WINTER 1997-98

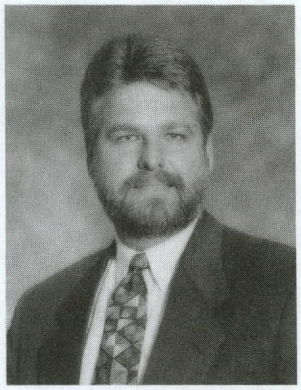
IMPACT

of Providing a Safe Place for Consumers

Photo by Candy Carr Howell

Having found a safe place through Daybreak Residential Center and Daybreak Interagency Youth Services at Life Resource in Beaumont, a group of teenagers helps restore the home of an elderly neighbor into a safe place. *See story, page 17.*

VIEWPOINT



Commissioner Don Gilbert

Most of us in Texas have the good fortune to be able to take for granted what others may consider a luxury: a place we call home, which offers shelter, comfort and a space in the world we claim as our own. Although what constitutes a safe place or home is unique to each person, that place typically doubles as an environment offering solitary refuge as well as opportunities to be with friends and family.

At the Texas Department of Mental Health and Mental Retardation, we believe a safe place to live is not a luxury. People must have a place in which they can quietly retreat or interact with others as they wish.

TXMHMR is committed to ensuring that healthy, affordable housing is available for people with mental illness or mental retardation and they have the supports they need to remain in their chosen home. We have made tremendous progress in this area. In fact, Texas is becoming a leader in the area of housing and supports for persons with mental illness. In September 1997, TXMHMR led a team of representatives from Texas agencies and organizations which attended a national housing conference on developing state-level partnerships among housing and mental health agencies. (See WorldView, page 4.)

Yet, much more needs to be done to ensure individuals throughout the state have real choices in where and how they function to their full potential. Rather than availability—or absence—of housing and support options dictating what will be home for a person, we want his or her preferences and abilities pointing the way. Appropriate supports can empower consumers to select and access the resources they need.

While this issue of *Impact* focuses on living well in the community, it should be noted that there are individuals with severe medical or behavioral conditions for whom our state facilities are the safest publicly owned place to live for whatever length of time necessary to achieve their potential.

Our state facilities have progressed from the dreary warehouse atmosphere of the 1970s to a more homelike, nurturing environment today. As a result of efforts to transform our facilities, TXMHMR has been dismissed from two longstanding lawsuits: the Lelsz lawsuit involving conditions in our state schools (November 1996) and the RAJ lawsuit pertaining to conditions in state hospitals (October 1997). Most important, we have the processes in place to ensure that our hospitals, schools and centers increasingly will become places where people not only are safe but where they can flourish.

In This Issue

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Expansion of housing resources is a top priority

According to a 1993 study on the affordability of housing among individuals with severe mental illness, there is not a county in the United States in which an individual dependent on Supplemental Security Income (SSI) can afford an efficiency or one bedroom apartment (McCabe, et al 1993). The study goes on to say that "individuals with incomes below 30 percent of the median income have essentially no access to integrated housing options in their communities."

To make matters worse, affordable housing stock in the United States is diminishing. Over the past few years, the Department of Housing and Urban Development has experienced cutbacks in funding, especially in Public Housing and Section 8 rental assistance, two programs available to persons with very low incomes (Turner, 1996).

In response to this crisis, the National Association of State Mental Health Program Directors (NASMHPD) issued in 1996 the following position statement that guides TXMHMR and other state mental health authorities in developing policies regarding housing and supportive services:

Housing Options— It should be possible for all people with psychiatric disabilities to have the option to live in decent, stable, affordable and safe housing that reflects consumer choice and available resources. These are settings that maximize opportunities for participation in the life of the community and promote self-care, wellness and citizenship. Housing options should not require time limits for moving to another housing option. People should not be required to change living situations or lose their place of residence if they are hospitalized. People should choose their housing arrangements from among those living environments available to the general public. State mental health authorities have the obligation to exercise leadership in the housing area, addressing housing and support needs and expanding affordable housing stock. This is a responsibility shared with consumers and one that requires coordination and negotiation of mutual roles of mental health authorities, public assistance and housing authorities, and the private sector.

Provision of Services— Necessary supports, including case management, on-site crisis intervention and rehabilitation services, should be available at appropriate levels and for as long as needed by persons with psychiatric disabilities regardless of their choices of living arrangements. Services should be flexible, individualized and promote respect and dignity. Advocacy, community education and resource development should be continuous.

TXMHMR will continue its commitment to the housing and support needs of persons with psychiatric disabilities through the establishment of an interagency housing task force, which will focus on expanding housing resources. The agency's commitment also is being reinforced through its continued requirement of supported housing as a best practice in all performance contracts with community MHMR centers and state operated community services.

Contributed by Melody Olsen, Housing/ACT coordinator in TXMHMR's Service System Development and Implementation Division. Olsen served as leader of the Texas Housing Team—comprised of representatives from Texas agencies and organizations—at the 1997 NASMHPD National Executive Training Institute: Developing State-Level Partnerships Between Housing and Mental Health Agencies.

Northeast Texas MHMR Center hosts Destination Dignity Celebration

'Life Goes On' star provides inspiration

In September, community MHMR centers throughout the state celebrated Destination Dignity Month, an initiative of the Texas Council of Community Mental Health and Mental Retardation Centers. At Northeast Texas MHMR Center, staff celebrated by welcoming a very special guest—actor and musician Chris Burke, better known as Corky Thatcher from the ABC hit series "Life Goes On."

The only American actor with Down syndrome to be commercially successful, Burke now can be seen on The Family Channel's reruns of "Life Goes On." His numerous acting credits also include appearances on "Touched By An Angel," "The Commish," and the mini-series "Heaven and Hell." His singing talents have been displayed on three CDs, which he recorded with his longtime friends Joe and John DeMasi.

Burke and the DeMasis—professional musicians and twin brothers—starred in the Sept. 4 show "An Evening with Chris Burke" at Texarkana's Special Events on the Boulevard. The dinner show helped raise funds to assist MHMR programs in the Texarkana area.

In a speech to the audience, Burke emphasized the importance of following your dreams. "Don't believe in obstacles. Overcome the obstacles, meet your goals and make your dreams come true," he said.

Burke and the DeMasis then performed fun and inspirational songs; the concert even included an Elvis impersonation by Burke. The trio—all natives of Long Island, New York—travel across the country giving concerts and making speeches; they perform at approximately 150 shows per year.

When Burke was born in 1965, the doctor told his parents that he would never be able to talk, walk or learn; he advised them to put Burke in an institution.

"Luckily, my parents didn't take his advice," Burke told the audience, adding that his parents treated him just like they treated his three older siblings. His parents and his siblings all helped teach him.

"It may take me longer, but I can learn," he added.

Burke eventually became interested in acting. The producers of "Life Goes On" took an unprecedented step—and a risk—in casting him in a network series in the demanding role of a youth with Down syndrome. In doing so, they opened a door that previously had been hammered shut to actors with disabilities.

With the belief that no challenge is insurmountable, Burke has learned to focus on his abilities rather than his disabilities. He makes room in his busy schedule to work part time for the National Down Syndrome Society as editor-in-chief of the quarterly newsletter *News & Views*. He filmed a public service announcement with President Bush and marched with Special Olympics in President Clinton's inaugural parade. A New York City public school is named in his honor, and he has received a number of awards, including a Christopher and a Youth in Film.

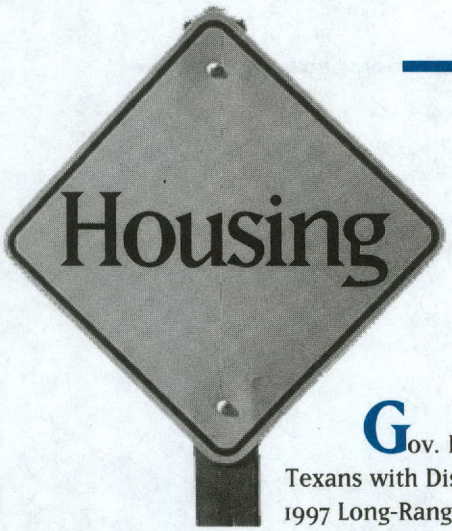
During his stay in Texas, Burke visited all of the centers and homes operated by the Northeast Texas MHMR Center.

Destination Dignity Month promotes dignity and quality of life for persons with mental disabilities and increases awareness of the services provided by local community MHMR centers.

Maureen Sander, community relations coordinator for Northeast Texas MHMR Center, contributed the information for this article.

Photo by Maureen Sander

Northeast Texas MHMR Center Executive Director Joe Bob Hall (seated) meets with John DeMasi, Chris Burke and Joe DeMasi during the trio's visit to the center in September, Destination Dignity Month.



Supported housing helps consumers succeed in living situation of their choice

Gov. Bush's Vision for Texans with Disabilities for the 1997 Long-Range State Plan stated, "The option to live independently and fully participate in Texas communities will be available to all people with disabilities through increased consumer-directed public and private independent living services."

TXMHMR's supported housing program helps make this vision a reality for Texans with severe mental illness. Started in 1990, the program was designated a best practice in 1996 fiscal year performance contracts. Sadly, budget constraints have limited housing services to a small portion of TXMHMR's priority population, those most in need.

"In fiscal year 1997, more than 4,000 individuals received this service," said Melody Olsen, TXMHMR Housing/ACT coordinator. "That's just the tip of the iceberg."

For the thousands of individuals in the priority population who have not been reached, services often are unsuitable or nonexistant. They may languish, unnecessarily, in psychiatric hospitals because they have nowhere else to go. Other individuals frequent hospital emergency rooms for costly and often inappropriate care and exist in substandard housing with no support services. "Our goal is to reach these people and help them live much more satisfying and productive lives," said Olsen.

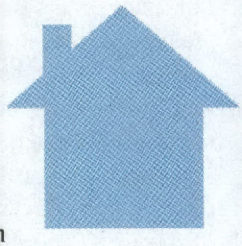
Empowerment through services

TXMHMR's Housing and Residential Services Policy supports the belief that most consumers—with the proper aids and services—can live safely on their own or with their families and that appropriate housing services, in the long run, are cost-effective. It aims to empower individuals to succeed in the living situation of their choice. Efforts to maximize consumer choice exist at many levels. Consumers and family members serve on TXMHMR boards, committees, commissions and task and work groups.

"At the service delivery level, too, choice drives the selection of housing and needed services," said Olsen."Choice gives people a stake in their lives, which promotes growth and positive change."

The supported housing program helps consumers access existing housing and assistance; clarifies relevant laws and federal programs; maintains a resource database; where possible, provides funding or services as match for individuals in accessing federal/local resources; and, when needed, distributes rental subsidies and other assistance. Long-term supports include in-home rehabilitation and service coordination, crisis support, assistance with daily activities, and help in establishing social support networks.

"Our housing services must be flexible to address consumer needs as they evolve over time," said Dave Wanser, Ph.D., director of TXMHMR's Service System Development & Implementation (SSD&I).



Program innovations

When the Texas Panhandle MHA began supported housing as a pilot site in 1991, the center "really went out on a limb," said Sara Northrup, program administrator.

The center serves urban and rural populations in the upper 21-county catchment area of the Texas Panhandle. "It was a real challenge to serve people out in rural counties where everybody knows everybody," said Northrup, adding that staff provided community education to overcome the stigma associated with mental illness.

Hospital use was reduced dramatically in 1991, and today, "the majority of our clients who were hospitalized now are living in the community," said Northrup.

Faced with limited funds, some supported housing programs craft unique tools to increase efficiency. Nueces County MHMR Community Center designed a RAFT (Rehabilitative Assessment of Functional Training) scale to gauge consumers' progress (or lack of it) and help guide them to their highest level of independence.

Russell Weir, M.S., social service supervisor II, describes the scale as a work in progress and said he hopes it will "eliminate duplication of services to prevent clients from sliding down the rehabilitative ladder."

The center's program, which started in 1992 and has served some 140 consumers, also developed a field guide to aid new hires. "We continually reevaluate our service delivery and devise new ways of improving the services provided here," added Weir. *—NB*

Standards of care and individual choice

TXMHMR's Quality Management staff sometimes is asked, "What happens if the consumer's preference or choice comes into conflict with standards of care?" The question tends to be posed in the context of "win-lose" thinking. It often arises in connection with housing. Most of us would choose shelter under the worst of conditions if ditches and bridges are our only alternatives, but the choice between a rundown boarding house and the street is more a dilemma than a choice. Having a third option of quality, affordable housing is perhaps the beginning of choice. To make choice a reality for consumers, we first must acknowledge that it is time-, resource- and labor-intensive—and it is effective.

Only within the context of an established trust can consumers reveal their strengths, liabilities, needs and desires. Most people remain superficial until they see evidence the helper is worth the investment of time and trust. Only after learning to know an individual can we begin to think we know what he or she wants, let alone suggest that he or she might need something else.

Two important questions for the self-assessment of any service system are, "How do you go about learning what the consumer wants?" and "What is your system-wide approach for nurturing therapeutic relationships?" These questions are not always considered. Clinical practice standards and standards of care are supposed to establish work *processes* that lead to relationships, which in turn lead to desired outcomes people choose for themselves.

Consumer preferences seldom really come into conflict with standards or rules. In fact, TXMHMR rules, including Mental Health Community Service Standards and the Quality Assurance and Improvement System (QAIS), formalize our duty to discern and honor consumer preferences.

More often, choice has the potential to bump up against *practice guidelines.* As managed care tools for utilization management (clinical "pathways," protocols and guidelines) proliferate in the quest for balancing quality with costs, chances increase for personal preference and individualized treatment to clash with superficial notions of efficiency. Individualized services are the most efficient over time because they produce better outcomes. For example, Assertive Community Treatment (page 18) not only drastically reduces hospital bed day utilization, but also provides far better continuity in the helping relationship, in a normal environment with consumers in housing of their choice.

When adopting practice guidelines, it is essential to consider the desired long-term outcomes, not just the quarterly bottom line. It also is essential to build and maintain a culture of advocacy and rights protection in the service system.

Contributed by Brad Pierson, LMSW-ACP, TXMHMR supervisor of Quality Management—Mental Health.

Consumer finds housing, employment through Laredo program

Guillermo Salazar once called a 10' x 13' tool shed home, but thanks to Laredo State Center, he now has an apartment and a job.

When Salazar was referred to the center's supported housing program in 1996, he was experiencing periods of mental instability. The program helped him choose an apartment and assisted with rent and utility hook-ups and in purchasing household items. The center's Gateway Industries Program helped him find a job in the community.

"During the time Mr. Salazar has participated in the program, there has been noticeable change in his independence and determination," said David Rodriguez, supported housing team member. "He is happier and more assertive with himself and others. He is closer to his family now that he has a suitable place to live."

Contributed by Sylvia Everett, director of community relations for Laredo State Center.

Photo by David Rodriguez

At his job at the Texas Tourist Bureau, Guillermo Salazar visits with Angie Hinojosa, Laredo State Center staffer.

PATH helps close gap between needs and services

The gap between needs and resources for individuals who are homeless is wide. Service providers for the homeless population in many communities claim that the number of those in need consistently and substantially outnumbers available emergency shelter beds.

> The federal PATH program provides a number of services for homeless individuals with mental illness. These services include outreach, connecting individuals with existing services and providing mental health services. The cost of the program is a fraction of what it costs to institutionalize individuals who are homeless and have a mental illness.

In Texas, an estimated 43,844 citizens experience homelessness throughout the course of a year. In Houston, a one-night shelter count revealed there were 9,216 people in shelters. Many other individuals were sleeping in places not designed for shelter, such as parks, abandoned buildings and bridges. In Austin, the cost of renting housing has soared 53 percent in five years, leaving many very low income households desperate for affordable housing. Crisis, ongoing poverty and chronic disability often are cited as the main causes of homelessness.

Housing and support services for homeless persons with mental illness in Texas are made available through the specialized and federally funded PATH (Projects for Assistance in Transition from Homelessness) and ACCESS (Access to Community Care and Effective Services and Supports) programs. In 1997, the PATH program served nearly 6,000 literally and marginally homeless persons, both children and adults—those individuals who are without shelter, except for emergency shelter provided by organizations such as the Salvation Army.

PATH in Texas serves as a vital bridge connecting the homeless person with severe mental disabilities to the community mental health system of care. In Texas, outreach, assessment, clinic, case management and referral services are available in the seven counties where PATH services are provided; individuals can access assistance in Amarillo, Austin, Dallas, Fort Worth, Galveston, Houston and San Antonio.

Many PATH sites are "co-located" with other service providers, such as county health department clinics, faith-based organizations, veterans services and housing authorities. PATH outreach workers serve as partners with these organizations and as the link in accessing the often fragmented system of care for individuals with mental disabilities.

Some PATH sites offer rehabilitative services close to where the consumer is located. Good Chemistry groups, which help individuals who have a dual disorder of mental illness and substance abuse, are offered at every PATH site. The Dallas site offers rehabilitative services through its Day Resource Center; therapist technicians help to develop independent living skills and pre-vocational skills with training and direct experience through daily structured activities. In San Antonio, staff provide general health education in daily hygiene, sexually transmitted diseases and the use of first aid. Also available are shower and barber services, nutritional counseling, and pre/post-test HIV counseling.

Contributed by Greg Gibson, state director for PATH and ACCESS in TXMHMR's Service System Development and Implementation Division.

Gulf Coast Center receives rental assistance grant

Galveston's Gulf Coast Center views a stable home as a critical prerequisite in the mental health treatment and recovery process. Over the past year, the center has made consumer housing a priority.

The center pursued several avenues of funding to increase housing choices for consumers. Diligence finally paid off in June 1997, when the center received a tenant-based rental assistance grant through the Texas Department of Housing and Community Affairs (TDHCA) Home Program for special needs populations. The $367,100 grant will help up to 50 consumers live independently in safe, affordable apartments.

Statewide, seven projects received funding, five under the special needs populations category. Also receiving special needs rental assistance grants were Twin City Mission in the Brazos Valley, Life Resource in Jefferson County, Austin Travis County MHMR Center and Waco Housing Authority.

Instrumental to the success of the Gulf Coast Center's TDHCA application was technical assistance provided by the Consumer Controlled Housing Initiative (CCHI). Established in 1994, CCHI provides resources, training and coalition-building to enable Texans with disabilities to secure appropriate housing. CCHI is affiliated with the Austin-based Enterprise Foundation.

To be eligible for the rental assistance, an individual must be a consumer of the Gulf Coast Center's services, live in Galveston or Brazoria County, have an income below 60 percent of the area median income and agree to participate in a self-sufficiency program. Consumers will receive rental subsidies for up to 24 months.

Melissa Tucker, the center's housing program director, and her staff of four have their work cut out for them. Not only must the center determine each consumer's eligibility, but also staff must inspect each housing unit to ensure it meets HUD Section 8 standards. Nevertheless, Tucker is thrilled to have the resources and hopes to see consumers moving into their new residences any day now.

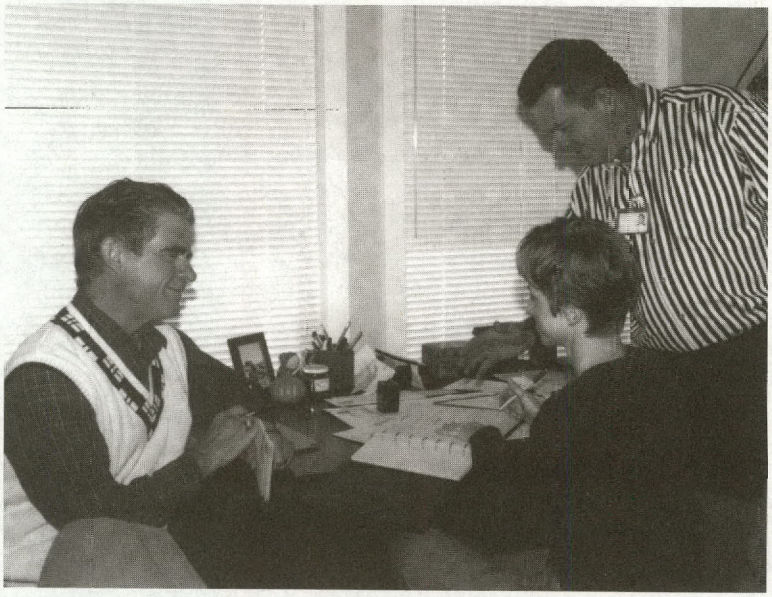


Photo by Trudy Trochesset

Melissa Tucker, Gulf Coast Center Housing Program manager, discusses a rent payment for a consumer with Galveston County housing specialists Calvin James (left) and Hudson Caro.

"Consumers receiving the rental assistance will be in our supported housing program," said Tucker. "The grant gives our supported housing staff the luxury of not worrying month to month whether the consumer will have a safe place to live; instead, they can concentrate on providing quality services."

Contributed by Mary Ann Amelang, resource development coordinator for the Gulf Coast Center. Amelang, who worked closely with the Consumer Controlled Housing Initiative (CCHI) in the preparation of the center's grant proposal, said the "CCHI is a resource that all community mental health centers should utilize."

Master Pooled Trust offers security to consumers, families

Under a new program developed by The Arc of Texas, parents of children with disabilities can leave assets to aid in their quality of life without interfering with government benefits such as Supplemental Security Income (SSI) or Medicaid.

The Master Pooled Trust, now open for enrollment, is the result of more than four years of work by The Arc of Texas and volunteer lawyers, banks, families and other experts. The Arc of Texas consulted with TXMHMR and the Texas Department of Human Services to ensure the trust will serve a wide group of consumers and families.

Photo by Nora Bender

Don Rettberg Jr. of Austin will benefit from The Arc of Texas' Master Pooled Trust, which enables families to leave assets to aid in quality of life for loved ones without interfering with disability benefits.

TXMHMR Commissioner Don Gilbert said the agency will inform the families it serves about the program, which will be administered by The Arc of Texas.

The brainchild of Libby Doggett, former executive director of The Arc of Texas, Texas' trust is based on successful models operating in Indiana and Colorado. It follows the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93). Any individual who meets the Social Security Act's definition of a person with a disability (for example, individuals with cerebral palsy, mental retardation or mental illness) can participate.

"This trust will benefit the families of our consumers who have estates to leave their loved ones," said Gilbert. "It will enable a person to leave an estate for a person with a disability without putting the recipient of the estate in the position of spending the estate in 30 days in order to maintain their Medicaid eligibility."

"The development of this trust is an excellent step toward security for many Texans," said Lisa Rivers, Texas Master Pooled Trust manager.

The program enables participants to establish trust sub-accounts funded through the donor's will, life insurance, settlements, gifts or other assets. Individuals with disabilities also can put their own money into the trust from sources such as a personal injury court awarded judgment, with some restrictions.

In the past, setting up such a trust to provide for a loved one was expensive and required a large initial donation. The Master Pooled Trust pools contributions from various donors and administers trust sub-accounts at much lower fees; families may contribute with significantly lower amounts. Administrative charges for the trust prior to funding are $300 at enrollment and $50 for annual renewal.

"Now almost anyone can provide a son or daughter a perpetual source of financial assistance," said Rivers.

Money in the trust can be spent on such "quality of life" items as a telephone, educational materials, health and dental treatment and equipment, vacations, entertainment and services for which there are no funds otherwise available. The individual's family identifies a primary representative who decides how the money should be spent.

"The Master Pooled Trust is something that's really needed," said Don Rettberg Sr., an advocate and former Arc of Austin executive director who helped develop the program. "It has the potential to do something positive for every Texas family with a member who has a disability. It may be the

Autonomy and Privacy Preferred

Until recently, mental health professionals presumed most people with serious mental illnesses required supervised, treatment-oriented, group living arrangements to be successful in their communities. Current research, however, provides strong evidence that people with mental illness neither need nor want to live in such settings.

In consumer preference surveys, people with mental illness cited autonomy and privacy as the two most important qualities of housing, neither of which are easy to achieve in group living situations (Carling, 1993). The success of people with severe disabilities in independent living depends on three central principles: (1) consumers choose their own housing; (2) they live in integrated, regular housing rather than in segregated, mental health programs; and (3) they receive the services and supports they need to maximize their success (Carling, Randolph, Blanch, et al, 1987; Brown, Ridgeway, Anthony, et al, 1991).

Results of a recent federal demonstration program administered by the Center for Mental Health Services (CMHS) indicate that residential stability is an attainable goal for most homeless people with serious mental illnesses when appropriate supportive services are available (CMHS, 1994). In Boston, one of five CMHS McKinney demonstration projects, 75 percent of project participants remained in community housing after 18 months.

best program to serve people with disabilities that Texas has ever had."

Rettberg and his wife, Jo Ann, have a 21-year-old son with Down syndrome. (See related article in the Fall 1997 issue of *Impact.*) "Our own experience with trying to set up a financial plan for our son for after we're gone showed us what other families are going through," added Rettberg, who for the past 18 months has been making presentations on the trust around the state.

"Parents who I've talked to are very worried about their children with disabilities," he continued. "The parents are in their 60s, 70s, 80s, and they say, 'What happens when I'm gone? All I can leave (my child) is $50,000, but as soon as I'm gone that $50,000 will have to be spent down to $2,000 before he again will be SSI-eligible.'

"The Master Pooled Trust will reserve those funds to enhance the beneficiaries' quality of life," said Rettberg.

The Rettbergs' son, Don Jr., said, "In my case, after my parents are gone, their will leaves money for my sister and myself. Part of the money left for me will go in the trust."

Another advantage of the trust is the expert and up-to-date advice, management and reporting assistance provided to families by the staff of The Arc of Texas. Families are freed from having to learn and keep up-to-date on Medicaid regulations and from having to complete reports to Medicaid. The program combines the experience of The Arc of Texas—which has worked on the behalf of individuals with mental retardation and other developmental disabilities for almost a half century—with the expertise of the Founders Trust Company, which pools and invests the trust funds based on guidance and review by The Arc Trust Finance Committee.

"The Master Pooled Trust is a resource that can improve the quality of life of people with disabilities for the rest of their lives," added Rivers. —*NB*

In-Home and Family Support assists consumers in living in community

Consumers not financially eligible for Supplemental Security Income (SSI) nevertheless sometimes require just a little assistance to live in the community. The In-Home and Family Support (IHFS) Program may be able to offer that assistance.

Available to individuals with mental illness, mental retardation or developmental disorders, IHFS is a cost-effective method of providing needed services and supports.

Through IHFS, consumers receive information on available alternatives to promote their self-sufficiency, and they determine what disability-related services and supports they need. Consumers or their families are required to contribute to the cost of the service, based on income. Although there are many allowable services, those most often required are respite, health services, transportation and residence modifications.

After the person identifies an allowable service, a small financial grant is disbursed. The grants are used for services and items (beyond the scope of usual needs) necessitated by the person's mental disability. These grants allow families with incomes above the federal poverty level to access assistance. Through the use of an IHFS grant, an individual can move from segregated, restrictive settings to the community with only the required supports.

Meanwhile, the annual cost of an average hospital stay or a year of care per person in a state school or community residence exceeds $20,000. In fiscal year 1996, the average grant was $2,168 for individuals with mental retardation and $1,444 for people with mental illness.

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Success stories abound

Stories of how IHFS has touched people's lives are plentiful. Tanya Mendez, IHFS coordinator for the MHMR Authority of Brazos Valley, tells of a consumer referred by the local women's shelter, where she was living with her two small children after fleeing from an abusive relationship.

"She had been diagnosed with a depressive disorder and was an alcoholic," said Mendez. "The grant provided funds to cover her rental and utility deposits once she was approved for HUD. Even though IHFS may have been able to help in additional ways, she refused further assistance, stating that she didn't want to become dependent on the system.

"Twelve months later, she has been sober for more than six months and has returned to college to get her nursing degree," continued Mendez. "She works as a home health aide for a number of persons in the area and has retained custody of her children."

The number of people helped through IHFS is impressive. In fiscal year 1996, a total of 8,317 Texans—4,646 with mental retardation and 3,671 with mental illness—received grants. Of the persons served, 3,071 were under the age of 21. Between fiscal years 1995 and 1996, the number of persons receiving grants increased by almost 1,500.

Quality improvement efforts

To make the program even more effective, TXMHMR Commissioner Don Gilbert in 1997 created the In-Home and Family Support Panel. A cross section of individuals familiar with IHFS (including family members, consumers, advocates and legislative staff), the panel assessed the current status of implementation; identified changes in the service delivery system that impact eligibility, service package and resource allocation; and suggested policy changes. The program also was reviewed by the Legislative Budget Board, which identified concerns and made specific recommendations. A number of changes were implemented in September 1997.—*NB*

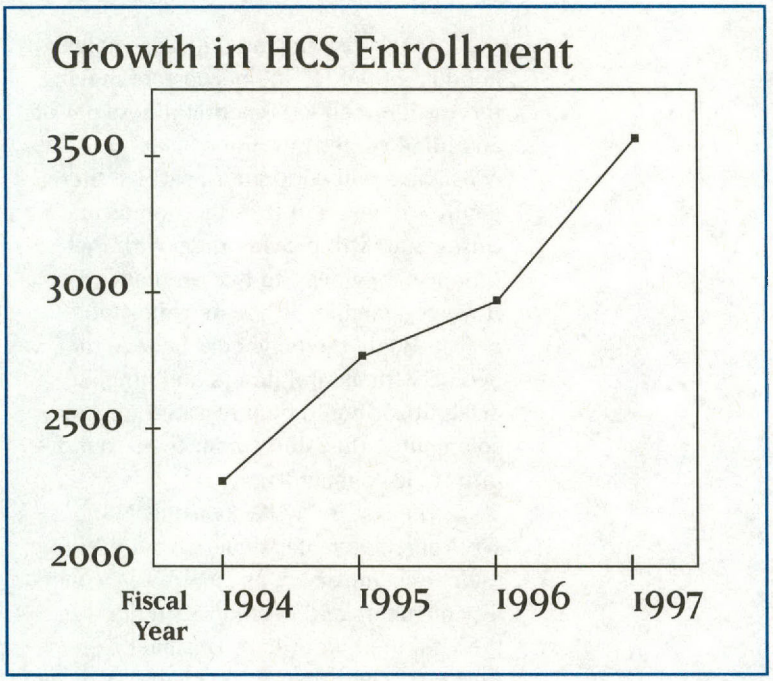
Medicaid services available through Home and Community-Based Services

The Home and Community-Based Services (HCS) Program offers a community-based alternative to institution-based programs. Individuals with mental retardation who live on their own, with their families or two other people with disabilities and who are supported by Supplemental Security Income (SSI) and otherwise eligible for Medicaid can receive services from HCS.

"HCS offers individuals the opportunity to live and work in the community and to experience challenges and opportunities that promote and fulfill their lives," said Larry North, TXMHMR contracts director, Medicaid Administration.

Through HCS, individuals may receive nursing services, day habilitation, residential assistance (including residential support, foster care and supported home living), respite care, supported employment, case management, counseling and therapies (including psychology, physical therapy, occupational therapy, speech/language pathology services, audiology services, social work services and dietary services), adaptive aids and minor home modifications. These support efforts all work together to help individuals with mental retardation achieve their maximum level of independence.

Persons from the community requesting HCS should contact their local mental retardation authority. When there is an opening in HCS, persons are taken off the HCS waiting list maintained by the local mental retardation authority according to their referral date.



An expanding program

Approximately 67 percent of TXMHMR consumers with mental retardation are Medicaid eligible. In January 1997, the agency began enrolling an additional 861 individuals into HCS in 10 service areas. The service areas selected for this expansion were chosen based on the equity of access funding formula. By 1999, it is expected that HCS will serve 4,600 Texans.

To maximize resources in the midst of HCS growth, TXMHMR in 1996 contracted with Deloitte & Touche Consulting Group to assist in restructuring the program's reimbursement methodology. Input from consumers, families and providers also aided the development of the new methodology, which is expected to increase federal earnings.

Rule implements Medicaid "freedom of choice" guarantees

Medicaid-eligible individuals living in state schools who have the ability to provide legally adequate consent or their legally authorized representatives (LARs) may choose from among qualified Medicaid providers under a new rule that was effective Sept. 1, 1997. The rule includes the right to choose continued state school/center residence.

When an individual living in a state school does not have an LAR and is not able to provide legally adequate consent, the interdisciplinary team—with input from actively involved family members or friends—will make decisions regarding living arrangements for the individual, including whether the individual will remain a resident of the facility or move into the community.

NIMBY prevents consumers from having place in community

A house in a middle class neighborhood is rented for the purpose of moving three adult men with mental illness out of an MHMR center into the community. The consumers will continue to receive therapeutic services and take their medication. Onsite staff will provide them with the supports they need to live on their own. However, families in the neighborhood object. While the neighbors believe that, yes, people with mental illness and other disabilities should be integrated into the community, they don't want them to move into **their** community.

The Not in My Backyard (NIMBY) syndrome deters consumers from fulfilling their roles in society as employees, community members and neighbors. In many cases, the vital ingredient in a consumer's education and progress in coping with his or her disability—that of being treated as a normal person in a normal environment—is the most difficult to obtain.

A 1990 national survey conducted by DYG Incorporated for the Robert Wood Johnson Foundation Program on Chronic Mental Illness demonstrated the pervasiveness of the NIMBY syndrome in American society. The survey, the first national study in almost 30 years to measure American attitudes about mental illness—and the first ever on the issue of locating mental health facilities in communities—uncovered an interesting paradox: While 31 percent of the 1,300 individuals surveyed said they or a family member had used mental health services and 74 percent agreed mental illness can be cured, the majority opposed the placement of any type of mental health facility or housing for people with mental illness in their own neighborhoods. (NIMBY was especially strong among white, higher income and older Americans.)

The study found NIMBY to be present even though the majority of respondents believed that "keeping up a normal life" (including living in the community) helped people with mental illness to improve, and seven out of 10 respondents strongly believed that "keeping people behind locked doors" is not the best approach to treatment. Two in three respondents acknowledged there is a great deal of stigma attached to people with mental illness.

A more recent survey, the Harte-Hanks Texas Poll released in March 1997, showed that half of Texas residents believe that homelessness is a serious problem in their community. (Approximately one-fourth of homeless Texans have a mental illness.) The poll, in which 998 individuals in urban and rural areas were surveyed, also showed that 51 percent of Texans believe that homelessness is caused by forces people cannot control.

Surveys aside, the fact is that 2.8 million Texans—nearly one in six—have some form of mental illness. It is more common than cancer, diabetes or heart disease. Yet, according to the National Alliance for the Mentally Ill—which has launched a five-year Campaign to End Discrimination—the treatment success rate for schizophrenia is 60 percent; for bipolar disorder, 80 percent; and for major depression, 65 percent.

Individuals with mental retardation also affected

Another group affected by NIMBY is the 527,000+ Texans who have mental retardation or developmental disabilities. While their conditions are not curable, individuals with mental retardation and developmental disabilities can learn, and, in most cases, live and thrive in the community.

In 1995, MHMR Services of Texoma encountered a great deal of opposition when they moved three women with mental retardation into a house in the Brookhaven Estates subdivision of Denison, a North Texas town of 23,000. Residents of the high-scale neighborhood feared their property values would fall, and at a community meeting one woman stated that the group

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Neighbors dwelling comfortably together

Editor's Note: The following is an excerpt of an article that originally appeared in the Aug. 2, 1995, issue of The Denison Herald (now Herald Democrat). It is reprinted with the permission of Herald Democrat.

By Peter Rejcek, Herald Democrat

A new "family" of three has recently moved into the Denison neighborhood of Brookhaven. They enjoy strolls along the sidewalk and a Texas barbeque in the backyard.

They are three women with mental retardation who have come here from the Denton State School, having spent between them a total of 89 years in state institutions.

The three ladies, two of whom are confined to wheelchairs and a third who is semi-ambulatory, were at the center of a controversy back in April. Many of the neighbors in Brookhaven and the surrounding area had protested the move of the women into the residence by MHMR Services of Texoma.

The residents, who repeatedly said their complaints were not made due to any prejudice against people who have mental retardation, were upset because they were not informed of the move by MHMR from the very beginning. They also complained that property values in the neighborhood would decline.

However, the neighbors eventually acquiesced and the three "sisters" moved in on June 15, following an Open House on June 12.

"The way things turned out, it should have been done several years ago," commented Allen Minnick, whose 48-year-old daughter Margaret seems to be adjusting well to her new environment, sitting quietly between her elderly parents during the interview Friday afternoon.

"She's done real good here," added Margaret's mother, Hazel. "She was in the Denton school for 34 years. I thought it would be a hard adjustment for her but she's alright."

The Minnicks are from Sherman and said they are glad to not have to make the long 45 minute trip to Denton when they want to see their daughter.

Christi McCorkle is 38 years old and has mental retardation but is able to communicate through head and eye movements as well as with a special communication board. She is confined to a wheelchair. Her mother, Lou, was worried the move from the Denton school would overwhelm her daughter.

"I always thought there was safety in numbers," she said. Dozens of individuals who have mental retardation stay in the state school. "Just the opposite is true. I think she's being spoiled. Except for her being spoiled, I think it's going to be great."

The third sister of this unique family was not feeling well and did not participate in the interview.

The three ladies are in an MHMR program which tries to assimilate individuals with mental retardation into society by moving them into a residential environment where they can interact with the community and learn social skills. MHMR operates several similar houses in Denison already

Herald Democrat photo by Joe Cole

Joette Gillispie, a MHMR service assistant, helps one of the residents of 2510 Brookhaven with a cookie. MHMR recently moved three of its clients into the neighborhood after a controversial clash with some of the neighbors in April. Things seem to have smoothed over since then.

The families said they were angry and shocked over the reaction of the Brookhaven neighbors to the MHMR move.

"I was angry," said Lou Minnick. "It seemed so unnecessary and prejudicial."

As far as property values declining, Lou McCorkle said, "It's absurd to think it would. I hate to think the world is so screwed up."

According to one neighbor, who asked not to be identified, he has received three postcards from realtors asking him to sell his house. Three and four bedroom housing in Denison is hard to come by, he explained.

The past seems to be staying in the past, as none of the Brookhaven residents have given their new neighbors any trouble, according to the families and case workers who help the ladies in their adjustment to residential life. In fact, several neighbors have brought over flowers and fruit, and a small group came over for the Open House in June.

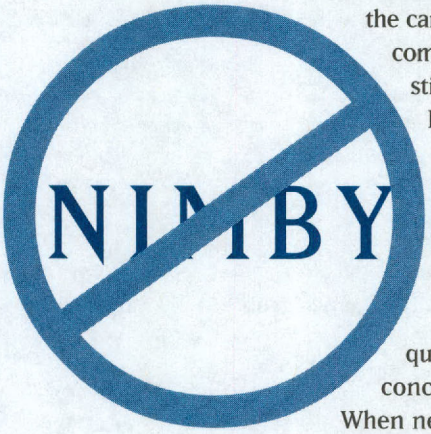
"The lines of communication are opening up and they (the neighbors) know they can contact us if there are problems because that's what neighbors do: help one another," said Andrea Tippitt, MHMR case worker.

Effective ways to combat NIMBY

Individuals with disabilities were aided greatly in their quest for housing in the community by the Texas Legislature's Community Homes for Disabled Persons Location Act (1985) and House Bill 356 (1987). The U.S. Congress addressed the issue with the 1988 Amendments to the Fair Housing Act and the Americans with Disabilities Act of 1990.

While discrimination in housing against individuals with disabilities is prohibited, community support is something that cannot be enforced by law. For persons with disabilities, facing an unaccepting public that is ignorant of the facts is as huge a barrier as blatant discrimination. Such prejudice can be eliminated only through personal experiences and education.

The following efforts may help to educate the public, encourage community support and reduce the NIMBY syndrome:



- Start an anti-stigma campaign in the local media (newspaper, radio, TV). In the campaign, consumers and community leaders can address stigma-related issues such as NIMBY and myths associated with disabilities. Stress "People First" language (for example, use "individuals with disabilities," not "disabled individuals").
- Promptly answer questions and deal with concerns of the community. When necessary, hold community meetings or small group meetings. Try to gain the support of a few families; acceptance will spread from there.
- Group home staff should facilitate consumer involvement in their neighborhoods and communities. Participation in such neighborhood functions as block parties and garage sales can aid in social integration and acceptance.
- Restrict the size of group homes. House no more individuals in the residence than are housed in the average home in the neighborhood.
- Locate group homes in residential neighborhoods where neighbors are likely to interact with consumers. Group homes also should be located near transportation services and a wide range of community resources.
- Group homes should not be concentrated in a part of town where there is an oversaturation of individuals with disabilities, nor should they be located at the end of an apartment complex or row of houses, where residents could be isolated or set apart as "outcasts."
- Group home staff and residents should receive training in being good neighbors. A neat appearance and social graces can go a long way in reducing stigma. Consumers should fit into the schedules and routines of the community as much as possible; atypical waking and sleeping cycles can disturb neighbors. Share the phone number of the group home with neighbors so that the staff can be contacted in case of problems. Also give neighbors the phone number of the officiating center's administration.
- Group homes should appear as regular homes. Parking arrangements and upkeep of residences should adhere to the norms of the neighborhood.

Life Resource teens help themselves by helping another

Editor's Note: *Now and then you hear a story that both inspires you and brings you to tears. The following is one of those stories. It shows that by providing "a safe place" for others, we also help ourselves. Thank you to the teenagers at Life Resource in Beaumont for their selfless concern for another human being and to Candy Carr Howell, Life Resource public relations officer, for sharing this story with the staff of Impact.*

Photo by Candy Carr Howell

Maggie Woodard (center) looks on as Beaumont Mayor David Moore honors her new friends, the 10 teenagers from Life Resource's Daybreak Residential Center and Daybreak Interagency Youth Services.

It was a hot afternoon in August, and 94-year-old Maggie Woodard was trying to work in the yard of her Beaumont home. The grass in her yard had grown up to four feet, and Woodard had only an old hoe with which to cut it.

Meanwhile, Chris, Marcus, Roxanne and Tiffany—teenagers at Life Resource's Daybreak Residential Center and Daybreak Interagency Youth Services (outpatient)—were out taking their daily supervised walk. The teens, who were receiving counseling for emotional or mental problems, walked by Woodard's house and observed the elderly lady working. They decided she needed help.

Sharing the story later, Woodard said Chris approached her and said, "Lady, want some help?" Woodard replied, "Yes, but you can't do this." Chris nodded and said, "Oh yes I can." Woodard said she had no money to pay for yard work. Chris said money wasn't necessary; he and the other youths promised to return the next day.

She didn't think they would come back. But the next day the teens showed up, and they brought additional recruits—Angela, Asmar, Gabe, Lynette, Quincee and Thomas—along with Daybreak staffers Bonnie Baker, Curley Laday and Marion Talbert.

The staff brought a lawn mower and weed eaters from their homes and rakes and other tools from the Life Resource facility. The teens worked all day in Woodard's yard, sacking up 14 bags of weeds and trash. Woodard said that every time she would pick up a hoe to work, one of the youths would walk over and take it out of her hand.

"It was a very hot day, and they worked very hard," said Candy Carr Howell, Life Resource public information officer. "The teens had no motive except to help Mrs. Woodard."

Woodard's husband died over a year ago; her children also are deceased. Her only granddaughter lives in another town. "She has no help and had no idea who to turn to for help," said Howell.

After the youths worked in Woodard's yard, they turned their attention to her house, which had very little plumbing and electricity and had broken windows and no locks on the doors. (People stole from the house when Woodard was away.) The house also was infested with roaches and rats.

In the ensuing weeks, the teens continued to take Woodard "under their wing." They had lunch with her, cleaned her house and did laundry. (The Daybreak staff and members of the public also have come forward to help make Woodard's residence habitable.)

While at Daybreak, the youths have learned "to respect the elderly and the value of helping others," said Howell. "All of the teens said they would not have done this before entering Daybreak.

"Most of the teens (at Daybreak) come with a great many problems and have not had an easy life," Howell continued. "While the youths who have an easy life are watching TV and hanging out with their friends, they don't experience what these teens have—that by helping others, you also

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ACT reduces hospital bed days

Assertive Community Treatment (ACT) has been remarkably successful in reducing the number of hospital bed days for consumers with severe and persistent mental illnesses who have a history of multiple hospitalizations, involvement with the judicial system, or time spent at homeless shelters or community residential homes.

The program, a best practice in 1996 fiscal year performance contracts between mental health community centers and TXMHMR, sends treatment teams (consisting of psychiatrists, registered nurses and experts in housing, employment and substance abuse treatment) into the community to provide whatever individualized services are necessary.

"ACT's comprehensive mobile treatment services address anything from mental health-related issues to housing to employment concerns," said Melody Olsen, TXMHMR Housing/ACT coordinator. "Providing education and support to the individual's family members also is a priority."

ACT teams are available 24 hours a day and have a small consumer-to-clinician ratio (maximum 10 consumers to one full-time team member), which takes into account evenings and weekends, special population needs and geographic coverage. Services are need-based vs. time-limited and are provided out of the office 80 percent of the time. If hospitalization is required, the ACT team coordinates admission and subsequent discharge.

An auspicious beginning

Developed in Wisconsin in the 1960s, ACT was first piloted in Texas at the Gulf Coast Center for MHMR Services and had its start-up at Texas mental health community centers in 1995. TXMHMR sponsored a national ACT expert conference in 1996.

"Expansion of ACT throughout the state is a priority for the agency," said Olsen.

ACT has helped reduce consumer hospital bed days by 69 percent. While the reduction rate of hospital days varies across the state, several community centers helped reduce hospital days by as much as 90 percent in the first year.

Increased quality of life

Abilene Regional MHMR Center implemented ACT in October 1994, with 16 consumers. Most had spent little time in the community since the onset of illness and had problems with daily living demands.

Abilene ACT's goal was to reduce state hospital bed day use by 50 percent in the first year. That goal was surpassed with an 82 percent decrease for the 16 consumers. Hospital bed day use was reduced from an average of 121 days per person annually during the three years before ACT entry to an average of 21 days per person during the first year after ACT entry (with only five of the consumers rehospitalized briefly). In the second year, average hospitalization fell to just four days per person—a 97 percent reduction from the three-year average before program entry. Caseload size increased to 40 consumers but hospital bed day use after program entry still declined. By September 1997, the ACT team reported a 68 percent decrease in annual bed day use during the first year after program entry (with only 12 of the consumers rehospitalized briefly).

Similar success has been experienced by the Collin County MHMR Center ACT team, which provides intensive rehabilitative services and support. In a one-year period, total hospital bed days for the program's 33 consumers dropped 45 percent.

ACT has gone a long way in proving that the old practice of isolating people with mental illness is ineffective. Paul Williams, Collin County ACT team housing specialist, emphasized that "it's better to keep people in the community and teach them to function there to the best of their ability."

—NB

The Crisis Alternatives Project

Hospitalization for severe psychiatric crises not always the answer

More and more medical surgical procedures once performed only on an inpatient basis in a hospital setting now are done in physicians' offices or day surgery centers. By the same token, many individuals with mental illnesses—once confined for years in psychiatric institutions—now receive treatment as outpatients. However, inpatient hospital treatment still is the norm for people experiencing psychiatric crises so severe that they may endanger themselves or others.

But is hospitalization for severe psychiatric crises always the most effective and cost-efficient solution? The Crisis Alternatives Project (CAP), a five-year services research demonstration project, made service providers question the old way of doing things.

Funded by the federal Center for Mental Health Services, CAP combined the resources of TXMHMR Central Office, the faculty from the psychiatry departments of The University of Texas health science centers in Houston and Galveston, and MHMRA of Harris County, which signed up more than 1,000 consumers as volunteers.

Marcia Toprac, Ph.D., TXMHMR's director of Research & Evaluation, said the consumers' "willingness to participate contributed to the growth of knowledge about alternatives to hospitalization."

Investigators were able to study 148 of the volunteers who experienced severe crises. They were randomly assigned to alternative treatment in the community ("respite care"), traditional hospitalization, or a combination of the two. The study showed:

- Individuals receiving alternative, around-the-clock care did just as well (if not better) clinically as those who were hospitalized. Hospitalization was less cost-effective than alternative treatment.
- Brief hospitalization plus respite care and respite care alone had similar outcomes. Respite care alone was slightly less costly.
- Respite care provided in consumers' own homes was slightly more cost-effective; however, it was more difficult to implement than respite care in residences rented for treatment purposes.
- Individuals with mental illnesses proved to be "effective and reliable" providers of alternative crisis services. (They accounted for half of the paraprofessionals specially trained to provide crisis care under the supervision of mental health professionals in the study.) CAP's final report recommended the inclusion of consumer service providers—with adequate supervision—in the development of alternative crisis services.
- The use of comprehensive medical screening and case management in conjunction with the respite care was essential to the success of the alternative crisis services.

"At MHMRA of Harris County, as well as The University of Texas health science centers, staff came to see non-hospital crisis alternatives as feasible and desirable," said Dr. Toprac. "Information about the project was disseminated within Texas and other states, and the study's findings continue to attract attention."—*NB*

Day camp provides innovative intervention

In summer 1997, Child and Adolescent Mental Health Services of Central Gulf State-Operated Community MHMR Services (Central Gulf SOCS) held a day camp that served as untraditional crisis intervention.

The camp provided teenagers a fun-filled summer in a safe, structured environment and also served as a respite for parents. It included a work program, crafts, recreation, communication and anger management sessions, life skills training, first time offender sessions, and experimental and art therapy.

One girl, a chronic runaway, stayed stable and in her home during the camp. A boy who had been in and out of the state hospital coped with home problems without becoming suicidal or homicidal and said, "If it weren't for camp, I might not be alive today. I learned that it is worth it to get up every day and live my life." Another teen summed up the feelings of many of the youths: "I learned that I am not the only one with problems, and that is good to know."

Contributed by Melaney McShan, child and youth services director for Central Gulf SOCS.

Respite service

Giving caregivers a break

Respite service is a blanket term describing a wide range of services that provide care for people with disabilities while primary caregivers engage in other activities.

Respite is included in the core services MHMR centers must provide to receive general revenue dollars from TXMHMR. They can be either *program-based respite services*, temporary residential placement outside the usual living situation, or *community-based respite services*, which bring respite providers into the usual living situation, provide a place for individuals with disabilities to go during the day, or offer other respite services.

Caregivers may feel guilty for needing respite, but such services can help them cope with their sometimes overwhelming responsibilities. Respite relieves stress, which helps prevent abuse and neglect and gives caregivers valuable time away from their duties.

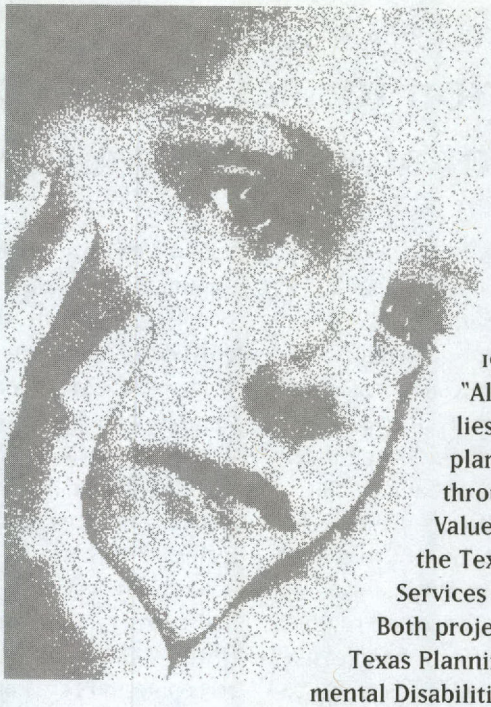
Reimbursement provides relief

One example of relief for caregivers is Respite Reimbursement through Austin Travis County MHMR Center (ATCMHMR). Designed to aid in the care of persons age three and over residing in private homes (not ICF/MR group homes, boarding homes or state schools), the program negotiates a quarterly amount of financial reimbursement. Services are provided inside or outside the home; the caregiver selects the providers.

"The program allows the caregiver to take a break from the day-to-day duties of caring for a person with mental retardation, autism or pervasive developmental disorder," said Traci Rinewalt Stone, program coordinator. "Because direct financial reimbursement is provided, reimbursement is on a sliding scale based on the family's annual income. Before a family is admitted to the program, a service coordinator must be assigned."

Supports strengthen families

Respite services are part of the philosophy of *permanency planning*, which



supports the belief that children need enduring and nurturing relationships. It honors the special child-family bond and supports services that strengthen those relationships.

First started in 1992 through TXMHMR's "All Kids Belong in Families" project, permanency planning continues today through "Families Are Valued," a five-year project of the Texas Health and Human Services Commission (THHSC). Both projects were funded by the Texas Planning Council for Developmental Disabilities (TPCDD).

In addition to respite, permanency planning can include habilitative training, parent education, emotional supports, service coordinating, and information and referral services.

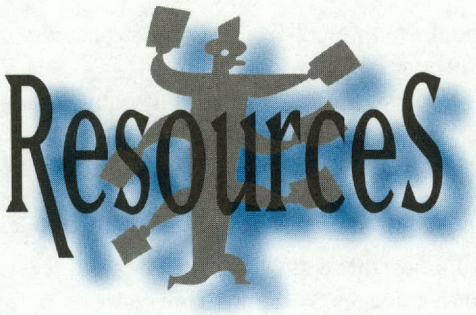
In summer 1997, four Texas "Families Are Valued" project sites were named: ATCMHMR and Children's Mental Health Partnership, Central Gulf State-Operated Community MHMR Services (Central Gulf SOCS), Life Management Center for MHMR Services, and Uniting Parents of Amarillo. Representing large urban, small urban, rural and border communities, the project sites will implement the practices of permanency planning and demonstrate the impact on service delivery for children.

The project "strengthens our commitment to children and improves the services for children with disabilities," said Jeff Enzinna, Central Gulf SOCS executive director.

Statewide system change activities to decrease the number of out-of-home placements of children with disabilities is the goal of "Families Are Valued." Project sites will analyze existing policies and programs; determine community issues and barriers; develop strategic plans addressing concerns; design community advocacy plans to broaden resources and services; promote community awareness; and design independent case management models. Successful strategies will be replicated statewide.

If a child cannot remain in the home full-time, permanency planning focuses on family-living alternatives (shared parenting, temporary therapeutic foster care and voluntary open adoption) that reinforce the "natural" child-birth parent relationship. A recent TPCDD publication quoted one mother who said her son probably would have been institutionalized if permanency planning hadn't been available. "That would have killed me, and I know it would have been the worst thing for him," she added.

The Texas Legislature in 1997 required that permanency planning be provided for children residing in institutions or in cases where institutional care is sought.—*NB*



Resources in Texas:

Northeast Texas MHMR Center
P.O. Box 5637, Texarkana 75505-5637
(903) 831-3646

Supported Housing/
Assertive Community Treatment
TXMHMR SSD&I, P.O. Box 12668
Austin 78711, (512) 206-4545

Texas Panhandle MHA
P.O. Box 3250, Amarillo 79116-3250
(806) 337-1000

Nueces County MHMR Community Center
1630 S. Brownlee, Corpus Christi 78404-3178
(512) 866-8974

TXMHMR Quality Management-Mental Health
P.O. Box 12668, Austin 78711
(512) 206-5831

Laredo State Center
P.O. Box 1835, Laredo 78044-1835
(956) 794-3223

Projects for Assistance in Transition from Homelessness
TXMHMR SSD&I, P.O. Box 12668
Austin 78711, (512) 206-4695

Gulf Coast Center
P.O. Box 2490, Galveston 77553-2490
(409) 935-7012

The Arc of Texas (Master Pooled Trust)
P.O. Box 5368, Austin 78763
(800) 252-9729

In-Home and Family Support
TXMHMR SSD&I, P.O. Box 12668
Austin 78711, (512) 206-5583

Home and Community-Based Services
TXMHMR Medicaid Administration
P.O. Box 12668, Austin 78711
(512) 206-5708

Life Resource
2750 South 8th St., Beaumont 77701-7719
(409) 839-1021

Abilene Regional MHMR Center
2616 S. Clack, Abilene 79606
(915) 690-5105

Collin County MHMR Center
P.O. Box 828, McKinney 75070
(972) 422-5939/(972) 562-0080

Crisis Alternative Project
TXMHMR Research & Evaluation
P.O. Box 12668, Austin 78711
(512) 206-5465

Austin Travis County MHMR Center
5225 North Lamar Blvd., Austin 78751
(512) 483-5800

Permanency Planning
TXMHMR Children's Services
P.O. Box 12668, Austin 78711
(512) 206-5575

Central Gulf SOCS
711 S. 11th, Richmond 77469
(281) 342-0090

Texas Respite Resource Network
519 W. Houston St., San Antonio 78207-0330
(210) 704-2794

MHMR Services of Texoma
203 Airport Dr., Denison 75020
(903) 786-4804

Resources outside of Texas:

National Down Syndrome Society
666 Broadway, 8th Floor, New York, NY
10012-2317
(800) 221-4602

National Resource Center on Homelessness and Mental Illness
262 Delaware Ave., Delmar, NY 12054
(800) 444-7415

Reader survey deadline extended

The deadline for the *Impact* reader survey has been extended to Jan. 11. Please take a minute to fill out and mail the survey on page 23 of the Fall 1997 issue. If you need a copy of the survey, please contact Nora Bender, phone (512) 206-5187 or fax (512) 206-5093.

NIMBY, *continued from page 14*

home residents would "scream and holler all night long."

Paula Cawthon, Texoma MHMR 's community relations and public information officer, turned to the local media for assistance.

"I said 'Let's invite a reporter in to tour our other homes in the area. Let's see what he thinks,'" said Cawthon.

In describing one of the homes he saw on the tour, a reporter for *The Denison Herald* (now *Herald Democrat*) wrote that it looked like "a typical family home with spacious living room areas and bedrooms cleaner than most teenagers'."

The newspaper also printed a number of letters to the editor from Denison residents; they were mostly supportive of the group home.

What Cawthon describes as the "heartburn" of the NIMBY situation eventually gave way to a tolerant (and often positive) relationship between the staff and residents of the group home and their Brookhaven neighbors. (See related article on page 15.)

Barry Waller, TXMHMR director of Long Term Services & Supports, encountered several NIMBY episodes in his former role as interim executive director of Dallas County MHMR Center. One neighborhood association filed a lawsuit to stop the center from building a group home for consumers with mental retardation.

"We won the lawsuit, and the home was built," said Waller. "Once it was opened and the neighbors saw the building—that it blends in with their neighborhood and that, yes, we do mow the lawn—the outcry died down. Once the consumers moved in, there were no more complaints.

"I think there is less controversy when you rent or buy a house. When you build, people get a mental picture of what the home will be like; they think of all the negatives," added Waller. He emphasized the importance of allaying the public's concerns and fears regarding group housing. "Respond to all inquiries for information, and be accessible."—*NB*

Life Resource, *continued from page 17*

help yourself—you receive a great feeling of accomplishment that comes with gaining self-respect and pride when you serve others and do something positive. They all learned a valuable lesson."

Believing that the public would enjoy a positive story about teenagers, the staff at Daybreak shared the experience with the local media. KFDM Channel 6 ran it as the top story on its 10 p.m. newscast and as the "teaser" story through the evening. "There was a tremendous response from the public about this act of kindness from these youths," said Howell.

On Aug. 19, the teens received a standing ovation in a capacity-filled room at the City Hall, where they were recognized by Beaumont Mayor David Moore and the City Council. Attending the ceremony was their new friend Woodard, as well as their family members and staff from Daybreak. Each teen received a certificate from the City of Beaumont stating, "When young people go out of their way to assist an elderly person in need, the entire community benefits. These teens have certainly set a standard by which we all should be measured."

All three Beaumont TV stations included the special ceremony in their newscasts. The Beaumont newspapers and a local radio station also covered the story and gave kudos to the teens.

"The words of praise and encouragement the teens received will have a lasting impact on their lives," said Howell. "Mrs. Woodard said she will treasure the mementoes from this experience for the rest of her life.

"This has been a wonderful experience for everyone," Howell added. "The amount of positive feelings this story brought to our community was tremendous. What I hear from people in the community now is, 'Life Resource is where those great teenagers were from who helped the 94-year-old lady!'"—*NB*

On March 13, 1996, I was headed westbound on Hwy. 359 toward Laredo in a full-blown manic phase, escaping from unnamed entities, products of my paranoid delusions that were relentlessly pursuing me.

My car stalled, and after several attempts to start the car it burst into flames and burned completely. As the result of my psychosis, I also was full term into a false pregnancy—labor and all.

Photo by Lourdes Castaneda

Janice McFarland

The attendants at Mercy Hospital quickly assessed my condition and transferred me to the crisis intervention unit at the Laredo State Center.

Later I was transferred to Wood Living Center, a group living home for mental health patients that operates under contract to the state. Wood Living provided me with a bed, three meals a day, medications, transportation to and from doctor's appointments, and a weekly stipend.

While Wood Living took care of my physical needs, the Laredo State Center ministered to my mental health needs. This included monitoring and prescribing of psychotropic medications by psychiatrist Dr. Gomez-Rejon; very productive psychotherapy by chief psychologist Dr. Timothy Brown; and last but not least, advocacy, counseling and efficient case management by Jenny Murrillo. Ms. Murrillo spent many hours visiting me during multiple hospitalizations over the past year.

I have gone from being indigent and homeless to having my own apartment, a part-time job and a part-time college career. Thanks to supported housing and Gateway Industries (both entities of Laredo State Center) and the Texas Rehabilitation Commission.

This Personal Note by consumer Janice McFarland was contributed by Sylvia Everett, director of community relations for Laredo State Center.

I have a dream: I want to live on my own. It's time for me to live alone. I want privacy. I could also go anywhere I wanted to go. I like to learn things on my own. I have learned how to cook and clean. I would make sure my apartment was clean. I could have friends over for dinner and dessert. I would like for my friends to feel at home at my apartment. I would like to have a talking bird. Birds are fun to look at and mess with. I might think about having a small dog.

I want to be independent. I will be miserable if I can't take care of myself.

By working it has helped me become independent. I can make money on my job.

The above essay, written by a MHMR Services of Texoma consumer with mental retardation, originally appeared in an issue of The Denison Herald *(now* Herald Democrat*). It was among 10 winners (out of 70 entries) in a Destination Dignity Month contest, which has been sponsored for the past three years by MHMR Services of Texoma. The contest was the brainchild of Paula Cawthon, the facility's community relations and public information officer, who said, "What struck me most deeply was how many shared dreams we all have . . . to be loved . . . to have a happy family . . . to have a job that we enjoy and which makes us feel like productive citizens."*

Personal Notes

Texas Department
of Mental Health and Mental Retardation
P.O. Box 12668
Austin, TX 78711-2668

1998 Regional Helen Farabee Conferences

- AUSTIN
  January 21- 22
- GALVESTON
  February 4-5
- ARLINGTON
  March 20-21
- LUBBOCK
  April 1-2

If you have questions call the Conference Hotline: (512) 440-7606 or Toll Free: 1-800-440-7064. Consumer stipends are available for all events.

Upcoming Themes

- Community Involvement in Planning for the Future
- A Salute to 1998 Farabee Award Winners

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