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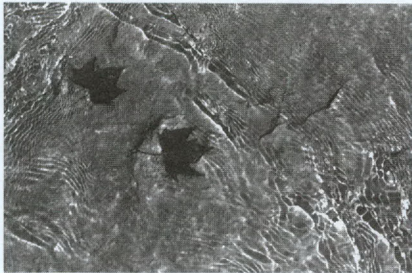
Tidemarks of Kinship



The summer of 1996 will be remembered as the time when the sun glared down on Texas and dry riverbeds scarred the land. But, despite the hardships it wrought, the 1996 drought also wore another face. As the waters receded, artifacts long submerged surfaced to remind us of many worlds we had forgotten or had never known. Each tidemark told a story.

The discoveries made possible by the ebbing waters parallel TXMHMR's growing awareness of the cultures that distinguish its service recipients. In June TXMHMR hosted its fifth annual conference on cultural diversity, and other efforts are underway to incorporate a respect for cultural differences into the system's everyday practices. These initiatives complement a general shift to individualized services, for as we pay more attention to the diversity of people, we cannot help but see the inadequacy of a stock response to consumers' needs.

However, if we view the world through the lens of white male society, we deny ourselves access to valuable cultural resources. This is true of both our professional relationships with one another and our interactions with consumers. A team in which everyone thinks alike might just as well consist of only one person.

As executive director of Dallas County MHMR Center, I realized that the center had a one-size-fits-all approach to a diverse population. Although Dallas County is about 21% Hispanic, fewer than 10-12% of Dallas County's service recipients were Hispanic people. Demographics such as these, as well as input from staff of minority populations, sent Dallas County MHMR a clear message that it was not serving its community as well as it could.

The diversity council at Dallas County MHMR was an early model for change. Charged with identifying needed reforms and implementing them, the council required significant autonomy. It had a budget. It was self-perpetuating, that is, the original council of applicants appointed replacements as members left. At the same time, each council members' job description stipulated that at least four hours of work per week be dedicated to making the Dallas County MHMR service system more culturally competent.

A process is now underway to assess and develop cultural competency throughout the TXMHMR system, first at the department's facilities and later in the community. Although responses will vary in different geographic areas, a clear picture of our strengths and weaknesses should emerge by the end of the fiscal year. We will then draw on our assets to shore up services and conduct regular meetings of the governing bodies and assessments to ensure that we stay on task. Clear expectations will guide us to success. Cultural competency—no less than treatment and discharge planning—deserves this focus.

By August the rains had finally begun to fill the rivers and lakes in Texas again. But we must remember that other terrain and take care that it never disappears.

Contributed by TXMHMR Commissioner Don Gilbert.

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WorldView

In today's world, cultural competency[1] is being seen as an integral part of professional competency. More attention has been placed on developing multicultural human services and assessing the cultural aspects of behavioral interventions, preventive interventions and service delivery. But neither the intended nor unintended consequences of the organization, financing and delivery of human services to culturally diverse populations have been adequately considered. As the helping professions advance through the 1990s, discourse on these issues will be imperative.

The dramatic increase and changes in culturally diverse populations in the United States will bring about new and exciting challenges to the human service infrastructure, including research, training programs and services provided by private and public human service agencies. Some responses will be necessitated by larger and more diverse patient caseloads. But the challenge to service providers is not limited to assessing the impact of their preconceptions on culturally diverse populations or to identifying strategies to change the human service infrastructure so it can respond appropriately to growing needs. While this is crucial, it is not sufficient.

Traditionally, changes have not been made by the parties with the greatest influence in the human services infrastructure: the parties responsible for accrediting providers of inpatient and outpatient care, educational institutions and specialized training for the helping professions, and services for families and children; for licensing and certifying human services professionals; and for sanctioning and supporting diagnostic and assessment tools, such as the *Diagnostic Statistical Manual-IV (DSM-IV)*, used extensively by the helping professions. Although contracted to protect society, these self-governing bodies have done little to develop and enforce accreditation criteria that incorporate the needs and characteristics of different cultures. As experience indicates, this omission has had a mostly negative impact on culturally diverse populations. Still, the much needed evaluation of policies has not been done. In the meantime, budget constraints have significantly affected populations that have neither representation nor a data base, much less advocacy, to counter the system's neglect. The challenge to these authorizing bodies to negotiate a social contract for protecting culturally diverse populations is long overdue. If met, such a challenge could effect greater change than all the conferences and workshops on culturally diverse populations.

Among the initial steps in improving services for culturally diverse populations should be retraining helping professionals through continuing education, revising the system for delivering services to culturally diverse populations, adding multicultural content to certification and licensing examinations, and including multicultural criteria in the accreditation process. These tasks must be incorporated in the authorities' processes.

What can a department of mental health and mental retardation do to recreate culturally competent professionals? How can the marketplace require authorities to adopt criteria that are responsive to the needs of employers? How can employers demand culturally competent professionals who effectively meet the needs of individuals and provide quality services? Some recent national developments, especially the inclusion of cultural considerations in the *DSM-IV*, provide hope that change is possible.[2] Much more remains to be done. But it is important that inefficient services not be tolerated and that serious steps be taken to create model programs based on a new set of assumptions. Then human services will truly improve the lives of persons in need.

Contributed by Juan Ramos, Ph.D., Associate Director for Prevention, National Institute on Mental Health.

[1] *See "Research," page 20, of this issue of* Impact *for a detailed definition of cultural competency and an overview of TXMHMR efforts to develop it.*

[2] *See "Resources," page 21, of this issue of* Impact *for references to literature on DSM-IV and revised guidelines.*

TXMHMR's Fifth Annual Multicultural Conference

As the overseer of services for Texas residents with mental illness and mental retardation, TXMHMR faces a challenge that easily matches and might exceed that of MHMR departments in many other states: accommodating the numerous cultures of its service recipients. With a border hugging Mexico for 889 miles and an amusement park named for the flags of six different governments, Texas is a state in which the phrase "average citizen" has little meaning. The average TXMHMR consumer is no less elusive.

A major forum for tackling the challenge of cultural diversity is TXMHMR's annual multicultural conference. Like the Office of Multicultural Services, the conference grew out of a Hogg Foundation grant for mental health. Originally designed to provide information about mental health services for multicultural populations, the conference has expanded since its inception in 1992. The audience now includes staff in mental retardation services, substance abuse, deaf services and the private sector; consumers and their families; and staff from other state and community agencies. Conference sessions address the cultural issues of consumers and their families; clinical services; best practices/model programs; and language/communication.

This year's June 26 - 28 conference in Austin focused on cultural competency. The practical application of cultural sensitivity, competency refers to skills and abilities in service delivery. In his welcoming remarks, Commissioner Don Gilbert emphasized the importance of this concept and advised conference participants, "Our system must move beyond cultural sensitivity to the level of cultural competency."

The conference's 24 workshops gave 400 conference goers an opportunity to explore various ways for transforming sensitivity into competency. Presentations included

- "The ABCs of Managed Health Care and the Cultural Impact on the Medically Indigent Community" by staff of the Austin Travis County Mental Health Mental Retardation Services (ATCMHMR);
- "Cultural Diversity: A Consumer's Perspective" by Ester Vaughn with the Texas Mental Health Consumers;
- "*DSM IV* Cultural Inclusion" by David Luna, TXMHMR Multicultural Services Director.

At the same time, exhibitors offered glimpses of cultural competency in action. For instance, the Cultural Diversity Committee of Vernon State Hospital showed videos of their activities and displayed the "American Quilt" created by the hospital's employees and residents. (See "Patchwork" in *Impact*, Spring/Summer 1996). The Texas Commission for the Deaf and Hard of Hearing introduced conference goers to an assortment of assistive listening devices.

An important component in developing cultural competency is workforce diversity. Ferdie McDowell, workforce diversity director at TXMHMR's Central Office, told conference participants of a plan soon to be implemented throughout the TXMHMR system. Key issues will be the recruitment/retainment of diverse employees; management accountability for diversity; and training initiatives. McDowell said, "Under such a plan, staff would feel more valued, be more productive and provide better services to TXMHMR consumers."

But the quest for cultural competency is and must remain a constant process to which all TXMHMR players are committed. At the close of the conference, Leroy Torres, former substance abuse director at ATCMHMR and current executive director of the Tropical Texas MHMR Center, described the progress that ATCMHMR has made and attributed much of it to the support of the center's executive director David Evans and diverse board of trustees. Torres also emphasized the importance of allocating necessary resources to cultural diversity councils. Both administrative support and resources are essential if diversity efforts are to succeed.

Contributed by David Luna, Multicultural Services Director at TXMHMR's Central Office.

To diversify the multicultural event, TXMHMR's conference planners will hold the 1997 summer conference in Houston rather than Austin. In addition, Texas may invite surrounding states to participate in and benefit from the program. For more information, call David Luna at (512) 206-4643.

Culture-bound Syndromes

Among the additions to the DSM-IV is a glossary of terms used by specific cultures to refer to "recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular diagnostic category." At right is a sample of "culture-bound syndromes" included in the manual.

bilis and **colera** (also referred to as *muina*) The underlying cause of these syndromes is thought to be strongly experienced anger or rage. Anger is viewed among many Latino groups as a particularly powerful emotion that can have direct effects on the body and can exacerbate existing symptoms. The major effect of anger is to disturb core body balances (which are understood as a balance between hot and cold valences in the body and between the material and spiritual aspects of the body). Symptoms can include acute nervous tension, headache, trembling, screaming, stomach disturbances, and, in more severe cases, loss of consciousness. Chronic fatigue may result from the acute episode.

ghost sickness A preoccupation with death and the deceased (sometimes associated with witchcraft) frequently observed among members of many American Indian tribes. Various symptoms can be attributed to ghost sickness, including bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, fear, anxiety, hallucinations, loss of consciousness, confusion, feelings of futility, and a sense of suffocation.

latah Hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trancelike behavior. The term *latah* is of Malaysian or Indonesian origin, but the syndrome has been found in many parts of the world. Other terms for this condition are *amurakh, irkunii, ikota, olan, myriachit,* and *menkeiti* (Siberian groups); *bah tschi, bah-tsi, baah-ji* (Thailand); *imu* (Ainu, Sakhalin, Japan); and *mali-mali* and *silok* (Philippines). In Malaysia it is more frequent in middle-aged women.

mal de ojo A concept widely found in Mediterranean cultures and elsewhere in the world. *Mal de ojo* is a Spanish phrase translated into English as "evil eye." Children are especially at risk. Symptoms include fitful sleep, crying without apparent cause, diarrhea, vomiting, and fever in a child or infant. Sometimes adults (especially females) have the condition.

rootwork A set of cultural interpretations that ascribe illness to hexing, witchcraft, sorcery, or the evil influence of another person. Symptoms may include generalized anxiety and gastrointestinal complaints (e.g., nausea, vomiting, diarrhea), weakness, dizziness, the fear of being poisoned, and sometimes fear of being killed ("voodoo death"). "Roots," "spells," or "hexes" can be "put" or placed on other persons, causing a variety of emotional and psychological problems. The "hexed" person may even fear death until the "root" has been "taken off" (eliminated), usually through the work of a "root doctor" (a healer in this tradition), who can also be called on to bewitch an enemy. "Rootwork" is found in the southern United States among both African American and European American populations and in Caribbean societies. It is also known as *mal puesto* or *brujeria* in Latino societies.

zar A general term applied in Ethiopia, Somalia, Egypt, Sudan, Iran, and other North African and Middle Eastern societies to the experience of spirits possessing an individual. Persons possessed by a spirit may experience dissociative episodes that may include shouting, laughing, hitting the head against a wall, singing, or weeping. Individuals may show apathy and withdrawal, refusing to eat or carry out daily tasks, or may develop a long-term relationship with the possessing spirit. Such behavior is not considered pathological locally.

Source: American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

Se Habla Español:
Kerrville's Interpretation Team

"A shared language makes for a shared identity."

"Mi nombre es Elva Perez. Estoy acqui para ayudarle a comunicarse con el doctor. Yo solo seré su voz."

Para el paciente hispáno enfrentando una enfermedad mental y en un mundo de habla inglés, buscando su propio voz puede parecer una tarea desesperanzada. En 1993, el Hospital Estatal de Kerrville (KSH) tomo pasos para hacer esto posible. Elva Perez es una de 28 empleados de varios departamentos en KSH que han cumplido un programa intensivo de seis meses y sirven en el equipo de interpretación sobre la idioma español en el hospital (SLIT).*

Aunque aproximadamente un tercer de la población paciente en KSH sea de habla español, Terry Rodriguez, la coordinadora multicultural del hospital y directora de tratamiento para la división de cuidado especialidado, anoto, "Antes del programa SLIT, yo fui una de los cuantos intérpretes residente en el hospital. Muchas veces tuvimos que preguntar la persona más cercano que hablaba español por ayuda en traduciendo, no importa de su profesión."

Los empleados son seleccionado para el entrenamiento de intérprete por Rodriguez, Mark Mosty y Jessica Edwards. Mosty, coordinador de la systema sobre vigilancia de calidad, es la conexion entre el SLIT y el Consejo de Mejoramiento de Calidad en el hospital. Edwards enseña los clases. Ellos junto buscan empleados con buenas abilidades en hablando y escribiendo español que quieren aprender el complejo terminología médica, legal y psiquiátrica requerido en el escenario del hospital. El proceso de selección también incluye una entrevista simulado con un paciente.

Después de completar el entrenamiento, miembros del equipo reciben un aumento de sueldo de un grado, que ellos pierden si se salen del equipo.

Perez ha visto el impacto positivo de SLIT con los pacientes. "Durante una junta reciente de los Alcoholicos Anonimos, yo noté un hombre joven que no hablaba ingles desesperadamente tratando de expresar sus sentimientos. Cuando yo interpreté por él, estuvo visiblemente aliviado de poder compartir sus experiencias con el grupo y recibir su comprensión y apoyo."

Contribuido por Dolores Schroeder, directora asistente de Relaciones Comunitarias, Hospital Estatal de Kerrville.

**Programas similares estan en operacion en los Hospitales Estatales de Vernon y Big Spring.*

"My name is Elva Perez. I'm here to help you communicate with the doctor. I will only be the voice between the doctor and you."

*To the Hispanic patient coping with a mental illness and an English-speaking world, finding one's voice can seem a hopeless task. In 1993, Kerrville State Hospital (KSH) took steps to make this possible. Elva Perez is one of 28 KSH employees from various divisions who have completed an intensive six-months training program and serve on the hospital's Spanish Language Interpretation Team (SLIT).**

Although approximately one-third of the patient population at KSH is Spanish-speaking, Terry Rodriguez, the hospital's multicultural coordinator and treatment director for the Specialty Care Division, noted, "Before the SLIT program, I was one of the few resident interpreters in the hospital. Many times we've had to ask the nearest Spanish speaker for help in translating, regardless of his or her profession."

Employees are selected for interpreter training by Rodriguez, Mark Mosty and Jessica Edwards. Mosty, quality system oversight coordinator, is the link between the SLIT and the hospital's Quality Improvement Council. Edwards teaches the classes. Together they look for employees proficient in verbal and written Spanish who want to learn the complex medical, legal and psychiatric terminology required in the hospital setting. The selection process also includes a simulated patient interview.

After they complete their training, team members receive a one-step pay increase, which they forfeit if they leave the team.

Perez has seen the positive impact of the SLIT on patients. "During a recent psychosocial AA [Alcoholics Anonymous] meeting, I noticed a young man who spoke no English trying desperately to express his feelings. When I interpreted for him, he was visibly relieved to be able to share his experiences with the group and receive their understanding and support."

Contributed by Dolores Schroeder, assistant director of Community Relations, Kerrville State Hospital.

**Similar programs are in operation at Vernon and Big Spring State Hospitals.*

Breaking the Silence Barrier

"A shared language makes for a shared identity. With the deaf as with others, identity is a prickly combination of pride in one's own ways and wariness of outsiders."— Edward Dolnick, in "Deafness as Culture," Atlantic Monthly, September 1993

Hearing loss affects one of every 16 Americans—about 20 million people. One in every 100 Americans is profoundly deaf—unable to hear speech well enough to understand it. In Texas, an estimated 1.5 million people have hearing problems.

Although people who are deaf or hard of hearing experience mental illnesses like schizophrenia and bipolar disorder at about the same rate as the general population, they are estimated to have three times the risk of developing serious emotional and behavioral disturbances as hearing persons, especially when deafness has been present since birth or early childhood. Nevertheless, only an estimated two to 15 percent of those needing mental health services are able to obtain them.

Erbie Johnson (left) and Lubivina Escalante use American Sign Language to discuss the educational television program they are watching at Texana Place, a community-based treatment and training program for deaf individuals who have a mental illness.

"At present, we really do not know how many deaf and hard of hearing people TXMHMR serves," stated Mike Collier, Ph.D., Deaf Services Specialist of Advocacy, Inc. A member of the Task Force on Mental Health Services for People Who Are Deaf or Hard of Hearing, Collier noted, "There may be many people who have gone to MHMR and received or are receiving inadequate treatment because their deafness has never been acknowledged as a barrier to services." Also, the Task Force found that many deaf and hard of hearing people avoid TXMHMR services altogether because of the agency's reputation for inaccessibility.

"Unless it's an emergency, people who are deaf do not go to MHMR even though they are experiencing extreme mental health problems," Collier said. "They somehow barely manage to function with assistance from other professionals not trained in mental health, volunteers and family. They may receive medications through MHMR or other doctors, yet not receive any other therapy."

What barriers do deaf and hard of hearing individuals most often face when they do reach out to MHMR for help?

- Shortage of services to meet their unique needs. Historically, the range of MHMR services for individuals with mental illness who are deaf or hard of hearing has been narrow. The Center for the Deaf, located on the Austin State Hospital campus, provides the state's only inpatient services for deaf persons with mental illness. Texana Place, also located in Austin, is a community-based treatment and training program for deaf individuals with a mental illness and history of aggression. The program serves a maximum of six persons at one time.

- Absence or shortage of telecommunications devices for the deaf (TDD), amplification devices and staff who know how to use them. Also, when a deaf person calls MHMR using Relay Texas, a statewide telephone interpreter service, staff may not

be familiar enough with the service to communicate well with the caller.

- Lack of qualified sign language interpreters for deaf consumers, or, when interpreters are provided, improper use of them. A common mistake when using an interpreter is to look at the interpreter while addressing the deaf individual or to speak to the interpreter as if the deaf person were not present.

- Too few MHMR staff who understand deafness and deaf culture as it affects the individual's environment and way of life. "Deaf people often feel uncomfortable with someone who does not understand deafness," Collier said. "Imagine yourself in Russia, in crisis and needing help *now.* Do you feel like explaining how American culture has influenced your life, or why the treatment you receive needs to be different? No, you probably would want help from people who understand you and know how to help you. You would want help from people fluent in *your* language. The reality is most deaf people can and do live normal lives and are happy as deaf persons. We need staff to understand this and help deaf and hard of hearing people and their families understand this. That is why we need qualified people to work with this population," he said.

The Task Force report *Mental Health and Deafness: Making the Texas System Work,* released in January 1995, explores and recommends solutions to these obstacles. It asserts, "Deaf consumers must have access to all the core services via either direct communication or interpreters, through assistive devices, and with cultural accommodations. Additionally, they must be able to participate in any other program a mental health authority may offer. . . . If the community center offers the service or program, it must be made accessible for people who are deaf."

Mental health services for people who are deaf or hard of hearing come under the Americans with Disabilities Act, which requires public entities to "take appropriate steps to ensure that communications with applicants, participants and members of the public with disabilities are as effective as communications with others." According to *Mental Health and Deafness,* accessibility measures for people who are deaf or hard of hearing fall into three areas: visual communication modes (such as sign language, signed/captioned videos); cultural competency (such as having staff members fluent in sign language and knowledgeable about deafness); and assistive technology (such as TDD, assistive listening devices, flashing lights for alarms, door bells and telephones).

The telephone has become a simple means of communication for people who are deaf or hard of hearing. With a TDD (telecommunications device for the deaf), two people with compatible equipment can have a typed conversation over the telephone.

A three-month demonstration program at eight non-profit service centers for the deaf in Texas is testing the feasibility and popularity of a video telephone system. The programs enable ASL users to make phone calls to hearing or deaf persons by using a video hook-up relayed through an ASL interpreter.

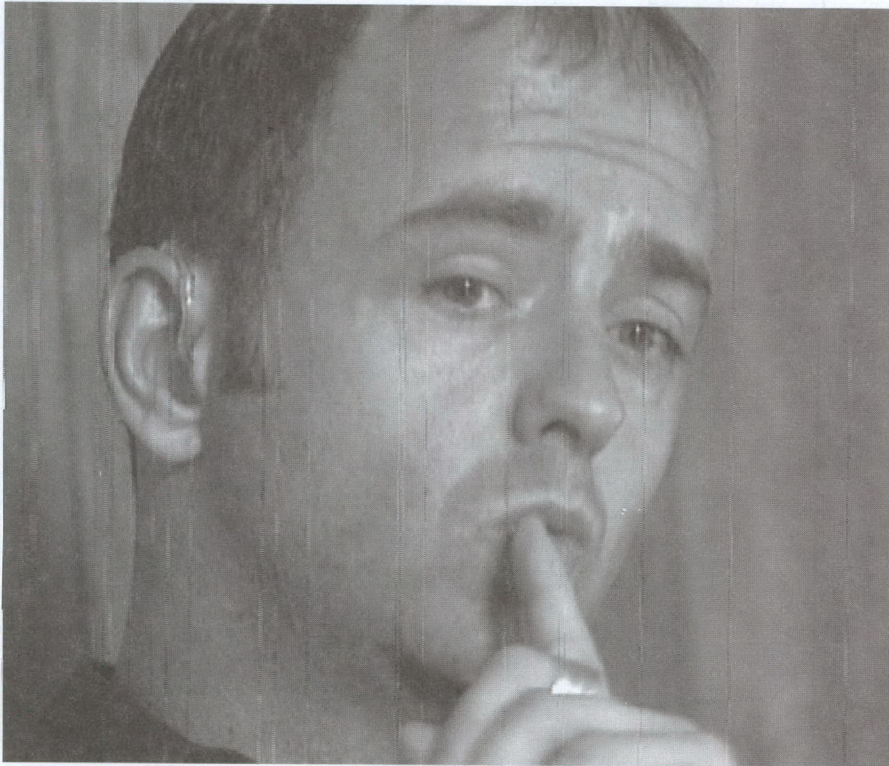
The report recommends several ways to address these areas and outlines levels of accessibility to be achieved in the system. Level I, the basic level all MHMR services and facilities are to attain, provides access to crisis services; information about MHMR facilities, services, programs and procedures; and appropriate services at community MH centers. Level II includes all the features of Level I plus a fully accessible, barrier-free and culturally supportive environment for residential programs, state hospitals, state centers and self-contained programs.

Some progress toward fulfilling the Task Force recommendations has been made.

- State facilities were required to attain Level I accessibility by August 1996.

- Two liaisons with deaf consumers and the deaf community have been appointed at each state facility.

- TXMHMR Human Resources Development (HRD) has created, in collaboration with deaf consumers and advocates,



Matthew Hutton, team leader for deaf services for Austin Travis County MHMR, leads classes at Texana Place, such as this one on time management, that give individuals skills needed to live independently in the community. **Photos by:** *Peter Baer*

sensitivity training for new employees. HRD also has developed a videotape of the *Consumer Rights Handbook*, narrated by a sign language interpreter, for viewing by all deaf consumers.

- The Quality Services Council is evaluating proposed changes to the MH Community Services Standards related to deafness issues.
- Efforts are underway to identify, count and track more accurately deaf and hard of hearing individuals through the MHMR client database.
- TXMHMR continues to contract with the Texas Commission for the Deaf and Hard of Hearing through local Councils for the Deaf to provide interpreter services. Local authorities now are required to use qualified sign language interpreters for deaf or hard of hearing consumers and should have contacts with their local councils for the deaf or other interpreter services providers.

Helen Keller, who was both blind and deaf, once said, "Blindness cuts people off from things. Deafness cuts people off from people." While much remains to be done, TXMHMR is working toward a system that is inclusive of all individuals regardless of their ability to hear.

—LL

Deaf Awareness Quiz

Following are excerpts from the *Deaf Awareness Quiz* included in training materials recently sent to TXMHMR facilities that provide mental health services. The curriculum includes a client rights video narrated by a person who is deaf, as well as written materials. The curriculum was a collaborative effort of TXMHMR Human Resources Development, counselors from Texana Place, Texas School for the Deaf, an American Sign Language instructor, Relay Texas and the Texas Commission for the Deaf and Hard of Hearing. Are these statments true or false? Answers appear on the back page.

1. All people who are deaf can benefit from wearing a hearing aid.
2. All people who are deaf understand sign language.
3. Most people who are profoundly deaf can speak and articulate with appropriate training.
4. A good way to describe a person who is deaf is "deaf and dumb" or "deaf-mute."

In Their Own Words

Depending on the situation and personal preferences, deaf and hard of hearing persons may communicate using American Sign Language (ASL) or some variety of signing that uses features from both ASL and English. Differences shown below underscore the importance of communicating with deaf consumers in their primary language.

Signed English: using arbitrary signs to represent English; there is at least one sign for each English word, and prefixes and suffixes are used. Example: *You have the right under the rules of the department. . .*

Signed Pidgin English: using ASL sign concepts in English word order with English word endings. Example: *You have right under departmental rules. . .*

American Sign Language (ASL): visual language with its own grammatic structures used by the deaf community. Example: *Not satisfied service you right complain. . .*

First Words through Assistive Technology

"Living" languages are those still changing through use. Among their vital signs are non-verbal cues like facial expressions and gestures—augmented communication. Modern technology has expanded augmented communication so people long consigned to silence might have a voice of their own.

Populations that can benefit from communication devices range from people who had strokes and need temporary assistance to individuals who have degenerative conditions and require long-term supports. In 1992, the United Cerebral Palsy Association estimated that 750,000 to 1.5 million Americans had severely limited speech. An analysis of TXMHMR data showed that 403 individuals at state schools required augmented communication during fiscal year 1996.

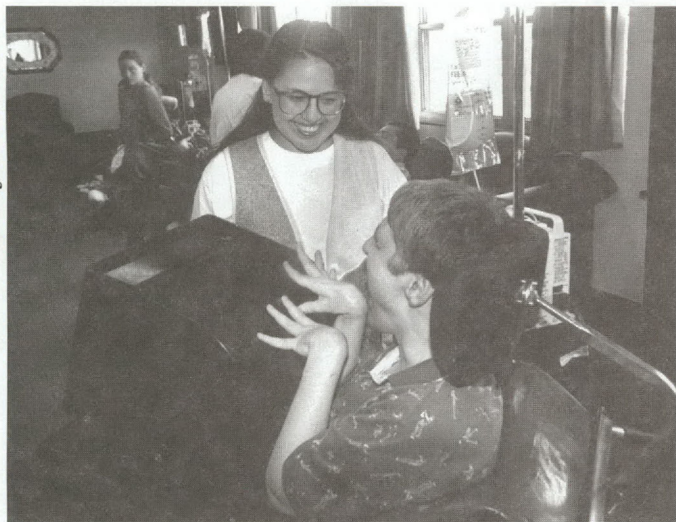


Photo by David Feemster

Terry Anderson, Abilene State School consumer, activates an Ablenet switch with the side of his head to access his augmentative system, which combines a laptop computer, Words+Talking Screen Software, and a Vocalite voice synthesizer.

Tina Wilson, associate director of the Family and Community Support System at Austin Travis County MHMR Center and a communication specialist, described two categories of communication devices. A "low end" device may consist of a few buttons, each corresponding to a single phrase used by an individual. "High end" equipment enables people to have full conversations. According to Wilson, Prentke-Romich offers the widest range of equipment, including the Liberator and its array of software that allows it to grow with the person.

The key to success is motivation.

"I worked with one man in his mid-twenties who had spastic cerebral palsy, was uneducated and was diagnosed as having mental retardation. He could only move his head," Wilson said. "When we introduced him to augmented communication, we discovered he could spell. Now in his thirties, he's married, has a child and is going back to college. He basically taught himself to use the Liberator."

But Wilson added that the Liberator is not for everyone and an in-depth assessment is critical for determining the most suitable device.

The greatest drawback to augmented communication is the $2,000 to $12,000 price range. In Texas, the public school system provides funding for children who are between 0 and 22 years of age and have been evaluated by the local assistive technology team. Funding for adults is more limited, often to the $3,600 of In-home and Family Support.

Other obstacles concern communication quirks, such as voices that sound automated and lengthy pauses in conversations. But augmented communication is acquiring the nuances that make languages—and people—truly alive. One researcher foresees the day when a person will be able to "signal [REMOVE], [YOU], [POLITE], and the aid would say 'Would you please leave?'" On the other hand, should the individual choose "[REMOVE], [YOU], [ANGRY]," the device will have no choice but to say, "'Get out of here!'"

—*KR*

A Sample of Assistive Technologies

Input

- Alternate keyboards
- Optical pointing devices
- Pointing and typing aids
- Switches with scanning
- Scanners and optical character recognition
- Touch screens

Output

- Braille displays and embossers
- Monitor additions
- Screen enlargement programs
- Screen readers
- Speech synthesizers
- Talking and large print word processors

Sources:

The Alliance for Technology Access. *Computer Resources for People with Disabilities: A Guide to Exploring Today's Assistive Technology*. Alliance for Technology Access, 1994.

Vanderheiden, Gregg C. "Visions of Augmentative Communication Hardware in the 21st Century," keynote speech for Technology in Developing Countries, 1990 Isaac Conference, Stokholm.

A Bridge to the Far East: Mental Health Services for Vietnamese Refugees

When thousands of Vietnamese refugees found new homes in Texas, they left behind the war-torn years. They left behind more recent trauma at the hands of North Vietnamese who held them captive in "reeducation camps." All too often, they left behind precious family members who weren't allowed to enter the United States with them.

Though they have survived these overpowering circumstances, most did not leave their memories behind. Or their nightmares. For some, snatched from families in the middle of the night, a knock at the door can bring back a flood of traumatic memories. Others still find their voices reduced to a whisper in the face of any authority.

Dallas County MHMR psychiatrist Trang Ma treated one man whose memories were more than he could handle. A recent immigrant who had been badly beaten in a camp where he was held for years, the man was waking up at night with flashbacks and trying to flee. His wife was forced to tie him to the bed.

Dr. Ma treated the man for depression and post traumatic stress syndrome (PTSD) at the Ferguson Road MHMR clinic in Dallas. He responded well to the anti-depressants she prescribed, she said, and was able to reunite with his children.

Ma said the majority of the Vietnamese immigrants cope with the stresses of their old wounds and the demands of their new culture quite well. But, not surprisingly, a certain percentage suffer from PTSD, psychosis and depression, often masked in physical symptoms that are more acceptable to the culture.

"Most Asian refugees have been through situations where family members have been killed. Many have witnessed the killings. High numbers have been through reeducation camps where torture, starvation and murder often occurred," said Dr. Steven Shon, TXMHMR medical director.

Shon added that a number of barriers hinder efforts to help this population. The Vietnamese language and perspectives on mental illness are especially challenging to staff in the mental health system.

Few mental health workers speak Vietnamese. Those who do, like Ma and Dr. Su Duong, a Houston psychiatrist at the MHMR Crisis Clinic, are called whenever possible, both by staff and by leaders in the Vietnamese community.

Doung and others say that the traditional Vietnamese view of mental illness may be a greater obstacle than language.

In Vietnam, most problems, including all but the most extreme forms of mental illness, are

Tuyet Bui's spirituality and religious beliefs have helped her survive the stressful changes in her life.

Photos by Dennis R. Ivy, Houston

handled within the family. Family members seek outside help only when someone is out of control or clearly psychotic, at which point the ill person is often institutionalized. This is a source of great stigma and makes the Vietnamese afraid to enlist the aid of mental health professionals in the United States. Psychiatry also is not an area of specialized training in Vietnam, Ma said.

Despite the barriers, mental health services are critical for this community.

Dr. Walter Nguyn, a clinical social worker in Dallas, studied the mental health of detainees, recent immigrants who had experienced the Communist camps. He found that most detainees needed clinical services, ranging from social support to hospitalization, and that social support from peers, relatives and the community were most important in maintaining a sense of well-being and happiness.

Fortunately, for many detainees and other immigrants, the community provides a great deal of strength.

Dr. Tuan Nguyn, who helped organize the 1996 Southeast Asian Mental Health Conference in Houston, said survival has depended on the strength of family ties. Families have kept one another alive in the most trying times and are focused now on working for a better future for their children in this country. Spiritual values, too, have helped detainees and their families survive the most horrendous situations. Nguyn said these strengths should not be overlooked by those who attempt to help.

The conference, sponsored by the MHMR Authority of Harris County and several other community agencies, sought to bring mental health providers together with leaders in the Vietnamese community to explore cultural issues as they relate to mental health. Panels focused on a wide range of topics, from developing cultural competence for mental health workers to recognizing and coping with mental illness in the family.

This kind of outreach is much needed, said Huy Nguyn, the mental health project coordinator for Research and Development Institute, an agency that provides services to immigrants and refugees.

"Dealing with stigma is the first step," according to Huy Nguyn. "The community leaders need to learn that mental illness is a treatable problem. Many do not know what depression is."

Many years ago, when Tuyet Bui first came to the United States, she was deeply withdrawn. The services she has received from the Northwest Clinic of the MHMRA of Harris County have helped her to begin relating to others again.

Often, depression in this group is masked in a variety of physical illnesses, from stomach problems to headaches. Seeking help for these ills is more culturally acceptable. Unfortunately, the medical help may be only partially successful in resolving the problem.

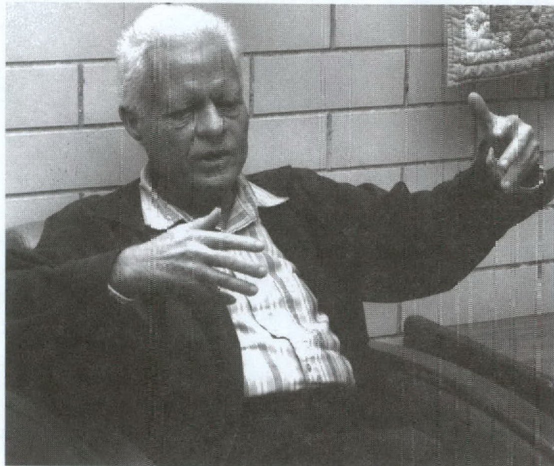
Dr. Duong said networking at the conference resulted in one such patient getting help. Duong was approached by a young doctor who had been trying to treat a newly arrived Southeast Asian woman for headaches and sleep problems. She had undergone physical and psychological torture in Vietnam and had barely escaped with her life.

"I was fortunate to get her an appointment at one of the clinics," said

Dr. Duong. "Without the seminar, she probably wouldn't have gotten treatment for depression."

Though it will take time to build bridges between the Vietnamese community and MHMR, community leaders regard this conference as an important start. Huy Nguyn noted, "It shows that the agency recognizes the need and importance of serving the refugee community."

Contributed by Leslie Sowers, health and fitness writer for the *Houston Chronicle*.



Older Adults in the TXMHMR System:

Storytellers of the Past, Guides to the Future

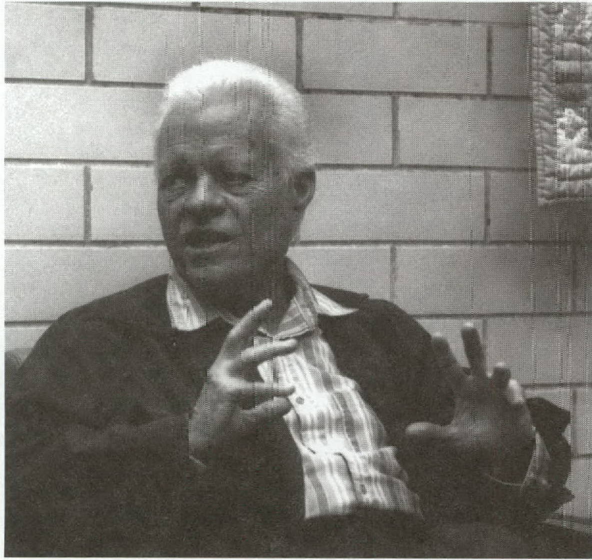
It is common knowledge that the older adult population is the fastest growing of all age groups. It is also widely accepted that mental illness is much more prevalent in the older adult population than in the general population. What may not be so well known and understood is that scarce community-based programs often leave older adults with serious mental illness with few alternatives to psychiatric hospitals and nursing facilities. When bereft of close family ties, the elderly are too easily abandoned and forgotten. But remembrances usually come easily to the older adult. When shared, they reconnect the narrator to his or her life story and mindful listeners to a bit of themselves.

Austin State Hospital (ASH) patient Peter Norton is a favorite storyteller of Marsha Weichold, a social worker for TXMHMR consumers on the ASH geriatric unit. Although she has had the opportunity to know and support scores of Austin's and Central Texas' aging population, Weichold considers Norton a special presence in her professional life. "Peter is a real character who loves to entertain the patients and staff with conversation. He has plenty of interesting stories to tell," Weichold explained as she smiled and we made our way through the corridor of the hospital unit to meet Norton.

At age 65, Norton may barely qualify as an older adult, but hypertension, diabetes, heart problems, kidney problems, and emphysema as well as a psychiatric diagnosis of schizoaffective disorder make for a complex hospital patient. In fact, the daily dose of lithium that for many years helped to stabilize Norton recently had to be discontinued because it had begun to jeopardize his physical health. ASH physicians and Norton's treatment team now are attempting to treat him with other medications.

Norton was first admitted to the TXMHMR system in 1979 and to ASH in 1989. His fifth and most recent admission to the hospital was prompted by a sleep disorder that caused Norton to wander the halls of the nursing home where he lived and to behave aggressively toward other residents. Although he had moved into a foster home after an earlier admission to ASH, his serious medical problems came to require the level of care that a nursing home can provide. For the past 13 months, Norton has called ASH home.

Once a strong and active man who worked for the Alcoa Aluminum Corporation for 25 years, Norton now walks with an unsteady gait and his hands tremble slightly when he sits and folds them across his lap. But when the conversation begins, he comes alive and the hard years seem to vanish as



he recounts the days of his youth.

Norton's memories, or at least thoughts of things past, extend all the way back to his birth and an early loss in his life. "You know what I looked like when I was born?" he asked and then mused, "My twin was stillborn. I think I came out first." According to Debbie Moore, rehabilitation supervisor for geriatrics, Norton often talks of the death of his twin brother.

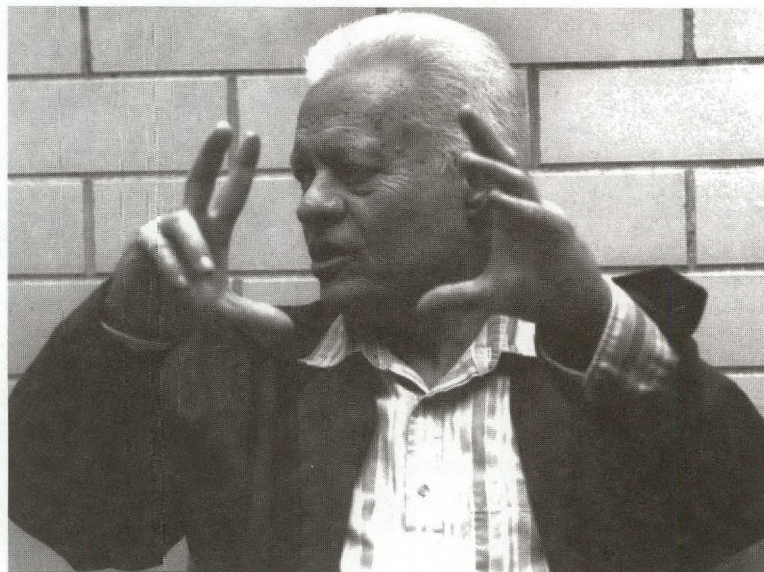
But he also describes a world in which family, religious and business ties were tightly bound together. "I grew up south of Houston with two brothers and two sisters. My parents both worked for Alcoa, so that company was kind of a family affair," he said. Although Norton would follow in his parents' footsteps, he briefly considered becoming a Roman Catholic priest. This may have been due to or despite the influence of the family's confessor who, according to Norton, often "poked his head outside of the confessional and yelled, 'Hurry up!'"

More recent events are less distinct to Norton. Weichold explained that on some days he can clearly recall when the police picked him up many years ago and brought him to the state hospital for the first time. He remembers that he was first committed for acting aggressively. On other days Norton is more confused and has difficulty remembering details of his past.

Norton remains in close contact with his sister Mary, who visits him frequently and occasionally takes him out to eat. He is fortunate that his sister is interested and supportive. In too many similar situations, family members remember the aggression and behavior that occurred long ago when the mental illness first escalated to the point where intervention was necessary. Unable to let go of these memories, family members discontinue their contact with the person with mental illness.

Then, as time and illness take their toll, the formerly strong individual is forced to slow his swagger to a shuffle down the hallway. But in the telling of the tale that other vital self might live on. In listening, so might we.

Contributed by Galen Brewer, coordinator of older adult services and special populations at TXMHMR's Central Office and editor of "Mental Health and Aging News and Views."



Photos by Sherry L. Grona

Fortaleciendo la Unidad Familiar

Strengthening Family Unity

At age 17, Jesse displayed symptoms typical of paranoid schizophrenia: unwarranted fear and withdrawal from the world. Nearly 20 years later family members came to realize he has a mental illness and is not "lazy" and "no good," as some had claimed.

For his mother, Guadalupe, understanding began to grow shortly after Jesse was arrested twice for assaulting strangers. In jail, he was evaluated by a psychiatrist who suggested the young man needed help. Guadalupe turned to The Center for Health Care Services in San Antonio and began attending support groups, accompanied by her daughter Lupe. But, the major turning point for mother and daughter came at the first South Texas Family Support Conference. They persuaded another sister, Rosie, to join them at the second conference in Laredo.

"My mother, sister and I are much closer to my brother now, and we hope to bring the rest of the family to a deeper understanding of Jesse's illness," said Lupe. "The conferences showed my mother we are not alone. She realized many consumers and their families have similar problems."

An employee with the Center, Lupe believes her own work in supported employment programs has benefited from the conferences. "When I work with consumers, I am much better prepared to serve them, to be compassionate. Like my brother Jesse, they want acceptance and love."

Although Jesse still has moments of withdrawal and fear, Lupe sees improvement, much of it emerging from how she, Guadalupe and Rosie learned to deal with his illness. "For all of us, it's been like coming from the dark into the light."

Contributed by Thelma Stone Ledger, Public Information Office, The Center for Health Care Services.

Cultural Diversity: A Family Affair

In the United States, *unidad familiar* unfortunately is becoming less and less familiar. Yet family support remains critical to the healthy development of individuals, especially people with mental illness or mental retardation. Three years ago, Ron Morales, now executive director of the Center for Health Care Services in San Antonio, established the annual South Texas Family Support Conference to expand and enhance family involvement in services to consumers. This year, the first North Texas Family Support Conference was held in Dallas.

"My idea was to strengthen family support throughout South Texas by bringing consumers, family members and professionals together to share their knowledge and experience," Morales explained. At the conferences, families learn about advocacy, supported work, medication, children's services, In-Home and Family Support and more. TXMHMR staff also learn from family members and consumers how to expand and improve services to the Hispanic population.

To encourage attendance, conference planners had to respond to individual needs. Language differences demanded special attention. The 1995 conference was the first of its kind in Texas to be conducted in Spanish with English translation. This was important to Hispanic participants. "Like anyone else, they can really tell what's in their hearts when they're speaking in their native language," said Maxine Buttler of Nueces County MHMR, an organizer of the conference. Stipends and collaboration with other human services agencies also have helped to draw large numbers of conference goers, including the approximately 400 people expected to attend the June 1997 conference in San Antonio.

The Making of a Metaculture:
An Aftermath Where the Whole Is Greater

In 1975 one 16-year-old, like many others, was beginning the awkward stretch into independence. He rode his motorcycle to school and dreamed of becoming a carpenter. Although his high school could have used the large young man on its football team, he had other plans. "I'm not gonna break no bones," he decided. And one night when he saw a friend's car at a nearby house, he went to visit—against his parents' wishes.

"I should have listened," Manuel Mendoza said.

Now 37, Mendoza struggles with a body at odds with his independent spirit. A shooting that paralyzed him from the neck down has left him dependent on others for his basic needs. But the bullet that entered and exited his skull could have killed him and divided the closest of families. Instead, the reverberations from one disastrous moment have coalesced in a continuum of support.

The details of the incident were quickly confused. Many people thought it was a drive-by shooting. In reality, a few men, under the influence of alcohol and youthful impulsiveness, became involved in a heated altercation over . . . a kitchen chair. Ernest Garcia, Jr., decided to resolve the argument with a gun.

Unfortunately, Mendoza joined the party at the same time. When Garcia returned with the gun, he didn't see his brother, presumed the Mendozas had hurt him, and started shooting. Manuel's cousins Juan and Carlos Mendoza were killed. Manuel was critically injured and lay in the hospital in a coma for a month.

Mendoza's journey to his current home in Lorenzo, Texas, has had some difficult stops. To keep from being a burden to his parents, Mendoza entered a nursing home when he was 18-years-old. "Dad went to work at the cotton gin and couldn't be with me," he explained. His diminutive mother would not have been able to care for her son by herself. During his 14-months stay in the facility, he was abused by a staff person. "I reported him," Mendoza said. "I didn't want him to get away with it and try to use other guys." Mendoza eventually spent his early adult years in a total of three nursing homes.

Photo by Karen Roop

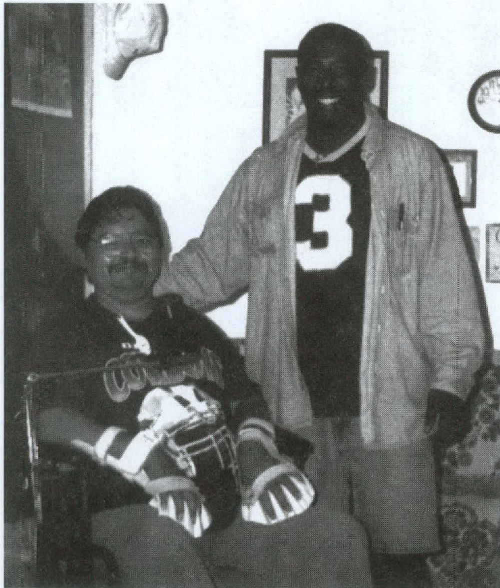
Reuben Mendoza (right) positions a ceramic figurine for brother Manuel to paint.

The Home and Community Services/ OBRA (HCS-O) program at Lubbock Regional MHMR Center helped Mendoza to move from the third home into the house he shares with his parents and brother. Now, through the coordinated efforts of his family, Lubbock Regional MHMR Center and others, Mendoza is developing the self-sufficient life he had begun to enjoy in his teens. Some of these efforts are providing him with the means to perform everyday functions most people take for granted. A remodeled bathroom allows him to shower with relative comfort; a sidewalk will be laid from his front door to the street so Mendoza can move about more on his own.

Equally important are those services that have given Mendoza a reason to be independent. At Lifetime Independence for Everyone (LIFE), he learned to paint and

carve ceramics with his mouth. His collection began with a tractor but soon grew to include animals, vases and urns. The significance of his work has been far-reaching.

On June 27, 1996, Mendoza's ceramics were included in an exhibit of work by TXMHMR consumers.* Mendoza came to the Austin event in a van with an entourage of his parents and brother, case manager Karen Fuentes and supported living staff Craig Flathouse. Fuentes described the trip as a turning point in her work with Mendoza.



Mendoza and supported-living staff member Mike Ross prepare for their weekly drive to Lubbock, where they are later greeted by Susan Wallace, owner of The Sugarshack ceramics shop.

"The trip gave me a lot of empathy for the family," Fuentes said. At the same time, she has gained much from Mendoza himself.

"At first, I was terrified about working with Manuel because he has so many medical needs. But I've learned a lot. Once I asked Manuel, 'Doesn't it [the shooting] make you angry?' Manuel simply answered, 'I prayed and forgave him in my heart.'"

A fellow traveler on Mendoza's journey is Reuben Mendoza, the Mendozas' youngest child. Only five months old when Manuel was shot, Reuben has become a primary support to Manuel. This is a role that Reuben readily accepts. "As long as I have my weekends, I don't mind," he said. "If I'm in Lorenzo when my parents have passed away, I'll still care for Manuel."

Reuben Mendoza recognizes that his brother's presence in his life is a gift. When he was also 16-years-old, he learned about the shooting and knew that others needed to hear Manuel's story.

"I have to be honest. I've shot guns in the air. But friends of mine in high school sometimes would have a gun to scare the other kids, to get respect. People would know their name. I told them about Manuel, and they came back and talked to him. This happened about five or six times during my senior year. No one ever got angry when I told the story."

The story of an ordinary man with quadriplegia who graduates from high school, creates art and plans to work with computers, live on his own and raise a family should be told. Manuel Mendoza continues to share his experience through such channels as church testimonies. However, it is not a "once upon a time" story of American individualism nor, according to Mendoza, a uniquely Hispanic story. Instead, it is a tale that Mendoza feels should begin

I want to thank the Lord for what he has given me—my ability to paint;

I want to thank the ones that help me do all this;

I want to thank Miss Karen Fuentes and all the people that gave me the opportunity;

I want to thank my family.

—KR

* Mendoza's ceramics and poetry were featured in the summer 1996 issue of *Impact*, have been shown in a Lubbock gallery, and will be included in an exhibit at the 1996 Helen Farabee Conference.

Photos by Craig Flathouse

Native Americans at the Great Divide

Among the populations identified for human services, one has remained strangely in the shadows: Native Americans. Culturally sensitive services, including those for mental illness and mental retardation, are often limited or non-existent for America's first born.

According to Bill Moss, a Choctaw and TXMHMR's interstate compact coordinator, "Native Americans underutilize services more than any other group. Although this is partly due to their traditions, a cultural canyon also exists between Native Americans and mental health providers."

Texas demographics seem to circumscribe a canyon within the TXMHMR system. The 1994 United States census indicated that .43% of Texans are Native Americans and include tribes on reservations in El Paso, Livingston and Eagle Pass. TXMHMR records for fiscal year 1995 identified only .002% of TXMHMR service recipients as Native Americans.

The Mexican Kickapoo in Eagle Pass present a special challenge and opportunity to a service delivery system striving for cultural competency. As their name suggests, the Eagle Pass tribe have strong ties with Mexico; until 1983, they lived under the international toll bridge. Primarily hunters, they turned to migrant work when state and federal regulations began to limit their supply of game. Dallas anthropologist Mary Christopher Nunley argues that their migratory habits have made the Mexican Kickapoo resistant to acculturation and one of the most traditional of all Native American tribes.

To date, social services have been erratic and may have eroded some of the strengths of Kickapoo society. Nunley maintains that the tribe has become stratified as it has divided into nuclear families to access benefits. Mental health and related services are generally limited to treatment for substance abuse. Twenty percent of the Mexican Kickapoo are said to be addicted to inhalants. Alcoholism reportedly is also a problem.

Until 1993, the Kickapoo received treatment for chemical dependency through a San Antonio State Hospital (SASH) outreach clinic. The Texas Commission on Alcohol and Drug Abuse (TCADA) then began providing this service at a clinic 30 miles from the reservation. According to Rodolfo Briseño, TCADA cultural/special populations coordinator, national budget cuts recently eliminated federal funding for the TCADA clinic, but TCADA funding will be used to develop treatment on the reservation. Treatment will combine Western medicine with traditional Kickapoo practices.

John Stockley, former director of the SASH clinic, cautioned that integrating Kickapoo and Western approaches must be done with a clear view of the Kickapoo world. According to Stockley, past nods to cultural sensitivity have amounted to such empty gestures as the BIA's sending a Cherokee to serve the Kickapoo. Porfirio Esparza, chief of logistics/support of Camino Real Community Services, said, "We don't neglect the Kickapoo; we don't *understand* them."

Understanding of this complex tribe will not come easily. With one foot in Mexico and one in the United States, they are a trilingual population. They require services that can accommodate a migratory lifestyle. Although most of the tribe members are determined to maintain their language and traditional lifestyles, "progressives" are more apt to compromise. Thus, the tribe's internal political factions must also be taken into account.

A possible model for services to Native Americans is the Boston Indian Clinic of Massachusetts General Hospital. In keeping with the mobile lifestyle of Boston's Native Americans, the clinic provides services on a walk-in basis and keeps cases—active and inactive—open. As a result of these and other innovations, the clinic's caseload had grown from 34 people in 1973 to 276 people in 1985.

However, numbers tell only part of the story. "Whether an MHA has three or three hundred Native Americans," Moss said, "we must still find out their needs."

—*KR*

Sources:

Nunley, Mary Christopher. *The Mexican Kickapoo Indians: Avoidance of Acculturation through a Migratory Adaptation.* Unpublished dissertation, Southern Methodist University, 1986.

Yukl, Trudy. "Cultural Responsiveness and Social Work Practice: An Indian Clinic's Success," *National Association of Social Work Journal*, July 23, 1985.

Cultural Competency

Cultural diversity. Cultural sensitivity. Cultural competency. At first glance, the many variations on "culture" might seem only a subset of politically correct buzzwords. But when used appropriately, the words become important indicators of a movement to honor human differences. Together they describe a continuum ranging from awareness to ability that has been set in motion in human services.

"Cultural competency" refers to an essential step in the journey along this continuum. Initially, a system must focus on cultural sensitivity, that is, it must acknowledge differences in lifestyles, backgrounds, values and ways of communicating. But in any shift from theory to practice, competency—skill and ability—becomes a central concern. As a social system matures, its practices should be distinguished by effective interactions with persons from diverse cultures. This can only occur through cultural competency.

Almost one half of TXMHMR's service recipients belong to an ethnic minority group.

In 1989 a group of mental health professionals published the monograph "Towards a Culturally Competent System of Care." Funded by a grant from the National Institute on Mental Health and sponsored by the Child and Adolescent Services System Program (CASSP), the monograph describes cultural competency as "the ability of systems, programs and professionals . . . to provide effective services to multicultural populations" and urges mental health systems to assess their cultural competency. According to the monograph, systems can be categorized within a continuum of six stages of cultural competency: destructiveness, blindness, passivity, pre-competency, competency and finally proficiency. Systems are encouraged to move towards cultural competency or proficiency by determining where they fit into the continuum and adopting necessary policies and developing/expanding resources. The monograph has become a national model for programs attempting to become culturally competent.

TXMHMR's efforts to advance through the continuum began seven years ago when the department created the position of multicultural services coordinator. Since then several changes have been made. For example, the community standards for mental health services now include requirements concerning cultural competency. Cultural diversity councils exist in a number of state and community programs, and trained interpreter teams are active at some state hospitals. TXMHMR has identified the deaf and hard of hearing as a distinct culture within the system. And more administrators have begun to support diversity initiatives.

Recently, the department established a process to evaluate the cultural competency of its state facilities. An instrument produced by a project team and based on the survey instruments of Quality System Oversight (QSO) will provide measurable data and scores for eight categories. After the assessment has been completed, the superintendent or director will receive a profile of the facility's strengths and shortcomings. The process was piloted this summer at Kerrville State Hospital. During fiscal year 1997, all state hospitals and three state centers will be evaluated.

The importance of this process is apparent. Indeed, the project team who developed the process' unique instrument received the TXMHMR Multicultural Services Showcase Award at the department's multicultural conference. Even more telling is the make-up of TXMHMR's consumer population. Data entered into the department's Client Assignment and Registration System (CARE) indicate that almost one half of TXMHMR's service recipients belong to an ethnic minority group. To provide effective and quality services to such a diverse group of individuals, TXMHMR must be able to address significant language and cultural differences.

Contributed by David Luna, Multicultural Services Director at TXMHMR's Central Office.

Cultural Competency

DSM-IV and Related Works

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition. Washington, DC, American Psychiatric Association, 1994. See the following:

- Introduction, "Ethnic and Cultural Considerations"; and

- Appendix I, "Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes."

The book *Culture and Psychiatric Diagnosis: A DSM-IV Perspective,* edited by Dr. Juan Mezzich and others, contains background papers on the *DSM-IV* cultural effort.

A *DSM-V* sourcebook volume, a booklet titled "Guidelines for *DSM-IV* Cultural Formulation," and a cultural casebook are in various stages of preparation and completion.

The report "Limited Efficiency as a Barrier to Health and Social Services" was prepared by Macro International with the Office of Civil Rights, the Department of Health and Human Services.

The Office of Civil Rights also is developing policy guidelines for federally-funded providers to address the needs of individuals who are not fluent in English.

Contributed by Juan Ramos, Ph.D.

Augmented Communication

Publications

The Alliance for Technology Access. *Computer Resources for People with Disabilities: A Guide to Exploring Today's Assistive Technology.* Alliance for Technology Access, 1994.

Legal Rights: The Guide for Deaf and Hard of Hearing People, National Center for Law and Deafness, Gallaudet University Press: Washington, DC, 1992.

"Mental Health and Deafness: Making the Texas System Work," *Report of the Task Force on Mental Health Services for People Who Are Deaf or Hard of Hearing,* January 1995.

TATP Resource Guide to Assistive Technology, 3rd edition. Ed. John Moore. Texas Assistive Technology Partnership: University of Texas at Austin, 1996.

Texas Organizations

Texas Assistive Technology Partnership
The University of Texas at Austin
Department of Special Education
EDB 306/35300
Austin, TX 78712-1209
(512) 471-7621
TDD: (800) TATP-TEX

Texas Rehabilitation Commission
4900 N. Lamar
Austin, TX 78751
(512) 483-4133

Texas Society for Augmentative
and Alternative Communication
P.O. Box 130156
Houston, TX 77219
(512) 478-9131

Underwood Advanced Technology Center
Texas Tech University Health Sciences Center
C-115 Thompson Hall
Lubbock, TX 79430
(806) 743-3038

United Cerebral Palsy of Texas, Inc.
900 Congress Ave. Suite 220
Austin, TX 78701
(512) 472-8696

National Organizations

International Society for Augmentative and Alternative Communication (ISAAC)
ISAAC, c/o NY State Association for the Help of Retarded Children
2900 Veterans' Memorial Highway
Bohemia, NY 11716

Trace Development and Research Center
University of Wisconsin, Madison
1500 Highland Avenue
Room S-151 Waisman Center
Madison, WI 53705
(608) 263-5788

Relay Texas

Through Relay Texas, people who are deaf are assisted by a communications relay agent to place or receive telephone calls statewide. Callers can request a male or female agent and one who speaks Spanish.

- If you are hearing, to call someone who is deaf dial **1-800-735-2988** (voice).
- If you are deaf, to call a hearing or deaf person dial **1-800-735-2989** (TTY).

Source:
TATP Resource Guide

Can I tell you what impact the diagnosis of schizophrenia had on a young African-American woman attending the University of Southern California (USC) on a full scholarship?

Devastation and disillusionment.

Graduating in 1969 from Compton High School and receiving an academic scholarship to USC in Los Angeles started an exciting new life for me. My only son, born during my senior year in high school, was a catalyst for me to continue my education.

I had grown up in Compton, a predominately minority neighborhood of LA. At USC I was the only black woman in some of my School of Business classes. For the first time in my life, I felt like a minority. Fortunately, bonding with other African-Americans through black cultural and political movements helped me survive.

Although drugs were not rampant in Compton, alcohol and marijuana were around at USC. Taking a pill to keep me awake to study seemed harmless—until I practically forgot the material as I took the final. I knew drugs were not for me and excelled at USC for 3 1/2 years. Then unbearable headaches made trips to the student health center a weekly occurrence.

Photo by Mary Urech Stallings

During my senior year, I started exhibiting bizarre behavior. I would try to withdraw money from banks in which I didn't have an account. I went to my church, got behind the pulpit and started preaching. I would go to stores and try to make purchases with no money.

I was hospitalized at least eight times, diagnosed with paranoid schizophrenia and given tranquilizers and Thorazine. But even after I came home, I was still depressed.

Studies have shown that non-black practitioners often misunderstand black psychiatric patients' language, behavior, style of relating and life experiences and misdiagnose the patients. I was finally identified as manic depressive and given lithium. But compliance remained a problem.

It was the early 1970s. Black became beautiful. Everybody had Afros. We protested the war while we sought our own culture.

But the antithesis of these movements was the "freedom" to get high.

Hangin' out in Los Angeles was the onset my tangled lifestyle. While working at a TV station, I dated an engineer who would budget money for cocaine as if it was part of his grocery list.

My addiction came gradually—first with the trauma of having to leave college, then my diagnosis of schizophrenia, the Thorazine, the restraints and finally the state hospital. Later, the murder of my mother helped pave my road of self-medicating with cocaine, crack and alcohol. I'm still coming to grips with her death.

The drug use led to a year in the Harris County Jail—a long way from the halls of USC.

That time is behind me. To help others with a dual-diagnosis, I've created videos of African-Americans suffering from psychiatric illness and/or drug addiction.

Before you can embrace recovery, you have to take a look at yourself, where you are and why you got there. Using resources and support groups and holding onto your willingness to progress are the wings to a new beginning. But above all you must believe in a power greater than yourself.

I am proof that recovery can happen. I have been sober for the last three years, working as a videographer and independent producer for Access Houston Community Television.

We can and shall overcome.

Contributed by Gretchen Hollingsworth, service recipient of the MHMRA of Harris County and nominee for the TXMHMR Rising Phoenix Award.

Photo by Sherry L. Grona

On September 1, 1996, Beth Holt became the first consumer advocate with mental retardation to be hired in the TXMHMR system. Mark Johnston, TXMHMR executive assistant to the assistant commissioner, was one of several staff who participated in her futures planning, a process through which consumers determine their goals and the supports necessary to attain them. Since Holt's hiring, fellow consumer Kevin Tracy has become coordinator of consumer affairs in TXMHMR's Central Office. Holt's story shows that, in a supportive system, unique cultures can take root and flourish.

In 1982 when I was put in a sheltered workshop, the system was quite different than it is today. You were put into the program. Since then I've seen In-home and Family Support come into being to keep people like myself out of state schools and in the community.

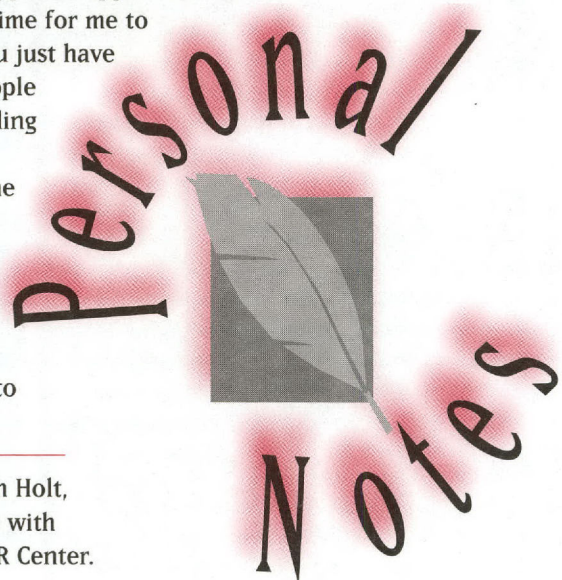
The difference between sheltered employment and working for Sabine Valley MHMR Center is that in a sheltered workshop you know what you're going to do. Working in the community, you might go into work to do one thing, but when you get to work there's something more important to do. Last Friday I didn't know we were going to set up for the Partners Training till Friday morning. It's quite different from a sheltered workshop. It's not as structured. In sheltered employment, you do *this* for six hours. I was trained very well to show up on time, to be prompt, to dress appropriately. I love my new job, but I would like to get it better structured.

I like my independence most about my job. If it hadn't been for my sheltered workshop boss Anka Harbor letting me be on committees, I couldn't have done this. You have to know the right people in the right place at the right time. One of the pieces to my puzzle, Jaylon Fincannon [former TXMHMR deputy commissioner of mental retardation services], is going to California. Anyway, I liked being in a sheltered workshop but I needed more.

My father died in June 1995. I wanted to prove to myself and my mother that I could be on my own. I wanted my mother to know I could take care of myself. I was the first person to do a futures planning plan in Texas. I had three meetings, one each in April, June and August. I came up with a team of about 12 to 14 people first. When I came up with the people on the team, I named Mark Johnston and others. My caseworker said, "She's even inviting Inman [White, executive director of Sabine Valley MHMR Services]; I'm scared." But I figured I'm going to work for him, I might as well get in on the ground floor. I also had three to four staff I was close to who had known me almost as long as I had been around. Then I volunteered at Sabine Valley in August so I could get my feet wet.

I want to see others like me sitting on committees, local and state. That would take the pressure off me. Like a Mark Johnston, I want to be their support. I appreciate all that I got, and it's time for me to give some back. You just have to put the right people together. I am building a culture of advocates. And when one of those advocates looks over at me, as I sometimes did at Mark, and says "I'm totally confused," I'll be able to help.

Contributed by Beth Holt, consumer advocate with Sabine Valley MHMR Center.



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Answers to the Deaf Awareness Quiz:

1. **False.** A hearing aid amplifies sound. Many people benefit considerably from hearing aids. Some may only be able to hear loud environmental sounds such as a yell or knock at the door. Others do not benefit at all. Some people who are deaf find hearing aids annoying and choose not to use them.

2. **False.** Many people who are deaf use sign language; others do not. While American Sign Language is the most common in our country, there are several kinds of sign language. Deaf children born to hearing parents may not be taught sign language as early as hearing children learn language.

3. **False.** People who are deaf have normal vocal chords. Some people who are deaf choose not to use their voice if they think their speech is difficult to understand. However, many people who are deaf use their voices during interactions. The quality of speech of a person who is deaf may vary greatly depending on the individual's skills and abilities. Since they receive limited feedback from their own hearing, deaf speakers may have inappropriate pitch or volume control.

4. **False.** The inability to hear does not affect native intelligence or the ability to produce sounds. Deafness does not make people dumb in the sense of being either mute or stupid. Understandably, people who are deaf find this stereotype particularly offensive.

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