with me. Since that time, I have come to realize how difficult it is to get anyone within the mental health field to feel good about hiring the mentally handicapped.

Most agencies across the country have strict policies against hiring anyone who currently is considered schizophrenic. It is alright to go for therapy but quite another thing to have a history of severe problems. Only recently, since the advent of community support programs and Fairweather Lodges, have I witnessed agencies allowing a client to move up within a program.

Unfortunately, the stigma of mental illness in my experience is not confined to the general public. Although I personally have not suffered a great deal because of people stigmatizing me, many others have.

While it was not clear to me at the time, I believe I went into psychology to try to do my part to ensure that treatment for the mentally ill makes sense to the mentally ill themselves. In addition, I always have vowed to do what I can to erase the stigma which the mentally ill face in their daily lives. I have felt that it is my personal calling to let my peers know how persons who receive their care may be feeling and to help the mental health staff become more sensitive to the needs of their clients, especially to their rights as human beings.

I consider myself fortunate to have more than one perspective on the mental health field. As a consumer, I have experienced both the good and the bad firsthand. As a psychologist, I have insight into the field and persons working within it. Having both of these vantage points helps me in working toward the needed reform in mental health treatment.

In addition, I am a TDMHMR employee. Although advocating within a system may be considered difficult for many reasons, it is an important and effective way to advocate.

Twenty years later, much is left to be done. I hope I can continue to be involved.□

Nadine M. Jay is mental health placement coordinator in Central Office. This article originally appeared in Positive Visibility, *the newsletter of Reclamation Inc., from which she received recognition in 1984 as a former mental patient who has helped reclaim the human dignity destroyed by the stigma of mental illness.*

Department molds flexible mental retardation services plan

TDMHMR recently completed a comprehensive plan that will guide program development for services to people with mental retardation in Texas over the next six years.

The Comprehensive State Plan for Mental Retardation in Texas, which was required by the *Lelsz* settlement, was presented to the Federal Court for the Eastern District of Texas May 31, 1985.

"A strategic planning process was already in place, but the *Lelsz* settlement gave us a deadline," says Vijay Ganju, Ph.D., director of programs, strategic planning, Central Office. "The plan not only develops objectives for the department's mission and goals but also addresses requirements of the *Lelsz* settlement and existing legislation."

The plan encompasses the future direction of mental retardation services, trends that affect the direction, the needs of people with mental retardation, the existing service delivery system and objectives for service delivery through fiscal years 1990–1991.

The plan's emphasis is on improving the quality of services to people with mental retardation in Texas and on the development of an expanded community service system, says Jaylon Fincannon, TDMHMR deputy commissioner for MR Services.

According to the plan, the state school population will be reduced by 1800 clients by fiscal year 1991, and community placements will be increased by 3,300. This 20 percent reduction in the state school population will increase staff-to-client ratios and improve service delivery, says Fincannon.

Simultaneously, a wide array of services will be developed so that persons with mental retardation can live in their natural homes or in homelike settings in their own communities. Among these services are case management, family support and emergency services.

Commissioner Gary E. Miller, M.D., appointed a task force to develop the plan, chaired by B.R. Walker, Ph.D., Austin State School superintendent, and co-chaired by Dr. Ganju. The task force was composed of representatives from state schools and centers, community MHMR centers, Central Office and the Mental Retardation Advisory Committee. The group developed a framework for the MR plan and a mechanism to obtain input regarding needs and priorities of local service providers. Information from a client needs study also was incorporated.

Each of the 60 MR authorities developed its own service area plan using guidelines issued by the task force. To help in this effort, the office of strategic planning supplied them with detailed information about population projections, service utilization rates, and prevalence and future demand data.

Assistant deputy commissioners for mental retardation services then combined the service area plans into five regional plans, from which the MR plan draft was distilled. The draft was widely circulated for input from state agencies and other service providers, citizen groups, the Governor's Office, plaintiffs and the expert consultant in the *Lelsz* settlement, and members of the Legislative Oversight Committee, Statewide Health Coordinating Council, and Health and Human Services Coordinating Council. Their suggestions were incorporated into the plan.

"This plan is different in that it is dynamic and will be continually updated," says Dr. Ganju. "What we have established is an ongoing live planning process that will be developed through a three-tiered approach."

Each tier is associated with a greater degree of specificity from the strategic to the implementation levels. For example, from the six-year strategic plan, the biennial budget request will be developed. The budget request will serve as a biennial plan for service delivery.

Annual implementation plans for state facilities and MR authorities will then be based upon the biennial allocation of funds. The annual plans will specify in detail the goals for each year. Evaluation of the accomplishment of these goals will be the basis for revisions in the six-year strategic plan, which will then determine the next biennial budget request.

According to the plan, all activities will flow from the department's mission and goals, but there will be feedback from the implementation level to the strategic planning level.

This process places great responsibility on the department's service providers. It also ensures that the plan is not etched in stone but is rather relatively fluid and malleable.

The MR plan sets forth a philosophy and set of principles that will guide the development of the mental retardation service delivery system. The philosophy states that people with mental retardation "are, first and foremost, people with a capacity to learn, develop and improve their ability to relate to and enrich the environment in which they live." The principles say this is best accomplished in as homelike a setting as possible with individualized services for both the client and the family.

Factors that affect the development of mental retardation services in Texas provide parameters within which the MR plan must operate. These include the Mentally Retarded Persons Act, the *Lelsz* and *RAJ* settlement agreements, and Senate Bills 633, 940 and 994. The bills relate to the delivery of required "core" services on the community level, the location of community homes for people with mental disabilities and the transfer of allocated funds to improve staff-to-client ratios in state schools, respectively.

A framework also is set by trends that suggest, for example, that Texas' population is projected to reach 20 million by 1990, an increase of 41 percent over the 1980 population. An expanded demand for mental retardation services is inevitable, the plan says. The population of Texans with mental retardation will increase from 458,733 in 1985 to 551,413 in 1990, based upon Texas Department of Health population projections.

The plan cites the need for creative management and innovative approaches to deal with major factors affecting service delivery. Among these factors are increased longevity of people with mental retardation, pre-existing unmet service needs and reduced state revenues.

Service providers—including state schools and centers, community MHMR centers and private residential and nonresidential facilities—prioritized programs that, according to demand, require additional funding. Those services ranked highest are residential, vocational, respite, case management and transportation.

In order to assess this need for additional funding, which translates to the needs of Texans with mental retardation, developers of the MR plan approached the problem from several angles, including examining prevalence and utilization rates, waiting lists, resource inventories and systemic needs.

The department also conducted a client needs study. A random sample of 400 clients was selected from each of the state's five service regions, and data was collected about the clients' development skills, behavior, health, mobility and service needs. This will help in development of specific resources to match the individualized needs of persons with mental retardation.

"This plan is different in that it is dynamic and will be continually updated. With it, we have established an ongoing, live planning process."

The department's MR plan embraces several other organizations besides TDMHMR as integral units in Texas' mental retardation service delivery system. These are the Texas Rehabilitation Commission, Texas Department of Human Resources, Texas Education Agency, Advocacy Inc., Parent Association for the Retarded of Texas, Association for Retarded Citizens–Texas and the private sector. These groups serve and advocate for people with mental retardation and have offered valuable input to the MR plan.

In the MR plan, objectives are developed for each departmental goal, based on analysis of relevant issues. Timeframes and indicators for monitoring implementation of each objective are then listed. Detailed plans for specific geographical areas will be set out in the annual implentation documents of state facilities and MR authorities.

One department goal, for example, is to offer services on a priority basis to those people with mental retardation who reside in or are at risk of placement in a state school.

Board policies establish that mentally retarded children up to age six receive priority for placement in off-campus residences and that they not be placed in an on-campus residential program without the approval of the deputy commissioner for mental retardation services. Educational services for people between age 6 and 21 must be arranged with the local independent school district before the mentally retarded person is admitted to a residential facility.

Other priority populations described in the plan are people in state schools who do not have mental retardation; people in state schools who are recommended for community placement, who are are willing and who have family support; and people under age 22 who have been recommended for community placement.

Other departmental goals that are addressed in the MR plan are containment, adequate community alternatives, quality services, prevention and effective administration.□

no place like home

Structured living. It sounds confining but it provides just the support and encouragement needed by people embarking upon new lives in the community after long and repeated stays in a state hospital.

At Big Spring State Hospital (BSSH) the program not only has reduced the patient population. The hospital no longer has a waiting list.

Structured living is for patients who are the most difficult to place in the community—people with chronic mental illness and people with both mental illness and mental retardation.

BSSH developed its structured living program in cooperation with community MHMR centers in Lubbock, Abilene and San Angelo. By working with the centers, the hospital staff was able to build upon existing programs and devote most of the $1.6 million program budget to client care. Only a modest investment was made to buy or rent housing facilities the first year.

Lubbock Regional MHMR Center, Abilene Regional MHMR Center and Concho Valley Center for Human Advancement, San Angelo, provide the sheltered dwellings and implement the hospital's objectives, which focus upon providing employment and socialization opportunites as well as stable living arrangements.

Through the program, which is voluntary, clients have gained independence and opportunities to develop as responsible members of the community. Only 13 of the 174 clients who have participated since the program began in January 1984 have had to return to BSSH for additional support; most of these have since reentered the program.

Because of the program's enormous success, BSSH Superintendent A.K. Smith has been invited to speak about it at the September 1985 national convention of the Association of Mental Health Administrators.

Those who leave BSSH to enter the structured living program at **Abilene Regional MHMR Center** have both mental retardation and mental illness. For some, those problems are compounded by substance abuse.

But in the Abilene program, clients progress well. They spend nearly every hour of the day learning community living skills, says Jim Riddles, and as they learn, their emotional problems tend to subside. Riddles is chief of mental retardation services at the center.

Another important factor, Riddles adds, is that clients' personalities emerge more clearly in a community living arrangement, which makes it easier for staff to target and address clients' emotional problems.

Twenty-seven clients, who have mild or moderate mental retardation and histories of repeated hospitalization, entered the Abilene program in its first 16 months of operation. They are evaluated for up to 90 days in the core residential facility. From that assessment the staff decide the most suitable living arrangement, which may be a foster home, a group home or an apartment shared with a person who is a private service provider. Staff continue to provide counseling and other support once the clients have moved out of the core.

The clients tend to be "real energy burners," says Russ Evans, center director. The group is divided among several caseworkers to balance the work load and ensure that each client is thoroughly cared for.

Most clients progress in Abilene's structured living program though. A few have found jobs in restaurants. Others contract with private businesses to maintain lawns. Two clients have a contract to clean the local assistant attorney general's office, and still others work at Goodwill Industries.

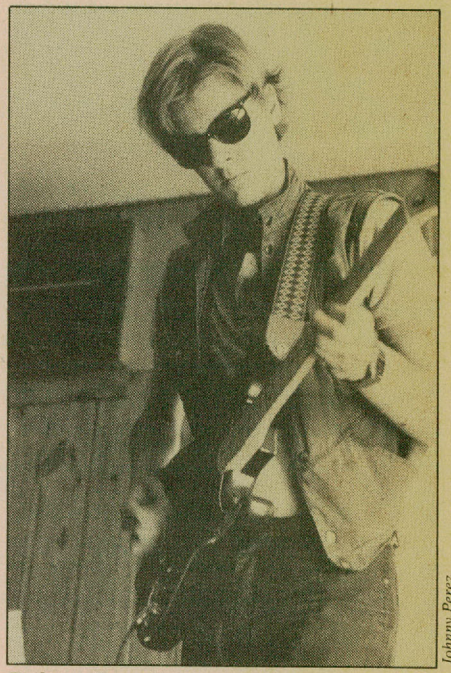
Those people who do not succeed in the community reenter BSSH for more intensive treatment and community skills training. Six clients so far have returned after their evaluation in the core facility. They have the option to return to the Abilene program when they're ready.

Clients with chronic mental illness who enter the structured living program at **Concho Valley Center for Human Advancement**, San Angelo, gain a new chance, surrounded by people who care about them. Friendships form as clients live, work and play together and communicate with staff about problem areas in their lives.

Staff at the center and at BSSH support each other in a similar way. They work together to identify clients who would most benefit from the program and to monitor their progress. This open communication is a major factor in the program's success, says James Young, center director.

Since April 1984, the structured living program has served 23 clients with chronic mental illness. Most clients had been hospitalized repeatedly, some as many as 18 times. Others entered the program to prevent what could have resulted in their commitment to a state hospital.

The 15 people who currently are



Johnny Perez

Robert Standlee, a participant in Concho Valley Center's structured living program in San Angelo, devotes free time to electric guitar and activities with friends at the center's social club.

involved in the structured living program live in four houses divided into apartments next door to the center. They pay room and board based on their income and disability payments. The houses have a common backyard with a greenhouse, garden and picnic grill. Residents gather twice a week to share meals.

A staff person works evenings in the sheltered apartments, and a case manager who is on call 24 hours a day lives nearby. Besides supporting the clients in such daily activities as coping with familial conflicts and keeping their apartments in order, the staff members help clients find and keep jobs.

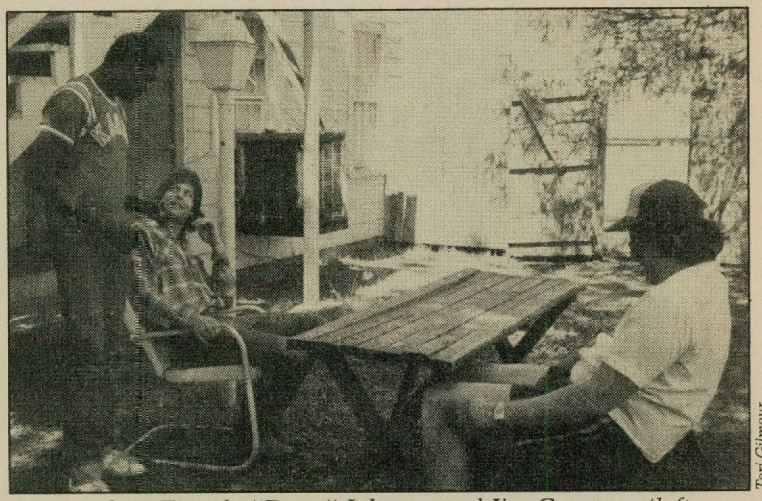
Most work full-time on cleaning crews or as grocery clerks. Others have part-time work. The center staff accompany clients on their work crews at first, then gradually step back and act as liaisons between client and employer, if necessary.

When they aren't working, residents of the structured living program participate in social activities at the center's Oasis House, a club that also offers vocational skills training and job-search counseling, says Carol Jeffers, director of community support programs.

Although the program is designed primarily for clients in transition, strict limits are not placed on the length of time one may stay. When clients do move on to live independently, they are encouraged to find a residence close to Concho Valley Center. Community life is stressful for most clients, and the center's proximity helps reduce their anxieties.

The structured living program at **Lubbock Regional MHMR Center** doesn't require clients to fit a mold, says Cathy Pope, mental health program director. Taking a holistic view of clients, staff developed the program around their needs.

Nearly 66 clients, who range from age 18 to 64, participate in the program. They live in semi-independent and sheltered apartments or in a halfway house where they are closely supervised. Valerie Neil, the center's community support services director, cautions staff members about overprotecting clients, though. She says that those in the 24-hour-supervised halfway house tend to be less functional and to return to the hospital more often than clients in more independent living situations.



Tori Gilmour

Greg Jordan, Temple "Dean" Johnson and Jim Courtney (left to right), clients of Lubbock Regional MHMR Center's structured living program, form a network of friends who offer each other mutual support.

The program has six levels of responsibility and freedom, which are based upon clients' mental disability, medical problems and social ability, explains Neil. Most participants remain in the structured living program six months to a year, progressing through the levels. Others may stay five years before improving enough to leave, and still others may find the program to be a suitable permanent arrangement. Clients who leave the program too early may not do as well in the community, says Ann Sikes, residential supervisor.

Sikes encourages clients to accept their illness just as they would any other medical condition. But she tells them they might have to work harder to overcome it. Sikes helps structured living participants build self-esteem and find their niche in the community.

Clients pay for their room, board and psychiatric care with their own earnings and government entitlements. Most have jobs as grocery clerks, hairdressers and restaurant table busers. They also work on janitorial and litter cleanup crews, at Goodwill Industries or in the center's Greenhouse, a community support program clubhouse similiar to Concho Valley's Oasis House.

Clients form a network of friends at Greenhouse, and many spend a lot of time there while not working or going to school.

The structured living program has doubled in size since its inception, says Pope. She says it is meeting a need that's been neglected for years.

Still, nearly 250 apartment beds are needed for people with chronic mental illness in the Lubbock center's service area, Pope says. Now apartments are located only in Lubbock. Center staff want to expand the structured living program to the city's outlying rural areas as more funds become available.

"Rural people dislike living in the 'big city' of Lubbock," says Pope. "We still have a long way to go to meet all our clients' needs." □ *J.G.*

Five new department computer systems are increasing efficiency in TDMHMR facilities and Central Office. And that can only help to improve services to clients in the department's care.

Computers have become easy tools to use, says Jack McMahan, Ph.D., training design coordinator in Central Office's management information services (MIS). MIS staff have designed training programs and user-friendly software for department employees learning to use the new systems.

These computer systems have the potential to strengthen the link between facilities and community MHMR centers, which will simplify the tracking of clients and help to ensure that the money follows them as they progress from one service to another.

Over the past few months, TDMHMR has begun introducing its new computer systems—general ledger, fixed assets, claims II, basic personnel and client information. All were developed by MIS staff in response to needs of divisions such as budget and finance, claims, training and staff resources, management and support, and mental health and mental retardation services.

For example, a steering committee established by the commissioner on service delivery information emphasized the need for an effective system to track clients and provide client profiles. The resulting client information system quickly can provide decision-makers with an unduplicated account of clients served and their needs. Information relevant to department litigation is also quickly obtainable.

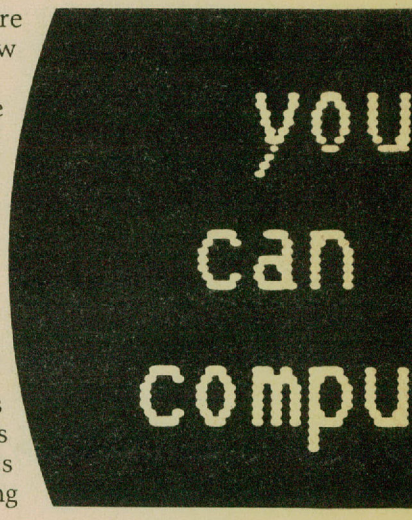
One benefit of these new computer systems is to make our jobs easier. Claims officers, for example, will be able to call up information on computer terminals that once took as long as six weeks to receive.

The claims II system is used for reimbursements, such as Medicaid collected for services rendered at the department's 28 residential facilities. Claims II generates bills and provides reports concerning claims accounts. Projected to be released for use in September, it will allow inquiry from remote on-line work stations in residential facilities.

The budget and finance division will be able to keep a more efficient inventory of fixed assets—land, buildings, improvements and movable assets costing more than $250—at all facilities with the fixed assets system.

The general ledger, or the department's financial records, will be available at the push of a button. General ledger also contains statistical data, such as the average daily population at each facility.

Pilot programs for the general ledger were performed this spring at Kerrville State Hospital and Mexia State School. By the end of September, all facilities are expected to have the new system in operation.



The five systems enable more efficient record keeping and the retrieval of records about funds, goods, services, employees and clients. With accurate, up-to-date records, it is possible to evaluate department resources more realistically within and across facilities. These systems allow statistical analyses that are too time-consuming to achieve manually.

Through the new client information system, for instance, a state hospital patient's history will be readily available when he moves from one TDMHMR facility to another. The new information system includes both client profile components and case record linkage. Professional staff, such as intake officers, will no longer need to repeat questions clients have already answered since their records can be called up on computer screens. This system, currently in the pilot stage, should be operative in facilities by the spring of 1986.

Storing and retrieving information is a simple step-by-step process. McMahan says learning to use these systems is "as easy as baking a cake." The user begins by logging into the system with a password, which tells the computer that the person "on line" is authorized to use the particular system.

The user then selects an "entree" from the "menu" on the computer screen. With a keyed-in command, the appropriate file appears on the screen. The user then enters new data or reads the screen for needed information.

Employees across the state are attending training sessions in these new systems. The general ledger, for instance, demands considerable interaction between the employee and the computer and required many training hours for accountants to become accustomed to it.

A major MIS training objective is to conquer computerphobia immediately. New users can relax while using the equipment once they have gained a few simple skills. They are taught early how to correct mistakes so that they don't fear fouling up the works, says McMahan.

Department trainees acquire psychomotor skills necessary for mastery of any computer system, McMahan says. Skills mastery also is the criterion for evaluating training. "The proof of training success is in how well they do their jobs," says Mareda Summers, MIS training materials development manager, whose staff develops training and reference manuals for the system.

Training exercises include simulated tasks that are as close as possible to those required in the daily routine. In training sessions at Central Office for the basic personnel system, for instance, facility personnel staff viewed, added and updated biographic, pay, benefits and educational data of fictitious employees.

Trainees also learned basic computer skills such as using the printer and keyboard; sorting, ordering and retrieving data; accessing a data system; inquiring about stored data; and formatting a printed report. The aim of these and other training sessions is not necessarily computer systems fluency, but specialized knowledge and efficient performance of particular tasks.

MIS training programs assume that trainees have no prior computer use, and all training is designed for hands-on computer interaction. Some training programs are self-paced. Trainers try to meet individual needs during instruction, which takes place in classrooms or on-site at facilities. Instructors may work directly with employees, or the employees may be trained through a computer-assisted program.

Current training teams include MIS employees who have helped develop the five new computer systems: project developers and leaders, program and systems analysts and some Central Office users. In the spring, basic personnel project manager Lesley Leming, a systems analyst, led classes with six other MIS instructors and Robert Everett, director of field operations, Central Office training and staff resources.

A new training coordinator and two new trainers assigned to continuing computer system instruction have recently been added to MIS staff. Summers seeks training designers with strong backgrounds in adult education rather than in computer science since MIS trainers agree that teaching ability and communication skills are more important than computer expertise.

During a three-day classroom session in Central Office, Lubbock State School assistant personnel director Barbara McCann called the new basic personnel system "wonderful" and said she's eager to learn more about computers. Mary Swanson, Wichita Falls State Hospital assistant personnel director, said that although she had to overcome a little computer shyness she welcomes the change brought by computers.

The basic personnel system, expected to be available at all facilities in October, includes data once kept on personnel forms, such as employment dates and education, salary and insurance information. This system, like all others, is confidential; only authorized users will have access to data.□*J.G.*

PLAY GROUNDS FOR GROWTH

By Terry Goodrich

The children who play in Austin's Zilker Park in the afternoons look like typical rough-and-tumble youngsters whose tempers sometimes flare when a playmate accidently shoves them.

But these children are not typical and neither is their play. They are emotionally disturbed, and their play is therapy.

Today the children are playing with a huge Earthball, and they squeal in anticipation as they make the Earth "rumble," drumming on it with their hands as they prepare to toss the ball aloft and volley. Somebody breaks in with a scrap of a song: "He's got the whole world in his hands."

One girl lags shyly behind, then runs to therapist John Holbert and tries to clamber onto his shoulders, apparently hoping to take aim at the ball from a greater height. Obligingly, Holbert boosts her up.

The children are inundated with love by the counselors: love in the form of tasty snacks, compliments on good behavior, occasional admonishments and, always, attentive ears. Those ears absorb a long monologue from one youngster that culminates in "I like Camp DayGlo."

He refers to the Children's Group Treatment Program–DayGlo, a project of Austin–Travis County MHMR Center for troubled youths ages 6 to 12 years.

On the cover:
Spinning yarns, caseworker Scott Harpst and a DayGlo client create decorative God's eyes and unravel confusion.

The children are learning to cope with problems that range from obesity to parents' divorce to a death in the family to physical or emotional abuse and neglect, says program manager Vivian Lewis-Heine.

The program—dubbed DayGlo by the children in it—was started eight years ago by a group of local therapists who became convinced that therapy with children on a one-to-one basis in an office was not the best way to meet the children's needs.

"Children's language skills haven't developed as much as their cognitive skills," says Lewis-Heine. "They don't come into your office and say, 'Today, out on the playground, I got frustrated.'

"We meet them where they are, in their play, rather than expecting them to come to us and negotiate in the adult world," she says.

Time out

The afternoon games play an important role in the therapy of abused children, who generally cope with problems in one of two ways: by withdrawing or by using violence on themselves.

"If they're at school or in the neighborhood, and the frustration level rises, they call upon what they've learned," says Lewis-Heine. "Neither one of those methods gets them along very well socially. So you have low self-esteem, poor self-confidence and no friends."

In DayGlo, the play—sometimes competitive, sometimes not—often leads to situations in which those children resort to their typical behavior of violence or running away.

"Then we 'stop the action.' We deal with the behavior," says Lewis-Heine.

After their play, the children split up into small groups, troop off to sit at picnic tables and discuss how to solve their problems better.

"They use each other to confront one another and deal with problems," says Lewis-Heine. "It becomes a microcosm of their life. When they start having success at DayGlo, seeing that what they have works, we work on transferring that to neighborhoods or their school system."

But the program goes beyond developing cooperation and friendship skills. Recently, a group of sexually abused girls discussed how that abuse made them feel.

"Sad."

"Mad."

"Scared."

"Disappointed."

The soft voices subside, and therapist Betty Miles asks, "Is it (abuse) a kid's fault?"

"No," comes the reply. "It's the adult's."

Parents abuse their children, volunteers one freckle-faced girl, "because they're mixed up."

At Miles' suggestion, they list what to do if they are abused, and they listen intently to each other's answers.

"Tell your mom."

"Or your dad."

"Or your grandparent."

"Or your teacher."

"Or," says one sober-faced child, "run away."

Beneath a nearby tree, a group of abused boys is meeting. They aren't quite so certain about whose fault abuse is.

"I had to leave home because of child abuse," remembers a boy who now lives in a foster home. "It was my mama, every day when I be bad. But I don't be bad no more."

Red rover, red rover

That feeling—that abuse is somehow deserved—can take years of treatment to eradicate, says Lewis-Heine. She knows DayGlo is not a cure-all, but she also has seen

how productive the sessions can be. And she's heard it from children who have "graduated" from DayGlo. So it's agonizing when she must turn children away.

"What I do is play God," she says. "Let me give you an example. You have a child who's been raped by an uncle and whose sister is murdered in the process. The man came out on probation and raped her again.

"Then you have a girl who copes with abuse by lying on railroad tracks—she's suicidal," says Lewis-Heine. "Finally, you have a child whose mother soaked him in a bathtub of hot water and then laid open his back with an extension cord."

Lewis-Heine pauses.

"You have one slot in the program. Who gets it?" she asks. "There's no way in the world you feel good about saying 'no' to one of those children."

Because public funds for such programs are drying up, DayGlo relies on fees for the service based on a family's ability to pay; contracts with the Texas Department of Human Resources, for example, to serve abused and neglected children; and donations.

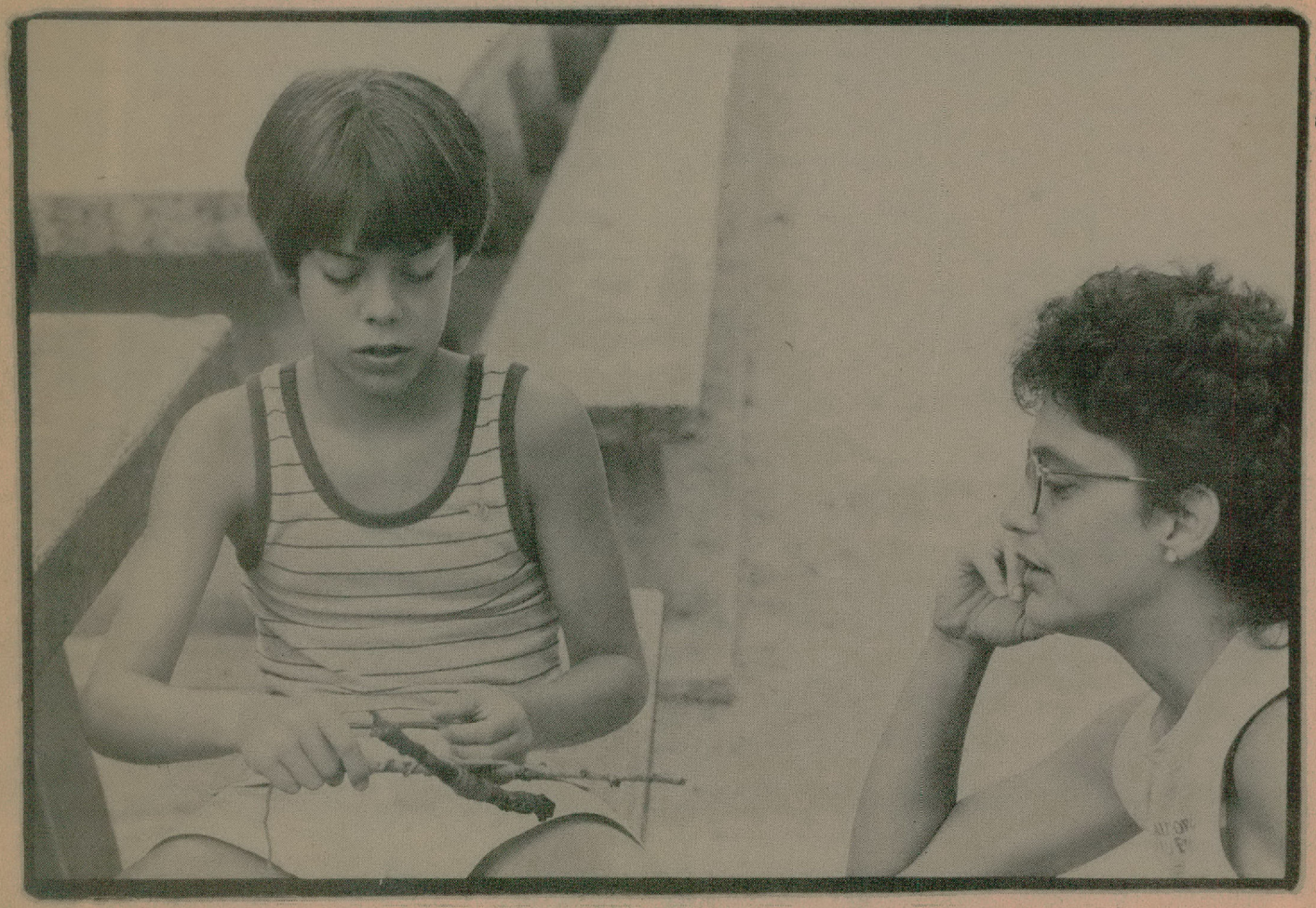
Lewis-Heine would like to see more donations from the public, particularly in the "scholarship" program that creates more openings for abused and neglected children. She points to the program's growth—it will expand from a three- to a seven-county service area next year—and success stories like that of 16-year-old Bobby (not his real name), a DayGlo graduate.

When he first went to DayGlo five years ago, "It was like I was all tied up within myself," he remembers. "I had a real violent temper—and I still do. But I learned to control it pretty much. It helped me relax, and I made some friends."

Lewis-Heine likes to hear that kind of story.

"I'm not into sad stories," she says. "We're an up-and-coming business that's trying to help kids."□

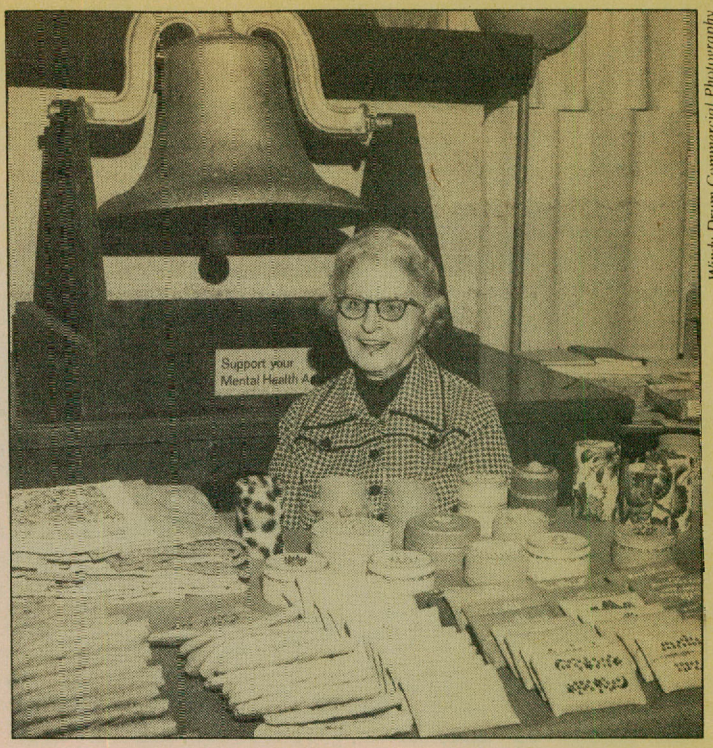
This article originally appeared in the Austin American-Statesman, *where Terry Goodrich is a staff writer, and was reprinted with permission, copyright 1985.*



Games and crafts are therapy for children at Dayglo, who "play" with caseworkers like Carmen Rumbaut, right.

Sherry L. Grona

from heart and hands



Windy Drum Commercial Photography

Mary Wood Dawson

When Mary Wood Dawson's homeroom class at Waco High School was asked to make Christmas gifts for Austin State Hospital patients, she worried that her students hadn't made enough gifts and took up knitting needles and crochet hook herself.

On that spring day in 1962, Dawson's second career was sparked. Since then, she has accumulated an amazing 23,000 hours of volunteer service fashioning handiwork for Austin State Hospital (ASH) patients in the Central Texas unit.

Dawson was lauded in May at ASH's volunteer recognition night, where she was the star attraction. At the reception, she received a pin specially made to commemorate her hours of service and was congratulated by ASH staff and acting superintendent Harold (Kenny) Dudley Jr.

Dawson's 23,000 hours of service are comparable to 23 years of half-time employment. She began to record her own volunteer hours in 1965, but these were not registered at ASH. Since her efforts were off the record, Dawson was not qualified for official recognition by TDMHMR's Volunteer Services Council. To achieve certified department volunteer status, a person must attend Volunteer Services Council orientation, have service hours recorded by the department and be on active department volunteer rolls.

In the 1960s when Dawson was an English teacher, she stole time from evenings and summer vacation trips across the United States, Mexico and Canada to stitch, clip, crochet and knit gifts to brighten patients' lives. When she retired from teaching in 1975, she launched full time into at-home volunteer gift-making for ASH patients.

Dawson makes at least 300 gifts a year and has been known to create as many as 800. Gifts include colorful handmade house slippers, cloth envelopes for lingerie, cases for glasses and tissues, dusting powder boxes, pencil holders, bookmarks, crosses and key chains.

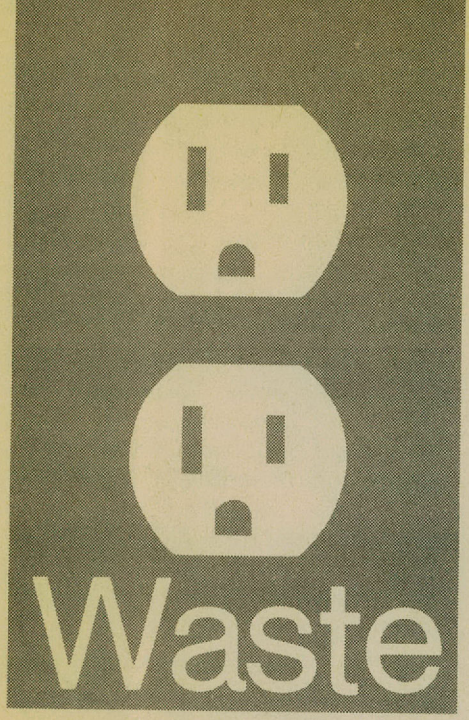
The slippers in assorted sizes take about 15 hours a pair to crochet and are popular gifts among patients. Both the men and women like them, probably because they are personal and wearable. In the early 1970s, Dawson made crocheted and felt-flower centerpieces to liven up dayrooms, but soon she decided to spend time more productively on practical gifts.

Most of Dawson's creations involve delicate beadwork, intricate stitchery, crocheting and knitting. "Her hands are amazing. She has such tiny hands," says Erin Coffey, assistant coordinator of ASH volunteer services. Coffey met Dawson when both were interviewed for a Waco television spot that solicited mental health volunteers. Coffey remembers well the booty Dawson added each year to the "Christmas Caravan," which consists of carloads of gifts delivered seasonally to ASH by the Mental Health Association of McLennan County in Waco. Dawson and her husband, W. Read Dawson, Ph.D., live on the campus of Baylor University, where he is a professor emeritus.

Dorothy Wienecke, administrative assistant at the association, is filling a scrapbook with memorabilia of Dawson's volunteer contributions throughout the years. Although she accomplishes a lot, Dawson tends to remain quietly in the background and seeks no recognition, Wienecke says.

Dawson, who is beginning to feel the early pains of arthritis, thinks her elaborate stitchery will help keep her hands limber. She has enjoyed handicrafts since she was a child and often teamed up with her parents to make things for the house where she grew up in Hillsboro, Texas.

Through the years, ASH patients have thanked her with their own creations, such as Raggedy Ann and Raggedy Andy dolls and grapevine wreaths. These gifts of the hand are also gifts from the heart. "She's an inspiration," says Coffey. "When I get to be her age, I hope I'm like her." □ *J.G.*



Waste not

Imagine a computer so "smart" that it can adjust electrical lighting in a room according to available sunlight or the presence of a person. This is just one energy cost reduction measure TDMHMR can employ as it strives to keep its utility bill in check. A dollar spent on strategic energy conservation measures often means several dollars saved.

Almost 80 percent of the nearly $23 million a year the department spends on utilities goes toward electricity and natural gas, says David McCormick, energy management specialist in maintenance and construction, Central Office. McCormick monitors the department's consumption of electricity, gas and other utilities and directs energy cost reduction measures toward their use. Already, energy cost reduction efforts have saved the department thousands of dollars.

Although they require sizable dollar investments, energy cost reduction measures result in utility cost avoidance within a few months to a few years after they are installed. These methods include, for example, recycling heat from laundry wastewater and using lower wattage fluorescent light bulbs. McCormick estimates that if Central Office, for instance, invested $334,223 for certain energy reduction systems, it would net a savings of $131,609 each year following installation. The original installation cost would be repaid in just over 2½ years, he says.

Austin State Hospital's computerized energy conservation system regulates energy use in campus buildings. The system, piloted in July 1982, saved the hospital $46,000 in its first eight months of operation. It has been programmed, for instance, to turn off air conditioners automatically during the night and on weekends and holidays. It also adjusts heating and cooling systems so that boilers, chillers and motors are not taxed.

As a result of this pilot, similar energy conservation systems were installed in eight of the department's largest facilities at a total cost of $669,000 in fiscal year 1984. In the first six months of operation, these systems avoided $269,000 in energy costs. This means that their installation cost will be recovered in utility savings in about 14 months.

Governor Mark White in August 1984 commissioned a study on reducing energy costs in Texas state agencies. It confirms many of the department's conclusions, one of the most significant being that TDMHMR could save $1.9 million annually if it were to invest almost $3.8 million on certain cost reduction measures.

Some state agencies, the study notes, lack motivation to conserve energy because the money saved is returned to the General Revenue Fund. If they could recycle the money within the agency, they might have more incentive to conserve, it says.

The Texas Public Utility Commission (PUC) submitted a bill to the 69th Legislature to establish a state agency that lends other agencies money for installing energy cost reduction systems. State agencies then repay the agency with interest directly from their energy cost savings.

The legislature passed the bill, resulting in creation of the Texas Public Building Authority. After Sept. 1, the authority will make available to TDMHMR more than $3.8 million for energy-saving projects.

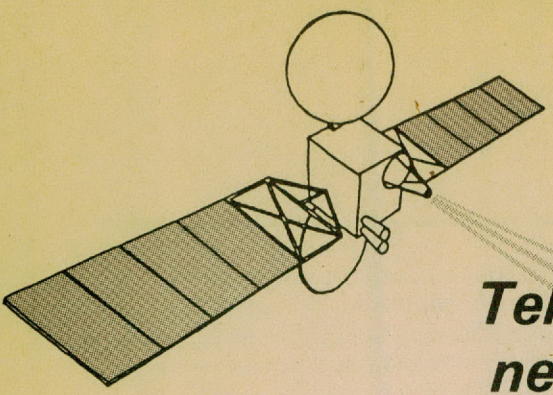
PUC endorsed the study's recommendation that certain state agency facilities use cogeneration, which amounts to taking advantage of by-products of an original energy source. For instance, a 1.3 megawatt electricity generator could save ASH 70 percent of its electric bill, McCormick estimates. The waste heat this generator makes also could provide enough steam for ASH's steam-heating requirements.

Currently, Travis State School employs waste heat recovery by recycling its laundry wastewater to heat fresh water, which saves $800 in monthly natural gas costs. Heat recovery systems can reclaim heat that escapes from any heat source and save utility costs.

Other energy cost reduction measures that have been inititated in facilities which have computerized energy management systems include timers for lights, air conditioners, heaters and fans. Now these energy users are cycled off and on according to demand instead of being on constantly.

A $2 plastic device that reduces water flushed down toilets by 40 percent will save many facilities both water and wastewater costs. Other retrofits have replaced energy inefficient devices, such as chillers and boilers, with newer, more efficient models.

Central Office exit lights, which utilized two 20-watt incandescent bulbs in the past, have now been fitted with 5-watt fluorescent lamps that produce equal lumens and burn ten times longer, or 10,000 hours. Their cost was recovered in just three months through electricity savings. These new bulbs also save maintenance time and are cooler than the originals, thus reducing the building's heat load. Bright ideas like these help conserve resources, especially electricity and natural gas.□*J.G.*



Telemedicine means new improvements in patient treatment

An Austin State Hospital (ASH) psychiatrist recently made Texas history when he and a patient participated in a video conference via satellite with psychiatrists in Dallas.

The telemedicine consultation was carried by satellite to Dallas, where it was shared with members of the American Psychiatric Association (APA) at their annual meeting on May 22. The cost for the satellite beam, which provided the live television link between parties in the consultation, was underwritten by AT&T Communications.

During the interactive video conference, David Beyer, M.D., ASH psychiatric resident, could see and talk with consulting psychiatrists in Dallas, Shervert Frazier, M.D., director of the National Institute of Mental Health and former commissioner of TDMHMR, and Jonathan Cole, M.D., director of psychopharmacology at Harvard University School of Medicine.

Before the patient joined the doctors for the consultation, Dr. Beyer reported on her current condition and medical history, which included hallucinations and suicide attempts. After she entered, Dr. Beyer asked her detailed questions while Drs. Frazier and Cole, visible on the screen, watched. Then the two consulting psychiatrists interviewed her.

The patient, who recently had moved to Austin, had been a patient in a Pennsylvania psychiatric hospital, where she had been diagnosed as suffering from depression and symptoms of schizophrenia. The three psychiatrists observed, however, that her main problems were related to mood and depression.

Drs. Frazier and Cole advised Dr. Beyer to discontinue her antipsychotic medication but to continue to administer antidepressants. Two months later, the woman was in stable condition without use of antipsychotic drugs.

This valuable learning experience will aid in work with other patients, Dr. Beyer says. As telemedicine becomes less expensive and more widely available, Dr. Beyer anticipates other medical professionals using it. The people who ultimately benefit from the new technology, however, are patients, he notes.

Telemedicine enables consultation, diagnostic conferences and training among medical professionals, important functions in an industry that confronts increasing economic and marketing demands. The sophisticated technology also facilitates networking among physicians, which has become an increasingly accepted way to exchange information and share high-level expertise.

Video technology and telemedicine have many possible applications in their ability to overcome time and distance, APA members and others in the health care industry are learning. For instance, a patient traveling in another state could consult his psychiatrist through telemedicine. The video component allows psychiatrists to observe a patient's body language, which can be important in understanding his feelings and medical condition.

With its video screens, telemedicine is more personal than a phone call and the next best thing to an office visit. Telemedicine, however, may rely on audio alone or work in combination with various kinds of video technology, including transmission by satellite, microwave, fiber optics, laser or cable.

The APA demonstration was in response to the initiative of Jane Preston, M.D., chair of the APA task force on telemedicine and a member of the TDMHMR medical advisory committee.

Telemedicine has many practical uses for the department, says Charles R. Schotz, chairman of the TDMHMR telecommunications steering committee. Through satellite or telephone links, the department could transmit medical information (including X-rays, CT scans, EEGS, EKGs and other diagnostic data) from distant locations to a consulting facility. Another possible application is staff training, an area in which this technology is being used widely in government and the private sector.

Schotz also foresees the potential of collaboration between TDMHMR and other human service agencies. A telecommunications network, enhanced by video technology, could enable sharing of medical resources and staff among state agencies. For instance, the Texas Department of Corrections, which is mandated by federal court order to provide for psychological testing and psychiatric evaluation of prisoners, could benefit from TDMHMR's expertise in these areas.

As part of a state agency network, telemedicine could be cost effective, Schotz says. It is a viable method for significantly multiplying resources, not simply within the department but within human service agencies and the medical community at large.

The department plans to demonstrate telemedicine's capabilities for key state officials, including TDMHMR's commissioner, other state agency leaders, the governor, lieutenant governor, speaker of the house and other elected officials in the near future. And plans for the new Houston psychiatric hospital, scheduled to open June 1986, include an advanced telecommunications system with video technology applications.

Currently telemedicine is used extensively in California, North Carolina, a consortium of Midwestern states and Alaska, which has its own health satellite network, Schotz says. TDMHMR administrators hope to follow suit and make telemedicine a part of the department's future.□*J.G.*

Dana Scragg

Commissioner's REPORT

Gary E. Miller, M.D.

The commissioner spoke to Central Office employees—and to those in the field via Comnet—on June 24 to update them on new legislation relating to TDMHMR and on other major activities in the department. James Adkins, executive deputy commissioner, and Sally Anderson, acting deputy commissioner for management and support services, reported on legislation and appropriations, respectively.

DR. MILLER: I believe the department fared very well this legislative session. If one looks at the difficult financial situation faced by the legislature when it convened in January, one acknowledges that members of the House of Representatives and Senate truly understood the special requirements of TDMHMR, the importance of our mission and our unusual circumstances vis-a-vis the two major class-action lawsuits.

The legislature was faced with the prospect of a deficit and with balancing projected revenues against money needed to run state agencies at the current level. TDMHMR did receive an increase in overall funding, but some areas were reduced. Facility staff are well aware of the reduction in their auxiliary and administration line items. Certain areas in Central Office were reduced. But in those areas that relate to our ability to comply with the major features of the two lawsuits, the legislature appropriated significant new dollars.

There are also major changes in the structure, administration and accountability of the department as a result of new legislation. One key item is Senate Bill 633, which passed both houses, was signed into law and is in effect today. The bill involves long-range implications about whom we serve, how we provide the services and who is responsible for delivery of those services. Also, it portends a change in how we in Central Office relate to community programs in the state, particularly those operated by boards of trustees.

The change in the structure of the department involves Texas Research Institute of Mental Sciences (TRIMS), whose operation in its present form the legislature has decided to discontinue. TRIMS is to be phased out as a department entity as of Sept. 1. The department is responsible during the next biennium to ensure continuation of inpatient and outpatient services and treatment now provided by TRIMS until the new psychiatric hospital in Houston is opened.

Genetics Screening and Counseling Service remains part of the department and becomes the responsibility of the deputy commissioner for mental retardation services.

ADKINS: The department submitted a modest legislative package because we knew most of our time would be needed for the budget process, which was a correct assessment. The Legislative Oversight Committee's effort resulted in two bills and six resolutions, all of which passed. Each of the department's six bills passed, although one was vetoed by the Governor and another did not receive a hoped-for record vote in the House, which sets back its effective date.


Sherry L. Grona

Our legislative package was successful, I believe, for three reasons. First, we had clear cooperation from all superintendents, directors and executive directors. Members of the Texas Board of MHMR, the advocate groups and the Volunteer Services State Council also were responsive and effective. The council held a reception honoring members of the legislature that was well-attended and got us off to a good start.

The second reason for our success is that TDMHMR has a good program. And thirdly, we had strong legislative advocates in the House of Representatives and Senate.

Our job now is to implement and take advantage of the bills that have been passed. We are isolating elements of each that must be accomplished by this department and assigning responsibility for them.

I'd like to mention a few bills. Senate Bill 633 is the centerpiece of the work of the Legislative Oversight Committee, a quasi-legislative committee appointed under the auspices of the Lieutenant Governor and Speaker of the House. It has members of both legislative houses, department employees and private citizens. We are in the process of analyzing the requirements of this bill and making recommendations as to how to implement it. Dr. Miller has set up work groups composed of field and Central Office personnel, and our time frame is set.

Senate Bill 1350 requires the department to sell Leander Rehabilitation Center. (Fifty acres of what is now the center will be set aside as a state park to be run by Williamson County.) TDMHMR will receive $18.5 million from the sale, which will be used for Life Safety Code requirements in state facilities, community MHMR center construction and renovation, and acquisition of another rehabilitation center. The remaining $40 million from the sale will go to the General Revenue Fund.

Senate Bill 679 authorizes the use of state dollars to renovate community MHMR centers.

Senate Bill 940 states that operating a community-based residential home with no more than six

Senate Bill 633
Blueprint for the future

Senate Bill 633 is an evolutionary step, not a revolutionary change. TDMHMR will evolve into a more comprehensive system of care, which is a process that began with development of the department's mission and goals in 1983.

"We have no intention of overturning the system of community MHMR system care or the relationships we have with MHMR centers," says Sally Anderson, acting deputy commissioner for management and support services. "With new rules and challenges, we are going to improve and make more accountable what we already have."

Passed in the 69th Texas Legislature, Senate Bill 633 amends and modifies the Texas Mental Health and Mental Retardation Act, which created the department in 1965. It clearly mandates that TDMHMR provide core services in each service area that include 24-hour emergency screening and rapid crisis stabilization services; community-based crisis residential services or hospitalization; community-based assessments; family support services including respite care; and case management.

"We can move ahead immediately with the case management requirement," says Anderson. "We already have a budget request based upon it; it's ready for implementation. We have case management pilots, we have training and, most importantly, we have appropriation."

Other core services are yet to be developed throughout the state. But in certain areas, core services like respite and crisis care are in full operation.

Another provision of Senate Bill 633 is that community MHMR centers be funded through contract. "We will contract with community MHMR centers for purposes of providing core services," Anderson says.

If a community MHMR center cannot provide a core service, the department will contract with another service provider. A community center's inability to provide core services would likely be a failure of the local community to support the effort, Anderson says. "But I don't expect that to happen. I expect our community centers to meet the challenge, come up with the program plan and contract with us for the services."

Anderson says local communities must provide matching funds so that services represent a state and local partnership. She stresses the importance of the local role in the provision of community services.

The requirements of Senate Bill 633 present management challenges, Anderson recognizes. "Community MHMR centers may have to cut back on current services they provide with state dollars and provide core services with the money," she says. "That may be painful. But I hope they'll go to their local communities and explain the reason for the changes."

Senate Bill 633 also requires the Texas Board of MHMR to appoint a citizens' planning advisory committee to advise TDMHMR on all stages of its long-range strategic plan. The budgeting process is to be based upon this six-year plan, which will be updated every two years.

"We need to be prudent in how we move forward," says Anderson. "Everyone expects change, and we must work hard to define the core services and discover how many we need. Then we can put them in place across the state."□*D.S.*

mentally or physically disabled people and two supervisory personnel is a permitted use in all residential zones or districts in Texas. So a city cannot zone out that kind of residence, and a special-use permit is not required.

For the first time, Texas will have one substance abuse agency effective Sept. 1 when Senate Bill 601 combines the Texas Commission on Alcoholism with the drug abuse prevention division of the Texas Department of Community Affairs.

Senate Bill 217 creates the new Central Office position of director of operations to assist the commissioner in the department's administration. The bill also moves rule-making authority to the Texas Board of MHMR.

Senate Bill 994 would authorize TDMHMR to establish an account in Central Office in fiscal year 1985 for improving staff-to-client ratios in state schools. We have received funds for the program in fiscal years 1986-87. Jaylon Fincannon, deputy commissioner for mental retardation services, is working to implement this program, which is similar to mental health's $35.50 program.

Our only vetoed bill, House Bill 226, would have authorized the state to pay up to $10,000 in attorney's fees if a state employee were found not guilty of a criminal offense that arose within the scope and course of duty.

Six resolutions also were approved that will require multi-agency effort to aid in the appropriate movement of state school and state hospital residents into the community. TDMHMR will take the lead in effecting those resolutions.


Sherry L. Grona

ANDERSON: The department has achieved a 5.4 percent budget increase overall, not counting the employee pay raise.

The employee pay raise this biennium is being handled differently: it was appropriated to the Comptroller who then will place the 3 percent salary increase in TDMHMR's budget. The comptroller also will remove three-quarters of one percent of our budget to fund the second year of the pay increase, which was enacted but not fully funded.

The budget increase was characterized by ups and downs. Central Office's budget was cut by almost half a million dollars. Yet certain areas received increases, such as standards and quality assurance, training and staff resources, and client services and rights protection. This is no accident. These areas are most closely tied to compliance with the department's two class-action lawsuit settlements.

Nutrition and food service's centralized food fund is almost $3 million less each year of the biennium than in previous years, which is based on the expectation that the facility population will drop. However, we did achieve the ability to transfer money from the budget of fiscal year 1987 to that of 1986 since we feel the budget cut was close to the bone. Just as we have flexibility with our utilities budget, we must also with the food budget since we have many people to feed.

The biggest change from previous years in the appropriations bill is two new line items: staff-to-patient ratios, mental health, and staff-to-client ratios, mental retardation. This new money represents an affirmation of the department's success in meeting staffing standards in state facilities. It reinforces our intention to reduce facility populations with improved community alternatives. The line items also give us flexibility to do whatever we must when we must. We can move money around Central Office more easily than in the past. We can transfer funds into key areas of facilities' administration and auxiliary, which will be helpful.

This appropriations bill places tremendous emphasis on the collection of fees and other reimbursements. The state facility outreach method of finance has shifted from general revenue to more emphasis on fees and collection. Community MHMR centers narrowly escaped a rider that would have required 12 percent of their total budget to be collected in fees. But we came out with clear legislative intent that those collections from people who receive services be increased. We'll have to put forward tremendous effort in those collections if we are going to maintain our budgets at their current level.□

Conference Calendar

Aug. 23, Portales, N.M.
Creativity and Humor Workshop for Nurses and Health Care Personnel
Mental Health Resources conference
Contact: Candie Garner
300 East First
Portales, NM 88130
(505) 359-1221

Oct 3-5, Dallas
Volunteer Services State Council
27th annual meeting
Contact: Volunteer Services
TDMHMR
P.O. Box 12668
Austin, TX 78711
(512) 465-4660, STS 824-4660

Oct. 4, Fort Worth
Changes in Tax Law and Their Impact on the Nonprofit Sector
Tarrant County MHMR Services seminar
Contact: Richard Garnett, Ph.D.
Tarrant County MHMR Services
1319 Summit Ave.
Fort Worth, TX 76113
(817) 335-5371

Oct. 22, Terrell
Trends in Mental Health: Where We're Going
Speaker: Shervert Frazier, M.D.
Director, National Institute of Mental Health
Contact: Sarah Kegerreis
Terrell State Hospital
P.O. Box 70
Terrell, TX 75160-0070
(214) 563-6452

Oct. 30–Nov. 2, Dallas
Into the 21st Century
Texas Association for Children and Adults with Learning Disabilities annual conference
Contact: Dorothy Strance
TACLD State Office
1011 W. 31st St.
Austin, TX 78705
(512) 458-8234

images

Newsmakers

► **Pamela Carley,** director of client services and rights protection, **Central Office,** was elected to the Employees Retirement System board of trustees.

The system administers $3 billion in trust funds and the largest insurance program in Texas, covering active and retired state employees.

► **James T. Moore,** chief of nutrition and food service, **Central Office,** was named to a two-year term on the International Gold and Silver Plate Society board of directors.

► The child and adolescent treatment unit of **Rusk State Hospital** was closed July 29, and the 24 patients are now receiving services from **MHMR of Southeast Texas,** Beaumont.

The unit's 40 staff members have been assigned to other treatment programs in the hospital, which will no longer accept people under age 18 for civil commitment.

► The laboratory at **Mexia State School** was approved by the Commission on Laboratory Accreditation of the College of American Pathologists.

► Innovative state employees could be rewarded with up to $5,000 by the State Employees Incentive Commission after it begins operation Sept. 1.

A recommendation that reduces state expenditures, increases state revenues or improves the quality of state services could earn a full-time employee 10 percent of the net savings or revenue increase, which must amount to at least $100.

► **Johnson County MHMR Center,** Cleburne, is the department's 32nd community MHMR center.

The center, serving Johnson county, now operates outreach services and a sheltered workshop for people with mental retardation in Cleburne. It also offers substance abuse and child abuse services in Cleburne and Burleson and plans an infant stimulation program, says Laura Gibson, secretary-treasurer of the center's board of trustees.

Chairman of the board of trustees is Willard Robertson, P.O. Box 436, Alvarado, TX 76009, telephone (817) 783-3817.

► **Rush H. Record,** Houston, recently resigned from the **Texas Board of MHMR.** On June 14 board members passed a resolution of appreciation recognizing his service.

Appointed to the Board by Gov. William P. Clements Jr. on Nov. 18, 1981, Record brought experience and idealistic realism to his service.

Record accepted committee assignments and offered valuable assistance in obtaining legislative appropriations for the department's programs.

Before becoming a member of the Board, Record served on the Mental Health Needs Council and on the board of the Mental Health Association of Houston and Harris County. He co-authored a council report on the incidence of mental illness and research efforts and helped raise funds for research into mental illness.

► **Life Management Center** is the new name adopted for the El Paso Center for MHMR Services by its board of trustees. The name is intended to distinguish the center from El Paso State Center and draw a wider segment of the community to its services by clarifying the private, nonprofit status.

► **Jack Fleming,** director of purchasing and supply, **Amarillo State Center,** was named certified purchasing manager by the National Association of Purchasing Management.

► The Texas Board of MHMR named **Harold K. "Kenny" Dudley Jr.** as superintendent of **Austin State Hospital** and **Diane H. Cano** as director of **El Paso State Center.**

Dudley, who has been assistant deputy commissioner for mental health services since 1971, has been the hospital's acting superintendent since December. He has been with TDMHMR since 1968 when he was employed as a Rusk State Hospital psychologist.

He holds bachelor's and master's degrees in psychology from North Texas State University, Denton, and has done graduate study in health administration at Southwest Texas State University, San Marcos, and in educational psychology at the University of Texas at Austin.

Cano has been the center's mental health administrator since September 1983. Since joining the center staff in October 1977, she has administered staff services, quality assurance, mental retardation and residential programs.

Cano's graduate degree is in public administration from the University of Texas at El Paso, and her undergraduate study in anthropology was completed at the University of California, Los Angeles.

Resources

Several informational publications are available by mail.

The Public Information Office (PIO) has published the brochure *Schizophrenia,* which is $.15 a copy when ordered in bulk, free in single copies. Request it from PIO, TDMHMR, P.O. Box 12668, Austin, TX 78711-2668.

Slogans and Euphemisms: The Functions of Semantics in Mental Health and Mental Retardation Care by Leona Bachrach, Ph.D., is available for $.60 a copy when ordered in bulk, free in single copies, from PIO also.

A booklet entitled *Supervising Adults with Learning Disabilities* is available in single copies free from the President's Committee on Employment of the Handicapped, Washington, DC 20036.

The Public Affairs Committee Inc., 381 Park Ave. South, New York, NY 10016, offers three new pamphlets: *The Cocaine Epidemic; Drugs—Use, Misuse, Abuse: Guidance for Families;* and *Anorexia Nervosa and Bulimia: Two Severe Eating Disorders.* They cost $1 each, and a free catalog is available upon request.

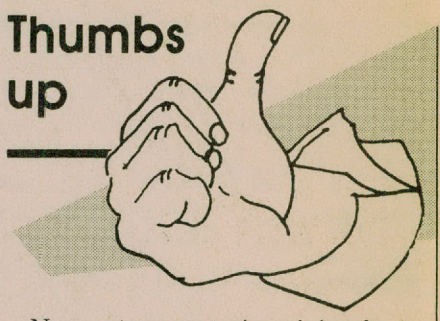
State holidays

1985	
Sept. 2, Mon.	Labor Day
Nov. 11, Mon.	Veteran's Day
Nov. 28, Thurs.	Thanksgiving Day
Nov. 29, Thurs.	Thanksgiving (additional leave day)
Dec. 24, Tues	Christmas (additional leave day)
Dec. 25, Wed.	Christmas Day
Dec. 26, Thurs.	Christmas (additional leave day)
1986	
Jan. 1, Wed.	New Year's Day
Jan. 19, Sun.	Confederate Heroes Day
Feb. 17, Mon.	Washington's Birthday
March 2, Sun.	Texas Independence Day
April 21, Mon.	Sesquicentennial Day
May 26, Mon.	Memorial Day
***June 19, Thurs.**	Emancipation Day
July 4, Fri.	Independence Day
***Aug. 27, Wed.**	Lyndon B. Johnson's Birthday

Holidays falling on Saturday or Sunday will not be observed by closing state offices on the preceding or following day.

*On these modified holidays, each state agency will have on hand enough personnel to carry out public business. State employees who work during these holidays will receive compensatory leave. Employees are entitled to observe the religious holidays of Rosh Hashanah and Yom Kippur in lieu of modified holidays.

Thumbs up



News representatives joined the Texas Board of MHMR for a **Fort Worth State School** tour in June.

Impressed by the quality of care and the school's clean and modern facilities, Board Chairman R. Coke Mills, Waco, spoke for the members in commending the staff for their caring dedication and the parents for their support.

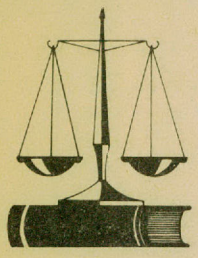
Board members asked to visit the school since it had been the subject of publicity in relation to the *Lelsz* lawsuit. They came away confident about the school's programs of care and treatment.

Live and work

People who leave **Wichita Falls State Hospital** and are willing to work now can join the Career Village program. They gain minimum-wage employment in areas of the hospital such as food service, motor pool, maintenance, music therapy, housekeeping, nursing service, library, and roads and grounds.

The 10-bed community-based residential program provides a structured living environment much like the program at Big Spring State Hospital (see story on page 10). In preparation for the transitional program, clients learn basic living and working skills and are evaluated to ensure proper job placement.

Message to the Nation



People with mental retardation living in the community won a victory July 1 when the U.S. Supreme Court unanimously ruled that the City of Cleburne violated their rights by refusing to issue a special-use permit for a group home in 1980.

The zoning law required the permit for operation of a group home for people with mental retardation in a residential neighborhood.

The court's decision said the law "appears to rest on an irrational prejudice against the mentally retarded" since other residences like fraternity houses and nursing homes are not required to have the special-use permit.

In 1982, the original decision was made in favor of the Cleburne zoning law, but in 1984, the 5th U.S. Circuit Court of Appeals overturned the ruling. The Cleburne City Council then appealed to the Supreme Court, which decided in favor of the group home, to be operated by Community Living Concepts Inc.

The case has attracted nationwide attention. "It sends a message across this state and nation that mentally retarded people are citizens (who can) live in the communities on an equal basis with everyone else," says Renea Hicks, an attorney for the group home.

The court, however, declined to classify mentally retarded people as a "quasi-suspect" class, which is the status afforded women under the Equal Protection Analysis.

This classification, say advocates for people with mental retardation, would give retarded people the same judicial protections that apply in cases involving race and national origin.

The Supreme Court ruling follows passage of Texas' Senate Bill 940, which provides that a "family home" composed of no more than six mentally retarded people and two supervisory personnel is a permitted use in residential zones and districts in Texas. But since the Cleburne home will house 13 people, this law does not apply.

Employees at the Mainland Center Home, a group home in Dickinson operated by Gulf Coast Regional MHMR Center, Galveston, were pleased with the ruling. This home was opened despite outcry from some neighbors. Rae Allen, a residential counselor, says some neighbors have reconsidered the home. "They've gotten to know the clients over the last few months" in church and stores, she says, and are becoming familiar with them.□

impact

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