Fall 2000-Winter 2001

# IMPACT

## of Strategies to Promote Mental Health Recovery



Photo by Frances Garza

*Members of the Peer Support Group at Nueces County MHMR Community Center include (back row, left to right) Darren McGee, James Sutton, Brenda Hudman, Leslie Wilson, (front row) Glenn Wilkinson and Monica Magill.*

*Commissioner Karen F. Hale*

# VIEWPOINT

The nearly 3 million Texans who have some form of mental illness face an uphill battle to enjoy normal lives. On a daily basis, they see areas of their lives that are affected negatively by their disorders. They see troubled families, failed relationships and missed employment opportunities. The stigma surrounding mental illnesses stands as a roadblock to seeking help—the very help that can guide them to recovery from these very common disorders (for more information, see pages 26-27).

We know that early detection and treatment of mental illness is crucial. As was emphasized in the surgeon general's 1999 report on mental health (for more information, see the *Impact* Research column on page 20), the earlier individuals with mental disorders obtain treatment, the greater their opportunity to live full and complete lives.

In this issue of *Impact*, we look at numerous strategies used by TXMHMR facilities and community centers throughout our state, as well as programs developed here at the agency, to promote mental health recovery. While the word "recovery" historically has been associated with abstinence from drug and alcohol abuse, in the mental health field it now represents the enabling of people to live at their highest possible level of wellness.

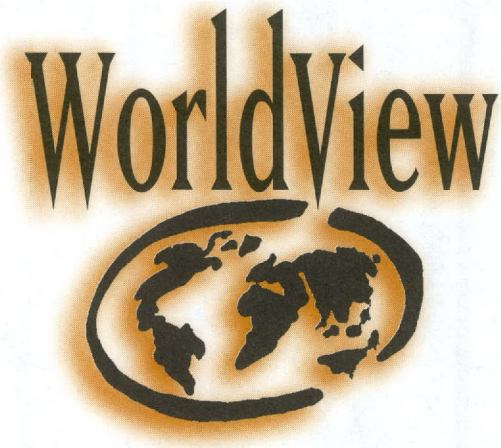
The recovery-oriented Texas Psychiatric Rehabilitation Toolkit (page 6) recently was developed by TXMHMR staff and other experts to provide resources to practitioners working with individuals in the community and in mental health facilities. In an effort to increase the respect and dignity afforded to individuals in mental health crisis by law enforcement, TXMHMR recently awarded $300,000 in grant monies to help 112 Texas counties develop Mental Health Peace Officer Programs (pages 21-23). Also highlighted in this issue are TXMHMR efforts in Supported Employment (page 7) and Assertive Community Treatment (page 32), as well as a new education program for consumers and family members involved in the Texas Medication Algorithm Project (page 28).

Texas' efforts to aid individuals in mental health recovery are innovative and varied—from consumer involvement in peer support groups at Nueces County MHMR Center (page 5) to the healing gardens being developed for residents at Austin State Hospital and Richmond State School (pages 18-19). Children and adolescents can receive crisis intervention services through the CAPES program, associated with MHMR Authority of Harris County (page 8). The Gulf Coast Center (pages 24-25) offers programs to increase independence of people with mental illnesses.

Last but not least, this issue of *Impact* includes special sections on programs available to assist individuals with dual diagnoses of co-occurring mental illness and substance abuse disorders (pages 9-13) and co-occurring mental retardation and mental illness disorders (pages 14-17). The featured programs underscore the importance of providing an integrated treatment approach to dual diagnoses.

# In This Issue

Fall 2000-Winter 2001




## Integrated services for dual disorders gain ground but are still the exception

*Around the country, many individuals with co-occurring mental illness and substance abuse disorders receive sequential treatment—that is, they receive treatment for one disorder and then treatment for the other disorder later. Referred to as "ping-pong treatment," this modality requires navigating through a bewildering number of multiple agency requirements.*

Some people receive **parallel treatment**—that is, they receive treatment for both disorders simultaneously but from different agencies, and therapists and case managers do not coordinate treatment.

Still others receive **linked treatment,** which is similar to parallel treatment. With linked treatment, therapists and case managers communicate with one another about the treatment goals, although this modality does not necessarily ensure coordinated services.

When people receive **integrated treatment,** however, attention is paid to both disorders simultaneously, through treatment from cross-trained dual disorder specialists. Integrated treatment often includes such extras as access to other areas of support, including help with developing psychosocial skills, housing, employment and physical health care.

## Recovery: Uncovering common themes

The Community Support Program, administered by the Center for Mental Health Services (CMHS) of the U.S. Department of Health and Human Services, is setting the stage for change in the area of recovery from mental illness. Recovery, long dismissed as attainable only for people with substance abuse disorders, is finally receiving significant attention.

To tease apart its essential components, the National Endowment Center, a CMHS technical assistance center, conducted in-depth interviews with 30 consumers in various stages of recovery.

"It's the first study of how people recover from mental illness," said Daniel Fisher, M.D., Ph.D., the technical assistance center's director and principal investigator of the study.

An analysis of the interviews revealed a number of themes common to those who have recovered or have shown significant progress in recovery from mental illness:

- Believing in one's recovery
- Having one's thoughts validated by others, especially by peers through support groups
- Being with people one can trust
- Having a voice in important events in one's community
- Taking care of oneself
- Transferring anguish into suffering that can have meaning
- Having hope and wondering what can be achieved
- Taking responsibility for one's own life
- Getting in touch with one's emotional and spiritual side

"Understanding the elemental themes involved in this process may lead to a new model of recovery," Fisher said. "When people know there can be an endpoint to their illness and that they can become well again, they have hope and are much more likely to continue to work toward recovery."

*Excerpted from the article "The Community Support Program Sets the Stage for Change," published in the Center for Mental Health Services KEN Bulletin, Volume 3, Number 1. For more information, contact Daniel Fisher, M.D., Ph.D., of the National Empowerment Center, (800) 769-3728.*

## *Nueces County's Peer Support Group*

# 24/7 advocacy for mental health

The Peer Support Group of Nueces County MHMR Community Center is a group of intelligent and caring advocates of mental health. The group supports persons with mental illness, as they put it, "24/7." They can talk to each other and relate to their problems. They share information and ideas and understand how the other feels.

The Peer Support Group's members want to dispel the stigma and myths of people with mental illnesses. They also want to stop the "revolving door"—people coming back time after time for crisis situations. While the new medications have helped tremendously in making people feel better, they are not enough. People with mental health problems need services, but they also need support.

"Services or support alone will not help. They need both," said James Sutton, a member of the Peer Support Group.

In their quest to help people with mental health problems, the Peer Support Group has developed computer classes that are available to persons wanting to learn to use computers and navigate the Internet. Thirty computers have been donated from various local individuals and businesses. With the help of group member Glenn Wilkinson, who got all the computers running, they now are available for use by consumers.

The group also has been able to donate computers to people who are unable to afford them. Because too often people with mental illnesses are isolated from their families and unable to leave home due to their illnesses, the use of a computer has enabled them to establish a new social network online. They also are able to get information about their illnesses and the new medications available. This computer donation program has helped put structure in their lives. It has given them the ability to put their lives together, to go on with their lives.

The Peer Support Group publishes a monthly consumer newsletter and has built a library of books, pamphlets and videos to help people learn more about mental illnesses. The group is in the process of becoming an established non-profit, 501(c) 3 organization. With the non-profit status, members will be able to write grants to raise money for their own building—a main goal of the group. It will be a building that members will have keys to and can go to whenever they need to be there.

Through its assertive efforts, the Peer Support Group is headed into the new millennium on the communication highway and is ready to advocate for mental health.

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*Contributed by Frances Garza, community relations coordinator at Nueces County MHMR Community Center, (361) 886-6900.*

*Photo by Frances Garza*

*Members of the Peer Support Group at Nueces County MHMR Community Center include (back row, left to right) Darren McGee, James Sutton, Brenda Hudman, Leslie Wilson, (front row) Glenn Wilkinson and Monica Magill.*

## *The Texas Psychiatric Rehabilitation Toolkit*

# Benefiting individuals recovering from mental illness

Based on evidence that psychiatric rehabilitation is the most effective approach to supporting people recovering from serious mental illness, The Texas Psychiatric Rehabilitation Toolkit was developed to serve as a compendium of resources—or tools—utilized by practitioners when working with consumers in the community, as well as in mental health facilities.

Utilizing input from practitioners, consumers and family members, the recovery-oriented Toolkit was developed by TXMHMR staff and other experts during fiscal years 1998 and 1999. The first version of the Toolkit for adults was published at the end of fiscal year 1999. To build on the Toolkit, practice guidelines currently are being formulated and tested. A web site containing Toolkit materials and hyperlinks to other relevant sites is under development.

### *An emerging philosophy*

"Psychiatric rehabilitation is a philosophy, as well as specific strategies that have been formed over the past 30 years about how treatment should be provided to those individuals with mental illnesses," said Sam Shore, director of TXMHMR Behavioral Health Services.

A growing consciousness has emerged that the quality of life for individuals with mental illnesses could be improved by skill building and social support, in addition to medications. This new rehabilitative paradigm reflected a consumer-oriented, community-based, recovery-focused, outcomes-grounded approach to delivering mental health care.

In response to this new philosophy, Texas, like many other states, has shifted monetary and human resources toward the development of a public sector mental health delivery system that incorporates a rehabilitative approach to treatment. Years of work by TXMHMR staff led to the creation of a psychiatric rehabilitation treatment model that sets new standards of quality and service effectiveness for care provided to the priority population for mental health. Consumer needs and system factors necessary to meet those needs are identified. The consumer needs include four areas that are considered equally critical to effective functioning: Symptom Reduction, Skill Development, Social Support Enhancement, and Environmental Adaptation.

The Toolkit, based on this model, represents an extensive effort by TXMHMR staff, state mental health facility and community center staff, advocates and national psychiatric rehabilitation experts—from within Texas and from outside the state. The Toolkit, in one convenient package, provides research articles, assessment guidelines and methods, and consumer and family curriculums that provide examples of the caliber of treatment that characterize the psychiatric rehabilitation model.

### *The future*

The Toolkit represents just the first of a series of state initiatives aimed at developing a comprehensive, individually centered, recovery-oriented system of care. A graduated approach to the development of demonstrated competencies will be introduced, and Texas will move towards formal certification of competence in psychiatric rehabilitation.

"Based on the model and resources contained in the Toolkit, the agency—working with local mental health authorities—has initiated revisions to the mental health service delivery system, including the Rehabilitative Services Medicaid option operated by TXMHMR," said Shore. —*NB*

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*For more information on The Texas Psychiatric Rehabilitation Toolkit, contact TXMHMR Behavioral Health Services at (512) 206-4533 or go to http://www.mhmr.state.tx.us. Click on Agency Administrative Offices and then on Behavioral Health Services and on Psychiatric Rehabilitation Toolkit.*

*Supported employment*

# Eliminating barriers to rewarding jobs

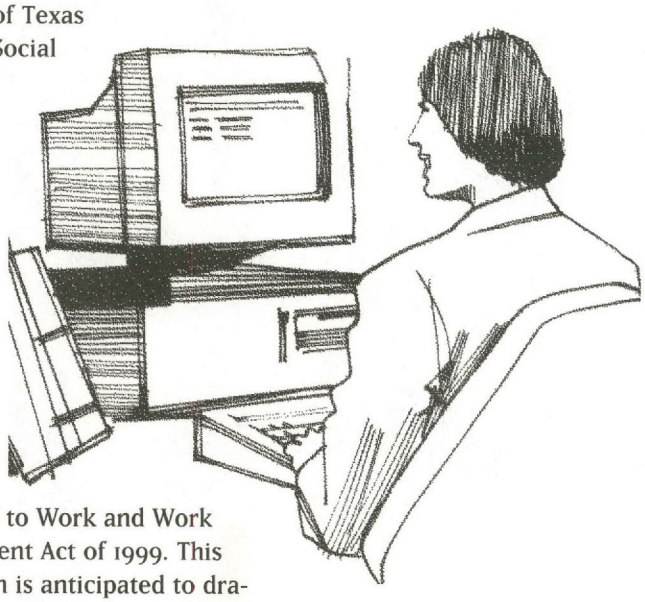
Through supported employment, TXMHMR works to eliminate the barriers to employment faced by people with significant disabilities and to help them find and maintain jobs of their choice in businesses and industries in the community. Productive employment can lead to fulfilling, rewarding lives. TXMHMR promotes employment by offering employment services, and also by participating in initiatives to improve the quality and availability of employment services.

"People with significant disabilities can work and have successful jobs and careers. TXMHMR and other entities are actively working to clarify the best ways to help people accomplish these goals," said Pam Daggett, coordinator for TXMHMR Community Employment.

A work group with representatives from TXMHMR, the Texas Rehabilitation Commission, Texas Commission for the Blind, and Texas Education Agency have met regularly to develop strategies for an interagency coordinated approach to supported employment. Input was gathered from a variety of stakeholders over an extended period of time. Based on this input, a plan was developed to implement strategies for improved coordination in a pilot area. Based on the success of the pilot, strategies could be implemented across the systems. More details regarding the pilot project will be available when all the local participants have confirmed their participation.

Texas and seven other states have participated in the Employment Intervention Demonstration Project (EIDP), a research-demonstration project funded by the federal Center for Mental Health Services. The project tested interventions and collected data that will contribute greatly to the knowledge of factors affecting employment outcomes among individuals with mental illness. Data collection has been completed, and is currently in the analysis phase. Through EIDP, the nation has had an historic opportunity to learn about employment and serious mental illness.

Texas' EIDP project, called EARNS—Employment Assistance through Reciprocity in Natural Supports—is a research demonstration project that develops social supports to enhance the success of supported employment. EARNS is a partnership among TXMHMR, The Center for Health Care Services in San Antonio, The University of Texas Health Sciences Center—San Antonio, and The University of Texas at Austin School of Social Work.



At a national level, information from the EIDP was used to inform the development of national policy. Because of involvement in the EIDP, Texas has had opportunities to help shape implementation of the landmark Ticket to Work and Work Incentive Improvement Act of 1999. This important legislation is anticipated to dramatically improve employment prospects for people with disabilities in years to come by removing disincentives to employment, providing medical insurance to people with disabilities, and creating a new source of funding for employment services.

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*For more information on supported employment, contact Pam Daggett at (512) 206-4533.*

# CAPES helps hundreds of youths in Harris County

The CAPES abbreviation may not be as well known as U.S. or U.N., but MHMR Authority of Harris County employees involved the program are finding that more and more people they meet recognize the acronym.

And speaking of recognition, the CAPES (Child and Adolescent Psychiatric Emergency Services) program also was recognized for honorable mention in the 2000 Wyeth Ayerst Hera Awards program. The Hera Awards honor programs and projects in women's and children's health that have resulted in quantifiable, improved health outcomes for participants. Programs are judged on improvements in clinical outcome measures, as well as any economic benefit produced.

Photo by Steve Howland

*Pictured outside the NeuroPsychiatric Center are MHMR Authority of Harris County CAPES workers (left to right) Diane Broady, M.A.; Susan Brock-Roberts, LPC; Rochelle Kibert, Ph.D., program director; Mary Locke, LMSW-ACP; Jamal Rafique, M.D.; and Dennis Friedel, M.A., LPC. Not pictured are Barbara Edmond, M.A., and Jaye Kelly, M.A., LPC.*

CAPES is a mobile crisis unit based in the NeuroPsychiatric Center (NPC) of the Texas Medical Center. The unit provides mental health assessments and intensive crisis intervention services to children and adolescents wherever and whenever they are needed in Harris County. The program's objectives are to increase mental health awareness by involving the community in its recognition and treatment and to increase accessibility of service and linkage to care within the least restrictive environment.

The program operates 24-hours-a-day throughout Harris County, and transportation is provided to families as needed. Services are delivered at schools, shelters, in the home, or at other child-focused program sites. Interventions start with an evaluation, followed by such options as referral, therapy, continuity of care, community-wide education and training, and access to medication.

CAPES, which serves youths from ages 2 to 17, has decreased the number of hospitalizations, leading to a decrease in mental health costs. An average hospitalization can cost $5,000 for 10 days. A CAPES intervention of three days costs $540. That's a potential savings in public mental health care of $4,460.

Another plus is that more children are continuing with mental health treatment after initial intervention. Referrals coming from throughout the community are seen as a success in the program's marketing and in consumer experiences with the program itself.

CAPES Program Director Rochelle Kibert, Ph.D., credits her staff for the recognition the program has received.

"I feel we are succeeding through the dedication of our staff members and their willingness to do what is necessary to achieve successful outcomes," said Dr. Kibert. "I also have to credit the outstanding cooperation we have received from all the Child and Adolescent Services clinics in the agency."

Since CAPES was introduced in 1996, the number of assessments offered annually rose from 252 to 720 in FY 2000. The ethnic and income level of the consumers served is representative of the county's population.

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*Contributed by Steve Howland, editor, Public Affairs Department, MHMR Authority of Harris County, (713) 970-7167.*

# DUAL DIAGNOSIS—
# Co-Occurring Mental Illness and Substance Abuse Disorders

TXMHMR is the state authority to provide mental health services to persons with severe and persistent mental illnesses, and the Texas Commission on Alcohol and Drug Abuse (TCADA) is the state authority to provide services to persons with substance abuse/chemical dependence. Services to persons with co-occurring mental illness and substance abuse disorders traditionally have been provided in parallel, separate systems of care. Evidence now suggests that integrated services, in which co-occurring serious mental illness and substance abuse disorders are treated simultaneously, results in better outcomes than parallel systems where disorders are treated in separate systems, or sequential systems in which one disorder is treated before the other.

In a combined effort in fiscal year 1995, TXMHMR and TCADA funded five pilot demonstration sites to create and implement integrated treatment and evaluation systems for adults with dual diagnoses of substance abuse and mental illness. (See related article, this page.) These efforts currently continue through 15 TXMHMR/TCADA-funded dual diagnosis sites. The evaluation of the original five dual diagnosis pilots suggests that clients receiving integrated services become more engaged in treatment over time, with reductions in incidence of arrest and decreases in homelessness. Focusing on jail and homeless populations is vital, since there is a significant population with dual diagnosis in these groups. It is estimated that as many as 94 percent of the people with mental illnesses in jails have co-occurring substance abuse disorders.

*For more information on TXMHMR/TCADA-funded dual diagnosis sites, contact A.J. Ernst at (512) 206-4763.*

## *Texas' dual diagnosis program lauded nationally*

In 1999, the Dual Diagnosis Integrated Treatment Program of TXMHMR and the Texas Commission on Alcohol and Drug Abuse (TCADA) received the Award of Excellence for Special Programs: Integrated Mental Health and Addictions Services from the National Council for Community Behavioral Healthcare. Texas' dual diagnosis program, the largest of its kind in the nation, serves the high-risk population of individuals with co-occurring mental health and substance abuse disorders.

Following the announcement of the national award, TXMHMR Commissioner Karen Hale praised the dual diagnosis program at a Central Office employee meeting and recognized the agency's Behavioral Health Services staff for their work on the program.

Also honored with the award were the seven community MHMR centers that in 1996 created five pilot programs spanning 33 Texas counties. The programs and centers are:

- The Dual Diagnosis Project of the **Central Plains Center for MHMR and Substance Abuse** in Plainview;
- The Dual Diagnosis Treatment Program of the **Tri-County MHMR Center** in Conroe;
- The Central Texas Partnership, comprised of **Austin Travis County MHMR Center, Bluebonnet Trails Community MHMR Center** in Round Rock, and **MHMR Authority of Brazos Valley** in Bryan;
- The Ocotillo Project of **Life Management Center for MHMR Services** in El Paso; and
- The Bueno y Sano Project of **Permian Basin Community Centers for MHMR** in Midland.

The 74th Legislature in 1995 directed TXMHMR and TCADA to study ways to improve services for the 30 to 50 percent of

*continued on next page*

*Texas program, continued from page 9*
their priority consumers with co-occurring substance abuse and mental illness disorders. Texas is the only state to attempt integrated treatment through state and local level integration of the established public mental health authority and the public chemical dependency authority.

An independent evaluation by Texas A&M University shows that—when compared with consumers of traditional services—consumers in the dual diagnosis program are more likely to report decreases in substance abuse, lower levels of psychopathology, lower arrest rates, higher attendance at substance abuse treatment programs and groups, and higher incidences of family involvement in the program.

The expansion of the pilots was endorsed by the 75th Legislature, and a dual diagnosis expansion request for proposals (RFP) was issued in fiscal year 1998.

The National Council for Community Behavioral Healthcare is a nonprofit trade association representing direct care providers, state associations, county authorities, integrated delivery systems, and other related associations.—*NB*

## Burke Center

## *Dozens of clients aided through new dual diagnosis program*

Sally Jones (name changed for article) had tried for many years to quit using drugs on her own but had never been successful. What made trying to quit using drugs even harder for Jones was that she had a dual diagnosis—a mental illness and a chemical dependency. Today, thanks to Burke Center's new dual diagnosis program, Jones is drug-free and living independently.

In February 1999, Burke Center was awarded a grant to open a dual diagnosis program. The program began enrolling clients in September 1999 and today serves more than 60 individuals through its Angelina County mental health clinic.

"We started the program with 20 individuals, and each one is still involved in the program today. Even more impressive, none of the 60 clients now enrolled are using drugs on a regular basis," said Linda Few James, LCDC, dual diagnosis service coordinator.

James attributes the program's success to its numerous approaches, including group therapy, individual therapy and rehabilitation services, and to a team of staff members dedicated to making a difference in the lives of those with dual diagnoses.

During group therapy, clients are taught relapse prevention therapy, behavior modification, and cognitive and reality therapy. They are provided group support from other clients who "have been there."

"The group celebrates small victories together," said James. "This moral support is so important and makes each client feel like they are not alone in the process. They now have a support network of other clients who are facing the same issues."

Staff focuses on educating the clients to be medication compliant and how their drug of choice effects not only their mental illness, but their medication as well.

According to James, most clients did not realize how their drug use interacted with their medication and the role this played in their recovery process. Once involved in the program, clients see they do not have to turn to drugs to deal with their mood—that if they are clean and sober, their medications can work as intended.

Also included in the program are

rehabilitation services, including teaching clients how to live healthy, cope effectively and use supports to achieve independent living. All these services are individualized to meet each client's specific needs.

"This program has greatly helped these clients to stabilize, and subsequently we have seen a decrease in our rehospitalization rates," said Mike Cunyus, service director for the mental health clinic in Angelina County.

The goal of the program is for these mental health clients to become clean and/or sober and ultimately move to a lesser need of services.

Sally Jones is a prime example of meeting the program's goal. She now attends college full-time (earning straight As), has a job and has set long-term goals. She plans to become a probation officer when she graduates from college. Her most impressive goal to date, however, is her nine months of sobriety. This is the longest she has ever been sober, and with the support of Burke Center staff she hopes to stay that way.

"I believe the program has seen great success, because staff have worked together as a team addressing the substance abuse needs of our mental health clients using a holistic approach," said James. "Due to the program's success, I would like to see it added as a Best Practice service. I think it is well deserving of such inclusion."

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*Contributed by Chauntel Moore Plopper, former public relations director for the Burke Center. For more information, call (936) 639-1141.*

## Big Spring State Hospital
## *Mental illnesses and substance abuse are best addressed simultaneously*

Big Spring State Hospital (BSSH) Patient Educator Renae Porch plants small seeds of knowledge in the patients attending her "Living Sober" class—giving them ways of coping once they're outside the safe confines of a state mental health facility.

The focus of this particular session is on relationships—the positive ones that help people living with co-occurring mental illness and substance abuse disorders deal with their feelings and develop coping skills to help prevent relapse.

One of the major problems these patients will face when they leave BSSH is establishing a dependable group of people for support.

"Friends can be a support network for you when you leave," she told the circle of patients, "but not the ones you used to smoke with or drink with."

"Where else in the community can you go?" she asked. "Alcoholics Anonymous? Narcotics Anonymous?"

Years ago, this particular type of treatment program—addressing both the patient's mental illness and co-occurring substance disorder at the same time—was nonexistent.

Until the mid-1980s, most clinicians in the field believed that the most effective way to treat people who had mental illness and abused drugs was to address the problems separately. Experts were not convinced the diseases were necessarily linked or that treatment needed to be integrated.

Many state mental health facilities treated these co-occurring disorders separately by providing treatment for people with mental illness and detoxification units for alcoholics and drug users. In the early 1990s, state psychiatric hospitals closed their substance abuse programs. Community mental health centers, along with other

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# DUAL DIAGNOSIS—
# Co-Occurring Mental Illness and Substance Abuse Disorders

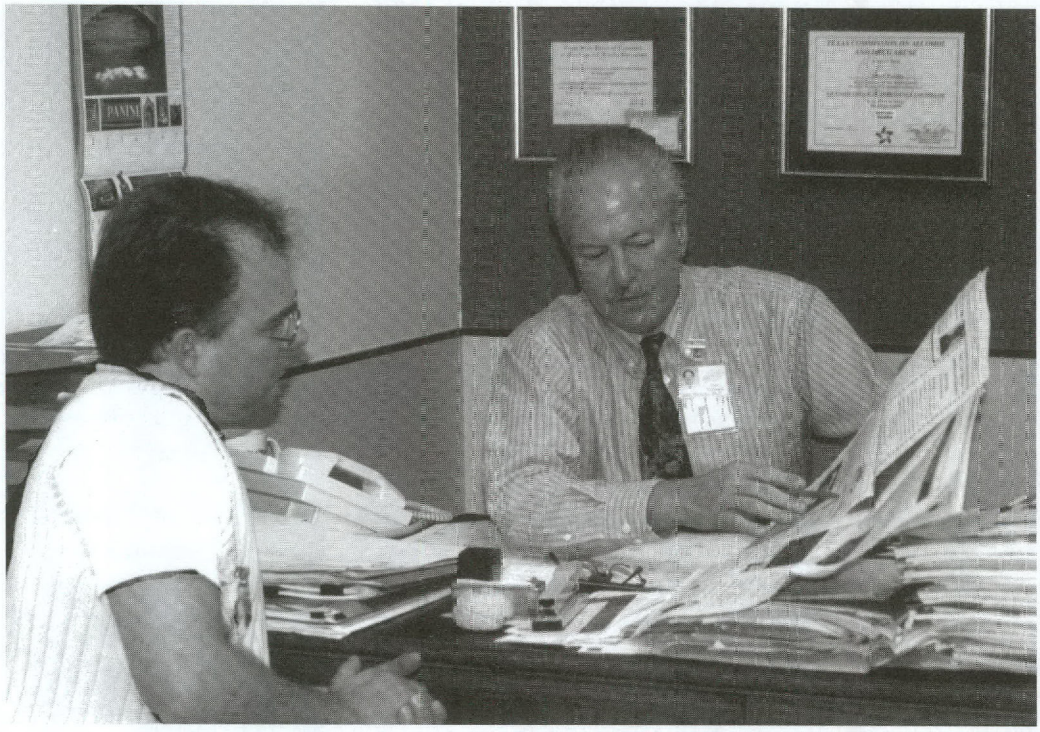

Photo by Valerie Avery

*Psychologists Tom Dawson, Ph.D., and John Pichitino, Ph.D., discuss plans for the dual diagnosis program at Big Spring State Hospital. The program will serve as a model for the other seven state mental health facilities in designing treatment programs for patients with co-occurring disorders.*

*Big Spring, continued from page 11*

community resources, assumed the responsibility for treating patients with substance disorders.

"What happened was that mental health facilities were treating patients with mental illness, and substance abuse treatment facilities were treating patients with substance problems, but patients with both disorders were falling through the cracks," said John Pichitino, Ph.D., BSSH chief psychologist. "The hospital came to the realization that they had many patients with co-occurring psychiatric and substance disorders."

Experts estimate that between 60 to 70 percent of all inpatients with serious mental illness also have a co-occurring substance abuse problem, Dr. Pichitino added.

This high incidence led state mental health facilities to rethink their policies, said Kenny Dudley, TXMHMR director of Mental Health Facilities. "We learned that you have to take into consideration their substance abuse problems. You can't separate the two."

"We aren't treating people with single diagnoses," Dudley said. "More than half of the people we're seeing with mental disorders also have a substance abuse problem."

In 1997, Dr. Pichitino and TXMHMR Board Member Rodolfo Arredondo Jr., Ed.D., began working on initiatives to provide integrated treatment programming at BSSH. The Mental Illness/Substance Abuse Treatment Program Pilot was developed as a Performance Improvement Project.

BSSH's program will serve as a model for the other seven state mental health facilities in designing treatment programs for patients with co-occurring disorders. An implementation plan for treating patients with Co-occurring Psychiatric and Substance Disorders (COPSD) now has been developed for use across the State Mental Health Facilities System.

Treating both disorders in conjunction

with each other is the only way to tackle the problem, according to Dr. Pichitino. "Some people drink when they get depressed. Since alcohol is a depressant, they then get more depressed. This cycle continues."

People who live with the hardship of mental illness often use substances, such as alcohol or drugs to feel better and cope with their disease. As they attempt to self-medicate themselves, their behavior often becomes more destructive.

"If we keep feelings bottled up, we sometimes don't know how to deal with them without smoking or drinking," Porch said. "I try to suggest other ways for them to deal with their feelings, such as listening to music, keeping a journal, talking to others. Just any way that helps us express our feelings in a positive way."

During one session, Porch urged the patients to use imagery to help themselves feel stronger when tempted. A welder talked about his pride in capping off wells; another patient talked about his love for fishing.

"At some point, you have to stop and go the other way and say, I've had enough," another patient says.

Dr. Pichitino said another serious side effect of not treating the two diseases simultaneously is the adverse problem substance abuse can have when combined with medications used to treat the mental illness.

"These patients present many complex problems and issues," he added. "When we care for them at the hospital, we have to help them learn better ways to cope with their dependency on substances."

During group sessions at BSSH, Porch leads patients on a discussion of how they will handle themselves when they go back home.

"What's going to happen when you leave and you start hanging out with your old crowd?" she asks the group, encouraging discussion. "What if they want to light up a joint or go drinking? What will you do? How can you avoid that situation?"

"Even if the person was committed to sobriety, having a mental illness may affect their judgment," Dr. Pichitino said. "They may hook up with people doing drugs."

He added that another reason it's important to treat people with co-occurring disorders is because they are much more likely to become violent when using. In most cases, persons with mental illnesses are not violent individuals.

> ***"Some people drink when they get depressed. Since alcohol is a depressant, they then get more depressed. This cycle continues."***
>
> *— John Pichitino, Ph.D., chief psychologist, Big Spring State Hospital*

Dr. Pichitino emphasized that once patients leave and resume their lives off the grounds of the state mental health facility, they must rethink with whom they can associate or risk falling into the same old habits. The problem is a lifetime one for most of the people living with co-occurring disorders. The team treating these patients must adopt a long-term perspective on treatment, because these patients are highly susceptible to relapse.

"Recovery is slow and characterized by frequent relapses," Dr. Pichitino added. "We really work on building their self-esteem, accepting them as they are, and instilling hope for a better life."

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*Contributed by Valerie Avery, public information coordinator for Big Spring State Hospital, (915) 264-0403.*

# DUAL DIAGNOSIS—
# Co-Occurring Mental Retardation and Mental Illness Disorders

All individuals desire to have the elements of good mental health—emotional well-being and rewarding social and interpersonal relationships. This fact of life is true of persons with mental retardation and developmental disabilities, just as it is true of individuals who do not have these disabilities.

In the past, mental illness was sometimes looked upon as an untreatable byproduct of a person's mental retardation. Today, while a person's mental illness still tends to be overshadowed by a primary diagnosis of mental retardation, the two are looked upon as separate. A dual diagnosis presents a unique challenge to service providers. Treatments for mental illness include psychopharmacology (medication); counseling/psychotherapy; cognitive therapy; behavior management; social skills training; and activity therapy.

*Mental illnesses in individuals with mental retardation are thought to be caused by a variety of biological and psychological factors.*

Since the early 1990s, TXMHMR and state facilities, community MHMR centers, and Medicaid programs have worked to develop appropriate services and supports to address the needs of individuals affected by dual diagnoses of mental retardation and mental illness. These efforts include specialized medication and diagnostic clinics, therapy programs, specialized residential services, and utilization of rehabilitation services.

Mental illnesses in individuals with mental retardation are thought to be caused by a variety of biological and psychological factors. Just as there are more than 200 known causes of mental retardation, there are many causes of mental illnesses. Some disorders may be entirely or mostly caused by biochemical and structural abnormalities in the brain. Other disorders may be rooted in psychological factors, such as prolonged exposure to negative social conditions. A person may develop a mental illness as a means of 'coping' with the negative public attitudes that he or she, as an individual with mental retardation, encounters on a regular basis.

The most common types of mental illness seen in individuals with mental retardation include personality disorders (long-term problems in adjustment); psychotic disorders (gross deterioration in behavior from previous levels); affective disorders (disturbances in mood); anxiety disorders (excessive fears); severe behavior problem (chronic aggression or antisocial or self-injurious behavior); avoidant disorder (avoiding peers for fear of rejection); and paranoid personality disorder (suspicion of others).

Mental illnesses in persons with mental retardation are much more prevalent in adults than in children aged 10 and under. Demand for mental health services for persons with mental retardation is highest among adolescents and young adults aged 15 to 30.

Individuals with mental retardation can have mental illnesses, just like individuals without mental retardation—and, with proper treatment, they can enjoy rich and fulfilling emotional lives.

# D U A L D I A G N O S I S—
# Co-Occurring Mental Retardation and Mental Illness Disorders

## Corpus Christi State School
### *Enabling consumers to enjoy rewarding lives*

Texans who are diagnosed with both mental illness and mental retardation present a unique set of challenges to MHMR facilities. Many of these individuals have received effective services through the Angelfish Dorm at the Tropical Unit of Corpus Christi State School (CCS).

One of the winners of five 1997 Showcase Awards—recognizing teams throughout the TXMHMR system that exemplify the key elements of the vision for mental health and mental retardation—the CCS program provides intensive structure in a level system that enables consumers to move into less structured environments. Angelfish is the most structured of five dorms at CCS; the others are Sailfish, Pompano, Dolphin and Porpoise (a female dormitory).

CCS began the program in 1995 with the admission of 15 men from Vernon and San Antonio State Hospitals and Mexia State School. The men were moved into the high-security Angelfish Dorm, which had been made available for alternate use through declining census.

The Angelfish residents had spent most of their lives in and out of state hospitals. The staff's first priority was stabilization of their mental conditions.

"The first thing we always want to focus on is to get an accurate diagnosis and to find out what the symptoms are that the individual is having difficulty with," said John Guerra, CCS psychologist, who started the program with fellow staff member David Jones, QMRP.

"We spend a tremendous amount of time trying to find the right medications or the right combination of medications that will help the individual to stabilize," added Guerra.

The program's structure sets expectations for individuals according to their abilities and special needs. The consumers work together to develop house rules and sign contracts agreeing to eliminate or minimize certain behaviors. A point system based on each individual's personal traits and goals also encourages new behaviors and modifies non-compliant ones. Consumers can earn points daily and bank them or redeem them at the end of the week for snacks and other rewards.

Once their symptoms stabilize and they start meeting the terms of their contracts, most consumers are able to socialize, go out in the community under supervision, and perform some type of work for income.

"As they become more and more able to keep their behavior under control, they gain more freedom and move to less restrictive dorms," said Everett Bush, unit director for the CSS Tropical Unit. "Residents of Dolphin Dorm, the most open dorm on campus, go to work on their own everyday. As the consumers progress, they eventually become candidates for community placement in group homes. We don't move them until they're ready."

> ***"The first thing we always want to focus on is to get an accurate diagnosis and to find out what the symptoms are that the individual is having difficulty with."***
>
> *— John Guerra, psychologist, Corpus Christi State School*

The consumers engage in 20 hours of recreation a week. Activities include fishing, basketball, golf, involvement in Special Olympics and, recently, a client fashion show.

The program features therapeutic sessions in such areas as anger management, as

*continued on page 30*

## San Angelo State School

### *Staff works with consumers, families to provide effective treatment*

San Angelo State School (SGS) serves a population of people with mental retardation and a concurrent diagnosis of mental illness. Admission data indicates that the trend toward an increasing percentage of consumers with dual diagnoses will continue. In the past three years, 97 percent of people were receiving psychoactive medication at the time of admission, and 76 percent came directly from a state mental health facility. It no longer is unusual for newly admitted residents to have charges pressed for various offenses, to be on probation, or to still have charges pending. These people require specialized services.

Because of the willingness of the SGS administration to accept the challenge of developing dual diagnosis treatment the mental retardation facility now serves the largest number of individuals with dual diagnoses in Texas.

In November 2000, SGS staff members Mike Dotson and Wendy Powell presented a workshop titled "Family Connections Project: A Model for Those with a Dual Diagnosis and a Legal History" before an international audience at the National Association for Dual Diagnosis (NADD) 17th Annual Conference in San Francisco. The workshop was based on a training program Dotson and Powell developed in 1999 after they attended the NADD 15th Annual Conference. The knowledge they gained at that conference led them to create new cutting edge services for individuals at SGS.

It has long been established that the family is one of the strongest influences in a person's life and that family members of consumers with dual diagnoses play a critical role in the prevention of relapse and continued successful placement in the community. Unfortunately, needed training and education opportunities either have not been accessible or not geared specifically to the needs of families or caregivers. Dotson and Powell's Family Connections Project seeks to fill this void by bringing relevant, up-to-date training opportunities to the people needing them most. The project seeks to empower families of those with a dual diagnosis and a criminal background. Powell, a social worker and team leader, sees the team as one that forges partnerships with families through ongoing training and support in order to enable them to support individuals in relapse prevention.

The Family Connections Project team assists the client in transitioning back into the community and arms individuals and their families and friends with the skills to avoid relapse and assume more active roles in the continuum of care. Training sessions for families and other support systems include general and specific education and information about mental retardation and mental illness. Topics include, but are not limited to, medication, supervision, court commitments, legal involvement, competency, coping, and problem-solving.

Dotson, a psychologist and director of SGS's intensive behavior therapy program Specialized Treatment and Consulting Services (STACS), has developed an innovative new program at SGS called The Success Center. It works on building new skills and enhancing existing skills through a variety of treatment modalities, including art therapy, cognitive therapy, role-playing, problem-solving, and group therapy. Residents with dual diagnoses attend group and individual sessions and classes at the center nearly every day. The Success Center's "Stop and Think" philosophy has been incorporated into the clients' daily vocabulary, and they are using it to make changes in their approaches to life's daily frustrations.

With the experiences from NADD still fresh in their minds, Dotson and Powell

decided to return to the organization's annual conference in 2000. Believing that it is as good to give as to receive, they submitted a proposal reflecting the new services SGS is providing to families. NADD accepted the proposal and added it to the curriculum for the 17th Annual Conference. Dotson and Powell then conducted training sessions and wrote articles for inclusion in the conference proceedings.

While the training for family members is conducted in a manner that is easy to relate to by non-clinicians, Dotson and Powell presented it as a program model at the NADD conference. Defining relapse prevention as it relates to those with a dual diagnosis, and how this works in tandem with family involvement and education, also was one of the presentation's objectives. Dotson and Powell hope that many at the conference will adapt the program into a model for use in their own facilities or centers.

*Contributed by San Angelo State School staff members Mike Dotson, psychologist and director of Specialized Treatment and Consulting Services, and Wendy Powell, social worker/Family Connections Project team leader, (915) 465-2669.*

## MHMR Authority of Harris County
## *ADAPT Program aims to strengthen individuals*

MENTAL HEALTH · MENTAL RETARDATION
AUTHORITY OF HARRIS COUNTY

To assist consumers in developing coping and self-management skills and accessing community resources needed to learn, work and live as contributing members of the community. That is the goal of the Adult Developmental and Psychiatric Treatment (ADAPT) Program of MHMR Authority of Harris County.

ADAPT is a rehabilitative day treatment program for adults with dual diagnoses of mental retardation and mental illness. Day treatment is a structured schedule of therapeutic activities designed to help each consumer better understand his or her psychiatric conditions and develop skills to maintain stable behavior in various community settings. The schedule alternates group therapy, individual therapy, and social skills training and practice, while continually reassessing a person's progress toward their individual goals.

ADAPT's treatment interventions are uniquely designed to meet the needs of adults who are experiencing behavioral and emotional problems that impede their daily life, work, relationships or physical wellness. The therapeutic plan of care allows options for continuous treatment and transitional planning based upon each individual's personal growth.

"Our program includes the consumer and their family and support network in their treatment planning. We offer a safe and therapeutic environment and an array of services to aid in the achievement of meaningful goals," said Maria C. Quintero, Ph.D., department head. "We aim to help the individual feel the sense of dignity, satisfaction and self-respect that comes from living a productive life of his or her choice."

ADAPT's outcome data speaks for itself. The average hospitalization of individuals six months prior to enrolling in ADAPT is 31.4 days; their average hospitalization six months after their ADAPT participation is just six days.

Involvement in ADAPT continues as long as the individual demonstrates progress and rehabilitative services are deemed necessary by the physician and the interdisciplinary treatment team. The next setting may be work, social activities or other options agreed upon by the consumer, legal representatives and treatment team members.

*For more information on ADAPT, call (713) 970-4510.*

# Gardens provide safe, healing environment

Remember the thrill as a child of going to a playground? Remember the rejuvenating feeling when you travel down a winding trail, communing with nature? Notice how good it feels to get out in the sunshine (unless it's late August in Texas and 112 degrees in the shade)?

More and more facilities throughout the United States and other countries are recognizing the need for individuals with disabilities to have calming, nurturing environments where they can spend part of each day. Not only are "healing gardens," as they are sometimes called, beneficial for individuals with mental illnesses, they also aid the emotional wellness of individuals with mental retardation or those with dual diagnosis of mental illness and mental retardation.

At Richmond State School (RSS), staff and family members saw the need for a garden area to provide multi-sensory experiences to consumers whose severe handicaps interfere with their ability to experience nature. In response to this need, RSS is building an Outdoor Therapeutic Center on 1.5 acres of the campus. The center will be easily accessible to the 400 individuals with multiple disabilities who live in four surrounding homes—Leon, Neches, Trinity and San Antonio. The center's construction was approved in August 2000 by the TXMHMR Board of Directors Business and Asset Management Committee.

"The center has been a dream of the parents and staff at RSS for an entire decade," said Sandra Rider Perdue, RSS public information officer. "They began preliminary concept documents back in 1990, and it truly is thrilling that it has come to fruition."

The RSS Volunteer Services Council (VSC), which helped to fund the project through sales of inscribed bricks that will be used to pave the site, designed the center around a 2,500-square-foot gazebo that will provide shade and be accessible to people with a wide range of disabilities. All the nature paths and gardens in the center will be wheelchair accessible. The landscape will enable visitors to participate in much-needed exercise programs and provide a variety of sensory experiences, many of which can be activated by the visitor. Special features include elevated herb and flower gardens, sound systems that can provide nature sounds or soothing music when activated by an individual, and water mist systems that can be turned on by motion or switches.

The center was designed by a number of architects, engineers and professional designers, led by Don Carter, AIA, and Louise Nicholson Carter, IIDA, of Carter Design Associates. The Carters are active volunteers at the school, and Louise serves on the VSC Board. Also involved in the project are John Garner of Garner Engineering & Consulting, and Earl Broussard and Bill Odle of TBG of Austin. All of the participants in the project are volunteering their time and donating their professional fees.

"The center will provide a pleasant social setting where people can learn to meet and greet one another," said Perdue. "It also will give each individual what a person with severe disabilities often lacks—the opportunity to make choices and to control one's own surroundings."

To help fund the Healing Garden Project at Austin State Hospital (ASH), the mental health facility's VSC also is selling inscribed paving stones, as well as using grant funds, community donations and fund raising proceeds. The TXMHMR Board of Directors Business and Asset Management Committee approved construction of the garden in March 2000.

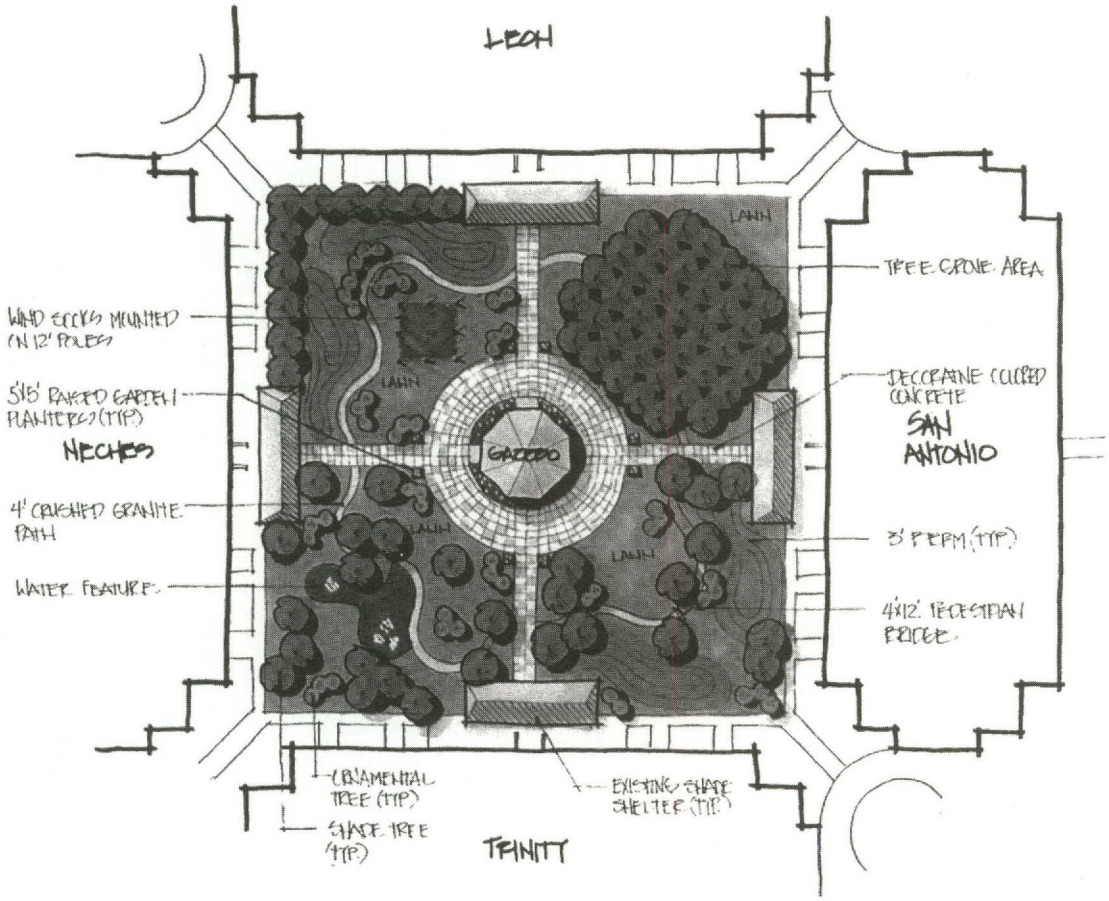
The Healing Garden, expected to be developed in 2001 at the ASH Specialty Services Unit, will include a safe wandering path, people-friendly plants and trees, a water feature, multi-purpose gathering space, planter area, seating area, small group gathering area, and family visiting area. The ASH Special Services Unit includes the Trinity Treatment Center (patients with mental illness and mental retardation), the Geriatrics Unit, and the Center for the Deaf.

"Some patients on the Geriatrics ward are unable to enjoy the outdoors due to the extent of their illnesses," said Carla Daws, former director of Community Relations at ASH. "The Healing Garden will be an outdoor sanctuary for the patients to walk through independently. The garden, which will be open to all ASH patients, also will provide a beautiful setting for family and friends to visit."

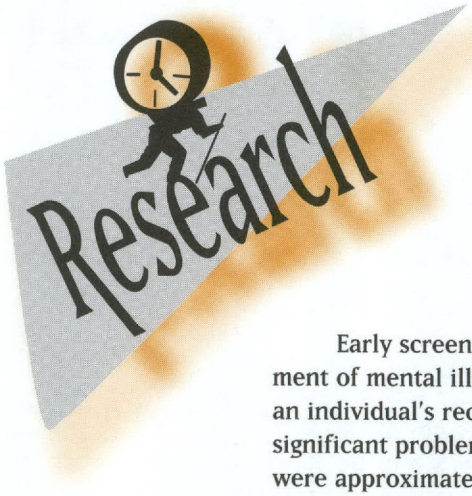
The design of the garden was conducted by Texas A&M University, College of Architecture, Department of Landscape Architecture & Urban Planning. A number of Austin groups and garden clubs assisted in the design and will be involved in the development and maintenance of the garden.

Daws stressed that there has been only limited research on the positive impact of healing gardens on persons with mental illnesses. "We hope that data collected once the garden is completed will benefit other mental health facilities in establishing their own gardens." —*NB*

*Outdoor Therapeutic Center*
*Richmond State School*




*For additional information on the Outdoor Therapeutic Center at Richmond State School, contact Sandra Rider Perdue at (281) 344-4335. For more information on the Healing Garden Project at Austin State School, call (512) 419-2333.*




## *Early screening and detection aid in recovery from mental illness*

Early screening, detection and treatment of mental illness is very important to an individual's recovery. Mental illness is a significant problem in Texas. In 1999, there were approximately 2.94 million Texans—nearly one in six people—with some form of mental illness. Nationally, about 20 percent of Americans are believed to experience a mental disorder every year.

According to *Mental Health: A Report of the Surgeon General*, issued by U.S. Surgeon General David Satcher in December 1999, early screening, detection and treatment of mental health disorders is essential. The earlier a person with a disorder obtains treatment, the greater his or her opportunity to live a full and complete life.

The report notes, "The single, explicit recommendation of the report is to seek help if you have a mental health problem or think you have symptoms of a mental disorder. Individuals should be encouraged to seek help from any source in which they have confidence. If they do not improve with the help obtained initially, they should be encouraged to keep trying to obtain assistance."

The surgeon general's report underscored the need for early screening, detection and treatment of mental illness when it cited a study by the World Health Organization. This mid-1990s study, conducted in collaboration with the World Bank and Harvard University, attempted to determine the "burden of disability" associated with the whole range of diseases and health conditions suffered by peoples throughout the world.

The study showed that in the United States, mental illness is the second leading cause of disability and premature mortality, finishing behind only cardiovascular conditions but ahead of cancer, respiratory conditions, alcohol and drug abuse.—*JM*

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*Adapted from the article "Early screening and detection aid in recovery from mental illness," published in the October 2000 issue of In Touch, a publication for the employees of TXMHMR Central Office.*

## *Presidential Task Force on Employment of Adults with Disabilities*

Access this web site for a vast array of resources for individuals with disabilities, including information about health, housing, education, transportation, recreation and employment. The site also features new Employers' Resource and Media Resource sections.

**www.disAbility.gov**

# Peace officer program grants awarded

In October 2000, TXMHMR awarded grants totaling $300,000 for development of Mental Health Peace Officer Programs in 112 Texas counties.

During the 76th Session, Texas legislators mandated that TXMHMR assist counties in developing Mental Health Peace Officer Programs through a one-time grant program. These grants will assist local law enforcement agencies with initial start-up costs, officer training costs, and other expenses associated with establishing a Mental Health Peace Officer Program.

"Mental health deputies are a tremendous asset to the community, supporting community MHMR centers in their responsibility to respond to mental health crises," said Sam Shore, director of TXMHMR Behavioral Health Services.

Grants were awarded to the following 16 single and multiple county applicants:

- **Brown County Sheriff's' Department**—covering six counties (see related article on pages 22-23);
- **Coastal Bend Council of Government**—covering 12 counties;
- **County of Uvalde**—covering five counties;
- **East Texas Behavioral Healthcare Network**—covering 23 counties;
- **Garza County Sheriff's Office**—covering three counties;
- **Hale County Sheriff's Department**—covering one county;
- **Johnson County Sheriff's Department**—covering one county;
- **Lamar County**—covering three counties;
- **Milam County Sheriff's Department**—covering two counties;
- **Nortex Regional Planning Commission**—covering 11 counties;
- **Palo Pinto County Sheriff's Department**—covering one county;
- **Panhandle Regional Planning Commission**—covering 23 counties;
- **Southeast Texas Regional Planning Commission**—covering three counties;
- **Texoma County of Governments**—covering three counties;
- **Titus County Sheriff's Department**—covering one county; and
- **West Central Texas Council of Government**—covering 15 counties.

To receive the grants, the applicants had to have jurisdiction exceeding 50 miles from a state hospital designated by TXMHMR to receive individuals under mental health commitments and emergency **or** be located within 50 miles of a state hospital that is predominantly rural and does not have trained mental health peace officers, and submit an application in conjunction with other counties outside the 50-mile radius.

"The agency gave highest priority to multiple county applicants who demonstrated the cost-effective benefits of providing program or training activities over a large geographic area," said Shore. "Successful applicants demonstrated collaboration and cooperation among elected public officials, law enforcement officers, and local mental health authorities."

> ***"Mental health deputies are a tremendous asset to the community, supporting community MHMR centers in their responsibility to respond to mental health crises."***
>
> *— Sam Shore, director of TXMHMR Behavioral Health Services.*

The funding period for the grants is Sept. 1, 2000 through Aug. 31, 2001.

"We at TXMHMR aim to report positive impact of general revenue funds upon the

*continued on next page*

*Central Texas MHMR Center*

# Program helps ensure safety, aids law enforcement's outreach to consumers

With decreases in funding, Central Texas MHMR Center (CTMHMR) in Brownwood has been challenged with the opportunity to be creative in service delivery.

Working at a rural mental health center and having the charge to serve individuals in their natural environment, at times, puts caseworkers in less than safe situations. Some individuals served are in remote areas where there are limited or no communication signals available. By teaming up with the Brown County Sheriff's Office, the center has been able to present law enforcement in a positive light to consumers while ensuring the safety of all involved.

After receiving positive feedback from consumers and the community, center staff decided to take this collaboration to the next level. With complete support from Glen Smith, Brown County sheriff, the center was able to contract with four off-duty Brown County deputies. Each of these mental health deputy techs, who have given up personal time to take on this joint project, works with several individuals on a frequent basis. Some individuals require visits two to three times per week, while others may only need weekly contact. These contacts usually occur after center business hours when these individuals would tend to isolate.

Initially, this Mental Health Peace Officer Program was intended to provide more frequent contacts with clients who have difficulty in many areas of their daily lives. The program is designed to meet the individual in his or her environment and to provide individualized training and support to enhance quality of life. Training is provided in medication monitoring, personal hygiene, socialization, budgeting, and other activities of daily living.

The criteria for being referred to the program are as follows: an active adult client of MHMR, a frequent user of crisis services, being in need of more frequent visits, need for medication monitoring, and other skills of daily living. These individuals have a history of psychiatric hospitalizations and non-compliance with medication. They frequently come to the attention of law enforcement. CTMHMR hopes to offer this program to adolescents in the future.

The program has been successful in keeping individuals out of the hospital and reducing the trauma that is experienced as a result of being hospitalized. It also has allowed CTMHMR to re-direct funding formerly used for hospitalizations to provide more quality services for individuals in their own community. The program operates in Coleman County and will

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*MH Peace Officers, continued from page 21*

development of Mental Health Peace Officer Programs that will better serve Texans," said Rod Swan, TXMHMR Supported Housing/ACT coordinator. "Halfway through the funding period, in March 2001, the grant recipients will be required to complete a one-page progress report. Upon completion of the funding period, in October 2001, the recipients will submit a summary report that will help the agency present program outcomes."

"Mental Health Peace Officer Programs already in operation have proven highly effective in increasing the respect and dignity afforded to individuals in mental health crisis by law enforcement," said Shore. "A strong and supportive relationship between local law enforcement and the local mental health authority is critical to the establishment of an effective Mental Health Peace Officer Program."

Swan added that the grants are an incentive to get Mental Health Peace Officer Programs started throughout the state. "Our main priority was to get a maximum number of officers involved with the money we had available."

be up and running in Eastland and Comanche counties by May 2001.

The first individual to participate in the program is an individual diagnosed with Schizoaffective Disorder; Bipolar Type. He has come to the attention of law enforcement numerous times and has been hospitalized 17 times with the most recent times being in August, September and November 1999. He has a history of aggressive behavior towards law enforcement, homelessness, alcoholism and medication non-compliance. This consumer benefits minimally from hospitalization, as he requires more than medication. He needs the added support from the deputies a couple of times weekly. From them, he receives continuous encouragement and assistance. Since inception of the program, he has had disability benefits reinstated and has obtained and maintained his own housing. He is medication compliant, gets to the clinic on his own for his injections, and looks forward to his frequent contact with his assigned deputy tech.

CTMHMR staff Lynn Glover, service coordinator, and Kim Cruz, program manager, and Brown County Sheriff's Office staff members Glen Smith, Rusty Forbes and Tony Aaron have provided mental health training to deputies in Coleman, McCulloch, Comanche and San Saba counties. Training also has been completed for officers at the Brownwood Police Department and deputies in Eastland and Mills counties.

Due to the many inquiries and the interest other centers have shown in the program, CTMHMR will provide information and technical assistance upon request. Individuals wishing to receive more information on the program can contact Kim Cruz at (915) 641-0642, ext. 283.

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*This article was contributed by Kim Cruz.*

*Photo by Gene Deason of the Brownwood Bulletin*

*Participants in the Mental Health Peace Officer Program at the Brown County Sheriff's Department and Central Texas MHMR Center include (left to right) Kim Cruz, CTMHMR program manager; Brown County Sheriff Glen Smith; Lynn Glover, CTMHMR service coordinator; Tony Aaron, deputy; Tracy Blair, CTMHMR crisis worker; and David Mercer, deputy.*

*Gulf Coast Center*

# Innovative programs increase independence of people with mental illness

***"Jimmy" is a client of the Gulf Coast Center, Galveston and Brazoria counties' mental health and mental retardation authority. He receives services from the center's Supported Housing program, which has the primary goal to reduce homelessness among adults with a mental illness while facilitating successful independent living and community membership.***

Jimmy has a long history of paranoid schizophrenia, which was further complicated when he self-medicated with illegal substances and experienced several incidences of homelessness. Two years ago, he was discharged from Supported Housing due to lack of motivation to stop using illegal substances. This discharge resulted in homelessness, which led to his desire to gain sobriety.

Through self-determination and assistance from the Gulf Coast Center, Jimmy has made significant strides in improving his life. He entered the Supported Housing program a second time after attaining one year of sobriety through the help of local residential chemical dependency treatment facilities. Staff described Jimmy as having a new outlook on life during this second admission. This new attitude allowed the new start he was in search of and resulted in a much more therapeutic working relationship with the Supported Housing program.

Supported Housing provides a team approach to community mental health treatment. The team is comprised of mental health professionals who serve adults suffering from severe mental illness and who also are homeless or at risk of homelessness. The program provides rehabilitative treatment to assist clients in securing and maintaining safe, clean and sanitary housing of their choice. Rehabilitative treatment is individualized and includes support provisions for independent living. In addition, a rental subsidy is provided through grant funding allowing more affordable housing, since most clients earn below $665 per month.

Staff members visited Jimmy at his home several times each week to support this new beginning; however, a consistent challenge continued to emerge. The medication to treat Jimmy's mental illness did not seem to be working. Staff felt this was due to how inconsistently he was remembering to take each dose. They feared he would relapse into self-medicating if his medication could not reach the right level. Jimmy understood the importance of his medication and the necessity to take each dose consistently, yet he was unable to follow the complex regimen prescribed by his doctor.

The staff had heard of a medication dispenser designed for individuals experiencing similar challenges; however, the dispenser cost $394. The expense of something so unique was not affordable to Jimmy due to his limited income. Staff suggested that Jimmy complete and submit an application to In-Home and Family Support (IHFS) for funds to purchase the medication dispenser.

IHFS, a legislated program administered locally by the Gulf Coast Center, was

created to grant funds to individuals with mental disabilities who are not financially eligible for Supplemental Security Income (SSI). IHFS applicants such as Jimmy are eligible for up to $3,600 per fiscal year. In addition, there is also a one-time only grant of up to $3,600 that can only be used for purchases of specialized equipment or architectural modifications to the home. Not everyone receives the full $3,600. Grant amounts and their terms are determined through negotiations by the applicant and IHFS staff. The amount funded reflects what is necessary to address an individual's particular needs or situation.

IHFS is designed to help consumers purchase goods or services that are required because of their disability, but for which no other resource exists. The program requires that funds be used to support the person in living independently in their own home rather than in a more restrictive setting at a higher cost.

Jimmy's request was clearly appropriate for funding, as it fit both IHFS criteria. Not only was no other resource available to help with the purchase of the dispenser, but without it, Jimmy was clearly at risk for a relapse and hospitalization. IHFS staff approved the application almost immediately and developed a plan of support obligating the funds. A check was cut, and the medication dispenser was ordered within two weeks.

Lisa Gall, R.N., of Supported Housing was the first to assist Jimmy in programming the medication dispenser for his exact medication regimen. Gall saw immediate results from use of the dispenser. "Jimmy was not missing any dosages, where as before, he was missing up to seven doses per week," said Gall. "An alarm goes off on the machine at 6 a.m. and 8 p.m. alerting Jimmy to take his pills. He has to turn the machine upside down and take the pills out before the alarm will turn off."

Jimmy's treating psychiatrist, Michael Fuller, M.D., also praises the device and indicates other benefits. Dr. Fuller, a psychiatric consultant to the Gulf Coast Center and a full-time faculty member with The University of Texas Medical Branch at Galveston, explained, "By definition, our clients have severe psychiatric illnesses. Many of our patients are on very complex medication schedules and suffer from illnesses further degrading their ability to take medication reliably.

"The automated dose dispenser became available only recently," Dr. Fuller continued, "The treatment team hopes it will enable Jimmy and many other patients to require less direct supervision in taking their medications and give treatment providers a more accurate means of documenting the success of each client's medication compliance. It certainly is a tool that is welcomed and has been long awaited. This device probably pays for itself within a two-week period."

***Jimmy has a long history of paranoid schizophrenia, which was further complicated when he self-medicated with illegal substances and experienced several incidences of homelessness.***

The machine has decreased the magnitude of Jimmy's psychiatric symptoms, reduced incidences of hospitalization for mental illness, and helped him maintain a higher level of independence and dignity, which further affirms the cost-effectiveness of the dispenser made possible through IHFS and work of the Supported Housing team.

For more information about the Gulf Coast Center and its programs or for intake, call (800) 643-0967. For additional information or to determine eligibility for IHFS, call (800) 499-1154.

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*Contributed by Cheryl Robinson, director of Community Relations at the Gulf Coast Center, (409) 763-2373.*

# Stigma inhibits mental health recovery efforts

Mental disorders, in any given year, affect as many as 50 million Americans, but only 25 percent of these individuals seek help. A major factor that keeps people from getting the treatment they need is stigma.

Stigma is about disrespect and the use of negative labels to identify a person living with mental illness; it is not just the use of the wrong word or action. Stigma is a barrier and discourages individuals and their families from seeking treatment due to the fear of being discriminated against. Many people don't seek help because they fear being labeled as "mentally ill" or "crazy." In many cases, stigma results in families and friends turning their backs on people with mental illnesses.

Persons with mental illnesses often have to deal with the fear and mistrust of others, especially because individuals with mental illnesses are frequently portrayed in the media as violent. Violence against people with mental illnesses is not uncommon.

### *NIMBY in the workplace and community*

With the passage of the Americans with Disabilities Act (ADA) a decade ago, discrimination in the workplace against individuals with mental illnesses finally was declared illegal. Under ADA, businesses that employ 15 or more people are prohibited from discriminating against a qualified candidate on the basis of his or her disability—including mental illness. Businesses must make reasonable accommodations—such as adapting training materials and providing flexible work schedules or routines—for qualified people with disabilities.

In spite of ADA, stigma continues to prevent people with mental illnesses from getting good jobs, and, in many cases, individuals who seek mental health treatment are prevented from advancing in their careers. People are deterred from fulfilling their roles in society as employees, community members and neighbors due to the Not in My Backyard (NIMBY) syndrome.

For many individuals, NIMBY makes it impossible for them to obtain the vital ingredient in recovering from their mental illness—that of being treated as a normal person in a normal environment.

A national survey by DYG Incorporated for the Robert Wood Johnson Foundation Program on Chronic Mental Illness uncovered a puzzling paradox. While 31 percent of the 1,300 individuals surveyed said they or a family member had received mental health treatment and 74 percent agreed mental illnesses can be cured, the majority opposed the placement of any type of mental health facility or housing for people with mental illnesses in their own neighborhoods. In short, survey respondents believed that individuals with mental illnesses should live and receive treatment in the community, just not **their** community.

The survey showed NIMBY to be pervasive even though most of the respondents believed that "keeping up a normal life" (including living in the community) promoted recovery in people with mental illnesses. Other findings in the survey: Seven out of 10 respondents strongly believed that "keeping people behind locked doors" is not the best approach to treatment, and two in three respondents acknowledged there is a great deal of stigma attached to people with mental illnesses.

***Many people would rather tell employers they had committed a petty crime and served time in jail, than admit to being in a psychiatric hospital.***

Many groups have begun campaigns to end stigma. Some of them include:

**The National Mental Health Services Knowledge Exchange Network**
P.O. Box 42490
Washington, D.C. 20015
(800) 789-2647
(800) 790-2647 (electronic bulletin board); www.mentalhealth.org

**The Anti-Stigma Project**
3421 Benson Ave., Suite 210A
Baltimore, MD 21227
(800) 704-0262

**National Depressive and Manic Depressive Association**
730 North Franklin St., Suite 501
Chicago, IL 60610; (800) 826-3632
www.ndmda.org

**Erasing the Stigma of Mental Illness Serving Hands International**
4507 Mission Gorge Place
San Diego, CA 92120
(800) 219-4854

**The National Alliance for the Mentally Ill**
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
(800) 950-NAMI or (703) 524-7600
www.nami.org

## Ending the stigma of mental illnesses

The Center for Mental Health Services of the U.S. Department of Health and Human Services recommends six steps to help end the stigma of mental illnesses:

1. Learn more. Many organizations sponsor nationwide programs about mental health and mental illness.
2. Insist on accountable media. Sometimes the media portray people who have mental illnesses inaccurately, and this makes stereotypes harder to change.
3. Obey ADA laws. The ADA prohibits discrimination against people with disabilities in all areas of public life, including housing, employment and public transportation. Mental illnesses are considered a disability covered under the ADA.
4. Recognize and appreciate the contributions to society made by people who have mental illnesses. People who have mental illnesses are major contributors to American life—from the arts to the sciences, from medicine to entertainment to professional sports.
5. Treat people with the dignity and respect we all deserve. People who have mental illnesses may include your friends, your neighbors, and your family.
6. Think about the person—the contents behind the label. Avoid labeling people by their diagnosis. Instead of saying, "She's a schizophrenic," say, "She has a mental illness." Never use the term "mentally ill."

**The National Empowerment Center**
599 Canal St., Lawrence, MA 01840
(800) 769-3728; www.power2u.org

**The National Mental Health Association Information Center**
1021 Prince St., Alexandria, VA 22314-2971
(800) 969-NMHA; www.nmha.org

**The National Mental Health Consumers' Self-Help Clearinghouse**
1211 Chestnut St., Suite 1207
Philadelphia, PA 19107
(800) 553-4539; www.mhselfhelp.org

# TMAP education program aids in mental health recovery

The Texas Medication Algorithm Program (TMAP), a collaborative effort administered by TXMHMR, is designed to implement and evaluate specific guidelines for the medication treatment of schizophrenia, bipolar disorder and major depressive disorder.

To help individuals affected by these disorders, along with their families, TMAP investigators and TXMHMR staff collaborated in the development of the TMAP Patient/Family Education Program. Representatives of the Texas Mental Health Consumers, National Alliance for the Mentally Ill-Texas, Mental Health Association in Texas, and the Depressive/Manic Depressive Association worked with TMAP staff in the program's development.

"Patient and family education can make the difference between treatment success or failure," said Cindy Hopkins, coordinator, TXMHMR Consumer Affairs, and co-chair of the Patient/Advocacy Committee. "If a person does not understand or identify with their diagnosis or why they are taking medication, they are less likely to adhere to treatment, no matter how effective the treatment is."

The education program's three modules—on schizophrenia, bipolar disorder and major depression—each cover such basic information as 1) facts about the disorder; 2) symptom recognition; 3) treatment and recovery; 4) coping skills; and 5) hopes and dreams for the future.

The materials in each treatment module are a combination of a video, written and pictorial information, and group education.

Mental health consumers facilitate group education. Groups discuss issues important to consumers, including adherence to medication, communicating with physicians, medication side effects and strengthening family connections. All materials, including videos, have been translated into Spanish.

More information about the TMAP Patient/Family Education Program is provided at the TMAP web site at http://www.mhmr.state.tx.us/meds/tmap.htm., or call (512) 206-5465.—*JM*

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*Adapted from the article "TMAP Patient/Family Education Program Aids in the Recovery from Mental Illness," published in the October 1999 issue of In Touch, a publication for the employees of TXMHMR Central Office.*

***"Patient and family education can make the difference between treatment success or failure."***

*— Cindy Hopkins, coordinator, TXMHMR Consumer Affairs, and co-chair of the Patient/Advocacy Committee*


*For more information on the programs discussed in this issue of* Impact, *contact the organizations below.*

**Resources in Texas:**

**TXMHMR Behavioral Health Services**
—Texas Psychiatric Rehabilitation Toolkit
—Supported Employment
—Assertive Community Treatment
—Co-Occurring Mental Illness and Substance Abuse Disorders
P.O. Box 12668, Austin 78711-2668
(512) 206-4533

**TXMHMR Long Term Services & Supports**
—Co-Occurring Mental Retardation and Mental Illness Disorders
P.O. Box 12668, Austin 78711-2668
(512) 206-4537

**TXMHMR Office of the Medical Director**
—TMAP Patient/Family Education Program
P.O. Box 12668, Austin 78711-2668
(512) 206-5465

**Nueces County MHMR Community Center**
1630 S. Brownlee, Corpus Christi 78404-3178
(361) 886-6900

**MHMR Authority of Harris County**
2850 Fannin, Houston 77002
CAPES—(713) 970-7167
MRMI Program—(713) 970-4524
www.mhmraofharriscounty.org

**Burke Center**
4101 S. Medford Dr., Lufkin 75901-5699
(936) 639-1141

**Big Spring State Hospital**
1901 Highway 87 North, Big Spring 79721
(915) 264-0403

**Corpus Christi State School**
P.O. Box 9297, Corpus Christi 78469-9297
(361) 844-7845

**San Angelo State School**
10950 US Hwy. 87 North, Box 38
Carlsbad 76934; (915) 465-2669

**Richmond State School**
2100 Preston, Richmond 77469-1499
(281) 344-4018

**Austin State Hospital**
4110 Guadalupe, Austin 78751-4296
(512) 419-2330;
www.mhmr.state.tx.us/Hospitals/AustinSH/AustinSH.html

**Central Texas MHMR Center**
408 Mulberry, Brownwood 76804
(915) 641-0642, ext. 283

**Gulf Coast Center**
600 E. Hwy. 6, Ste. 400, Galveston 77553-2490
(800) 643-0967

**Recovery Web Sites:**

**Support and Technical Assistance Centers**
National Empowerment Center:
www.power2u.org
National Mental Health Consumer's Self-Help Clearinghouse:
www.mhselfhelp.org
Consumer Organization and Networking Technical Assistance Center:
www.contac.org

**Advocacy Unlimited, Inc./Mindlink**
www.mindlink.org

**Center for Psychiatric Rehabilitation, Boston University**
www.bu.edu/sarpsych

**Mental Health Recovery**
www.mentalhealthrecovery.com

**National Mental Health Association**
www.nmha.org

*Corpus Christi, continued from page 15*
well as training in the legal system for those consumers who have charges against them. Vocational training and locating jobs that match the clients' skill levels also are important to the individuals' therapy, according to Jones.

"If you can teach a man to work and have focus on where he wants to go—give him something meaningful in his life to work towards and that gives him money in his pocket—you build his self-esteem. He feels he is worth something in the world," said Jones.

Even in Angelfish, the most restrictive dorm, all consumers who want jobs have them. "They build furniture and package mop heads and coat hangers, as well as make sandbags through a contract with the Texas Department of Transportation," said Bush.

CSS clients also have found employment in such areas as janitorial services, lawn maintenance, laundry and dishwashing.

Seeing consumers function at their maximum level and living at their optimum level of independence is the program's ultimate goal. For more information, call (361) 844-7845.—*NB*

## *Legal Hotline for Older Texans provides free information*

Are you age 60 or over? If so, the Legal Hotline for Older Texans can provide a wealth of information on consumer issues, housing, public benefits, wills, trusts, taxes, pensions, health, nursing homes and more. The information is free and will be mailed to you.

If you are age 60 or over and your income is low, the Legal Hotline can provide free advice from attorneys on such issues as landlord/tenant disputes and debts. Attorneys also can help low-income callers with such services as powers of attorney, do-not-resuscitate orders, and declarations of guardianship. Call toll-free, **(800) 622-2520**.

# Personal Notes

The disruptive wave of mental illness began to flow over Bobby Baggerman's life when he was 15 years old.

It first reared its ugly head when he drank a cup of coffee in a restaurant when returning from a Florida church youth group trip to his home in San Angelo.

"I felt as if someone put something in my coffee," Baggerman said of the memory 14 years ago that is now seared into his consciousness. "My mom said I was really disoriented. Right after (drinking the coffee), I was paranoid."

Baggerman traveled in and out of high school and hospitals as he struggled with his new way of life. The likable high school football standout would cruise through a school year without a blip on the radar screen, but suddenly the psychotic episodes would punctuate his life, and he would be readmitted for care.

While the newer, more powerful medications helped him live with his illness, it caused a whole new set of problems. "It started giving me hallucinations," Baggerman said. "From 1985 to 1994, I went back and forth on medications and in and out of the hospital."

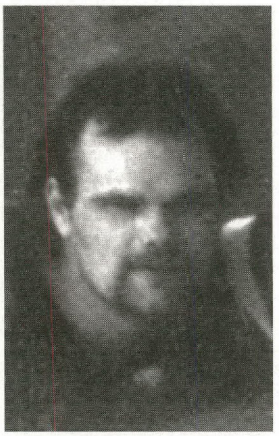
The young adult was admittedly violent during some of his hospitalizations, including the two-year span he was cared for at Big Spring State Hospital in the mid-1990s.

"I was real, real rebellious," Baggerman said from his home in Lubbock, which he shares with his longtime girlfriend, Janet Fuentez. But with a handful of medications that he says "keeps me mellow and keeps me positive" and years of intensive behavioral therapy through Assertive Community Treatment (ACT—see page 32 for more information) at Lubbock Regional MHMR Center, Baggerman finally is satisfied with the control he has over his life.

The 30-year-old monitors his own medications and holds down a full-time shift at a Lubbock cotton gin. But he is most proud of being awarded a $6,500 grant to attend Texas Tech University in the spring. He will major in animal science and minor in agronomy.

"My dad is a ranch foreman in east Texas, and I like working cattle and raising beef. I'd like to be a feedlot manager."

Many people may be surprised at Baggerman's success, but not Mary Jane Phillips, Big Spring State Hospital Patient Rights officer, who has known Baggerman since the early 1990s. They met when Baggerman was referred to her art class, and the two continue to keep in touch through regular phone calls.



*Bobby Baggerman*

"When Bobby would come into the hospital, he was very ill and had to work long and very hard to stabilize before returning to the community," Phillips said. "What stands out in my mind is how he has always been goal-oriented.

"Recently, he purchased a car and told me he volunteers to take his peers to the store," she continued. "He is to be commended for meeting and overcoming a most difficult challenge. When I think of those people I admire, Bobby is on that list. He continually has met the challenges of mental illness with success, and I have never heard him utter a complaint."

Years ago, when mental illness had a vice grip on his life, Baggerman never knew it could be this good.

"I took charge of my life," Baggerman said. "It took me awhile, but I did it."

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*Contributed by Valerie Avery, public information coordinator for Big Spring State Hospital, (915) 264-0403.*

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## *ACT reduces hospital days, helps people stay in community*

Since its start-up in Texas mental health community centers in 1995, Assertive Community Treatment (ACT) has shown phenomenal success in reducing the number of days that individuals with severe and persistent mental illnesses spend in the hospital. Some centers reduced hospital days by as much as 90 percent during their first year of ACT operation.

ACT, which in FY 1999 served 2,778 individuals in the mental health priority population, is designed to provide long-term support to individuals with mental illnesses who have a history of multiple hospitalizations, involvement with the judicial system, or time spent at homeless shelters or community residential homes.

Texas' program represents a system-wide replication of the National Alliance for the Mentally Ill-endorsed Programs for Assertive Community Treatment (PACT) model. (ACT and PACT differ in their staffing standards.) The Schizophrenia Patient Outcomes Research Team has identified ACT as an effective and underutilized treatment modality for persons with serious mental illness. Texas is one of only five states to implement the program statewide.

Most ACT services are provided in the consumer's natural environment; 80 percent of services are provided out of the office. Comprehensive mobile treatment teams comprised of psychiatrists, registered nurses and experts in housing, employment and substance abuse treatment are available 24 hours a day, 365 days a year to address a wide variety of concerns. With this immediate availability of support, consumers are more likely to seek help before a serious crisis occurs.

The ACT teams, which now number approximately 50 throughout the state, maintain a small consumer-to-clinician ratio of no more than 10 consumers to one full-time team member. If hospitalization is necessary, the ACT team coordinates admission and subsequent discharge. The team also provides education and support to consumers' family members.

The program has flourished in the five years since its inception. Current two-year outcome data reflects a 57 percent reduction in hospital bed day utilization, which is consistent with national outcome standards.

For more information on Assertive Community Treatment, see the Winter 2000 issue of *Impact* (pages 14-16) or contact Rod Swan, TXMHMR Supported Housing/ACT coordinator, (512) 206-4533.

***Upcoming Theme***

- Coping, Grief and Hospice Programs

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For additional information on TXMHMR, please refer to our web site:
**http://www.mhmr.state.tx.us**