A DESCRIPTIVE ANALYSIS OF THE RELATIONSHIP WHICH EXISTS BETWEEN BAYSHORE MENTAL HEALTH MENTAL RETARDATION CENTER AND GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT AS A RESULT OF CONSULTATION SERVICES

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CHAPTER I

HISTORICAL AND THEORETICAL FRAMEWORK FOR THE RESEARCH PROBLEM

The Problem Defined

Statement of the problem.--This study defines the relationship that exists, past and present, between the Bayshore Mental Health Mental Retardation Center and the Goose Creek Consolidated Independent School District. Consultation services offered by the Mental Health Center to Special Education Department students in the school district were significant in the historical development of special education services in the school. The problem is stated in the form of a historical descriptive study about the working relationship between these two publically funded institutions--Goose Creek Consolidated Independent School District and Bayshore Mental Health Mental Retardation Center.

Importance of the study.--According to the Joint Commission on Mental Illness and Health there is not a single community in this country which provides an acceptable standard of services for its mentally ill children, running the spectrum from early therapeutic intervention to social restoration in the home, the school and the community.[1] Baytown, Texas, is no exception to this statement. In the limited area of special education in Goose Creek Consolidated Independent School District in the city, 847 case studies were reported to the

[1]National Committee Against Mental Illness, Inc., Report of the Committee, What Are the Facts About Mental Illness? (Washington, D.C., 1966) p. 5.

Texas Education Agency at the end of the school year 1970-71. The case study reports early in the 1971-72 school year revealed that 960 children had special education problems.[2] This study does not include children with serious emotional problems who are totally neglected or who are referred to private psychiatrists. These children need consultation and educational services from professional personnel. Karl Menninger said it well:

> We can help them. We must help them. They need help - that is what their illness means, no matter how disguised. It is a cry for our assistance, and we must know how to answer.[3]

Baytown is one city where public school personnel and mental health personnel have co-operated in consultation and evaluation services since 1968 to assist these children.

Rationale of the study.--Consultation, when applied to the health care process, is considered an indirect service. In mental health systems, consultation and education are considered together to comprise one of the five basic services generic to the National Association of Mental Health concept. Co-ordination and collaboration, diagnosis and treatment, training and research evaluation are the other four services.[4] At the present time consultation and education services are apparently the least understood of all the services. At times the consultative process appears to be relatively straightforward and cognitive and to have much in common with the educative process. At other times, the transference

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[2]W. T. Thomas, interview held in Goose Creek Consolidated Independent School District Special Education Department, February 17, 1972.

[3]National Association for Mental Health, Inc., The NAMH - How We Serve (New York: National Association for Mental Health, 1966), p. 1.

[4]American Psychiatric Association, Planning Psychiatric Services for Children (Washington, D.C.: American Psychiatric Association), p. 13.

aspects of the consultative process are obvious. Often this leads to a feeling of accomplishment and personal growth on the part of the consultee with little impact on the consultee's relationship to either his organization or his client.[5]

Services in consultation provided by the Bayshore Mental Health Mental Retardation Center have been cognitive and therapeutic. They have been cognitive in the analysis of special education problems and therapeutic in the treatment of extreme cases. This study attempts to define the role of consultation services used by Bayshore Mental Health Mental Retardation Center with the Special Education Department of the Goose Creek Independent School District.

As a professional activity, consultation is used in many fields other than the field of mental health. Persons using consultation as a tool include professionals from a variety of disciplines, including psychology, education, social work, behavioral science, psychiatry, nursing, medicine, public health, business and management. In a recently completed reference guide to the consultation literature available, 646 articles were listed and classified, representing the writings of these various groups.[6] These articles reflect the diversity of opinions and practices in the consultation field. This investigation attempts to define educational consultation as one of the practices in the larger field of consultation.

Scope of the problem.--The investigator considered two separate and underlying dynamics in the approach to this problem: the time

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[5]Fortune Mannino and Milton Shore, Consultation Research (Washington, D.C., 1971), p. 1.

[6]Ibid, p. 2.

dimensions and the intent dimension. The time dimension used is historical rather than descriptive or experimental. The intent dimension used is descriptive rather than comparative or evaluative.[7] The thesis, therefore, is an historical description of two publically-funded institutions that work with students who have special emotional and educational needs. An historical survey of the mental health movement and the public school counseling movement placed the problem of the local school district's special education services in perspective. Included in the study is a survey of legislation, theory, and programs from the national to the local level.

Limitations.--There are four limitations in this research: (1) geographical, (2) chronological, (3) structural, (4) subjective.

The project is limited in geography to the Bayshore Mental Health Mental Retardation Center as it relates to the Goose Creek Consolidated Independent School District of Baytown, Texas, even though the mental health program and the public school counseling program operate on national levels.

The chronological limitation defines a brief period in the Baytown community since the development of the Bayshore Mental Health Mental Retardation Center March 12, 1968, to the present status of the program May 31, 1972.

Structural limitations are defined by laws on a national and state level. The mental health program has its primary impetus from Public Law 88-164, Senate Bill 1576, passed by the Eighty-eighth Congress on October 31, 1963. This was a part of the New Frontier Program under

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[7]David J. Fox, The Research Process in Education (New York, 1969), p. 45.

the leadership of President John F. Kennedy and implemented later by his successor, President Lyndon B. Johnson.[8] The special education program is a result of Senate Bill No. 230, passed by the Senate on March 5, 1969, the Texas House on May 6, 1969, and signed by the Governor on June 21, 1969. This bill enacted a program titled Plan A for Special Education in Texas.[9] Research is limited to results of these two laws.

Subjective limitation is a factor in personal interviews. Diverse opinions were expressed about the same event by different individuals. These opinions were analyzed and reported according to the most reliable information available and according to the investigator's interpretation.

Procedures.--The data-collection process used for this research project was predominately personal contact rather than impersonal contact. The investigator followed four steps: (1) interviews, (2) researching historical files, (3) analyzing legislation, (4) reading related literature. Refinement of the outline and narrative material occurred at several stages of writing.

Three personal interviews provided the first data. An initial contact with Don Marler, Director of the Bayshore Mental Health Mental Retardation Center, provided a general over-view of the relationship between the Mental Health Center and the School District. A second interview with W. C. Herring, Director of Curriculum and Guidance, Goose Creek Consolidated Independent School District, added another dimension to the material previously provided by Marler. These two

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[8]Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, 77 Stat. 282 (1963), 88 U.S.C. sec. 164 (1963).

[9]Comprehensive Special Education Act of 1969, Article 2654, Vernon's Civil Statutes, Senate Bill 230, 61st Texas Legislature, (1969).

interviews provided enough information to place the problem of this thesis in perspective. A third interview with Mike Madison, Director of Special Education Department in Goose Creek Consolidated Independent School District, was conducted to gather specific data on the development of special education, specifically the consultation services provided by Bayshore Mental Health Mental Retardation Center.

Once the personal interviews were completed, a second procedure was used to collect data. The investigator gathered specific data from the historical files of the two institutions under consideration--the Bayshore Mental Health Mental Retardation Center and the Special Education Department of the Goose Creek Consolidated Independent School District.

The importance of federal and state legislation became apparent. The third procedure was an investigation of legislation. A great amount of data was contained in the two pieces of legislation that had the most impact on the Mental Health Center consultation services to the school district. Senate Bill 1576, passed October 31, 1963, by the Eighty-eighth Congress of the United States, and Senate Bill 230, passed June 21, 1969, by the Sixty-first Texas Legislature, contain the heart of the program of consultation.

The fourth step in the collection of data was the reading of related literature. Research literature, conceptual literature, and program literature were areas for investigation. A summary of this literature is contained in Chapter II.

Once the personal interviews were completed, the historical files of the two institutions under consideration were investigated, the legislation on federal and state levels was analyzed, and the related literature

was read, the investigator refined the outline and narrative contained in this thesis.

Sources of materials.--Sources of materials for this paper have been derived from two primary instruments: the personal interview with individuals and the historical records from the two institutions under consideration. Documents published by the National Association for Mental Health, the Texas Education Agency, the Statewide Citizens Committee for Mental Health Planning in Texas, the Harris County Mental Health Mental Retardation Center, and the Texas Legislature were of assistance in placing the problem of the paper in historical perspective. Numerical data related to consultation cases by the Bayshore Mental Health Mental Retardation Center for public school students provided the basis for a summary of the co-operation that exists between the two institutions.

Theoretical Framework

Assumptions.--The word "assumption" used in this paper refers to fundamental postulates that are statements of belief taken for granted and assumed to be true whether demonstrably so or not. The investigator used three categories of assumption: (1) philosophical, (2) substantive, (3) procedural.

First, philosophical assumptions underlie all research in this report. One of these assumptions is that national groups are concerned with the welfare of mentally ill children and are dedicated to the provision of the best possible services for their treatment and education. A second philosophical assumption is that every child has the right to an education suited to his needs. Educational services should be provided within the framework of public education systems for these

mentally ill or mentally retarded children. A third philosophical assumption is the belief that consultation can be used in the educational systems. Although mental health consultation may still be struggling for a place beside the various activities of the more traditional mental health functions, it ranks high among the techniques used by community-oriented practitioners. It is a major, if not the major technique and focus of community psychology, community psychiatry, and community mental health.[10]

Second, substantive assumptions are underlying guidelines for a study of consultation. Consultation in the current mental health effort has emerged, not so much as a tool, but as a whole new direction for the field. There is no greater consensus regarding consultation than there is in the field of psychotherapy. In a request for a staffing grant by the Bayshore Mental Health Mental Retardation Center to the United States Department of Health, Education and Welfare, the purpose of consultation with the public school was stated as follows: "The purpose of the proposed consultation and education program is early preventive intervention, to be achieved primarily through support of caretakers."[11]

The basic substantive assumption, therefore, is that local mental health and local school officials are using consultation services for preventive more than curative purposes. Another substantive assumption is that teachers should be trained to deal with mental health problems among children.

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[10]Fortune Mannino and Milton Shore, Consultation on Research, p. 1.

[11]Harris County Mental Health Mental Retardation Center, Board of Trustees, "Application to Federal Department of H.E.W. for Staffing Grant for Task Force Teams for Children of Harris County Area 2," Baytown, 1972, p. 21.

Third, procedural assumptions upon which consultation for the public school is based are directed toward programs and staff. There are three basic programs in the school system where consultation occurs by mental health personnel. These three programs are: (1) the early childhood education program for children with potential learning disabilities, (2) the kindergarten program of the Goose Creek Consolidated Independent School District schools, (3) the elementary school program of the school district. Staff members for these programs are professionals who have been trained in mental health, psychology, and consultation.

Definition of terms.--Definitions are conceptual and functional. Conceptual definitions provide academic concepts while functional definitions state how the concept will be applied in a specific study. This listing contains both conceptual and functional definitions. Mental health, mental retardation and exceptional children are defined conceptually. Consultation, community mental health center and special education are defined functionally.

Since we have no ideal model of man to help distinguish mental health from mental illness, the definition of mental health varies. Attempts to determine what is meant by the term "Mental Health" have been approached from four viewpoints in various writings: direct academic statements, multiple listings of personality traits considered essential to mental health, theoretical views of man's nature and functioning, and research techniques applied to relevant problems concerning man's nature and behavior. "Mental health" in this paper is defined as the National Association for Mental Health defines it:

> Mental health is defined by describing a mentally healthy person. Such a person it is said -- feels comfortable about

> himself...feels right about other people...and is able to meet the demands of life.[12]

"Mental retardation" is a term defined by Heber in a manual of terminology and classification for mental retardation workers. The American Association on Mental Deficiency published the book with the support of the National Institute of Mental Health. Heber defines "mental retardation" as follows:

> Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.[13]

This definition will be used in this paper.

"Consultation" is used in various ways: any professional activity carried out by a specialist, treatment by physician, or professional activity carried out by a highly trained person. Caplan's basic text on consultation, The Theory and Practice of Mental Health Consultation, defines consultation in a narrow sense:

> Consultation is the process of interaction between two professional persons - the consultant, who is a specialist, and the consultee, who invokes the consultant's help in regard to a current work problem with which he is having some difficulty and which he has decided is within the other's area of specialized competency.[14]

This definition by Caplan will be used by the investigator in this paper.

"Community Mental Health Center" is more than a synonym for an outpatient clinic or a new name to describe the regional unit of a state hospital, or a psychiatric unit of a general hospital. It is not a

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[12]R. F. Heber, A Manual on Terminology and Classification in Mental Retardation (Washington, 1961), p. 3.

[13]Gerald Caplan, The Theory and Practice of Mental Health Consultation (New York, 1970), p. 13.

[14]Brewster Smith and Nicholas Hobbs, The Community and the Community Mental Health Center (Washington, 1966), p. 10.

complex of resources housed in a new building. The ideal concept is that of a community mental health program that provides total mental health services to meet the total needs of the community. The center is comprehensive in the sense that it offers, probably not under one roof, a wide range of services, including both direct care of troubled people and consultative, educational and preventive services to the community. According to the administrative regulations issued by the United States Public Health Service, a center must offer five essential services to qualify for federal funds under the Community Mental Health Centers Act of 1963: (1) inpatient care for people who need intensive treatment, (2) outpatient care for adults, children and families, (3) partial hospitalization, (4) emergency care on a twenty-four hour basis, (5) consultation and education to community agencies and professional personnel. The regulations also specify five additional services which together with the five essential ones, complete the comprehensive community mental health center: (1) diagnostic service, (2) rehabilitative service, including both social and vocational rehabilitation, (3) precare and aftercare, (4) training for all types of mental health personnel, (5) research and evaluation concerning the effectiveness of programs and problems of mental illness and its treatment.[15]

"Special education" is defined as follows:

> Special education is the provision of services additional to, supplementary with, or different from those provided in the regular school program by a systematic modification and adaptation of instructional techniques, materials, and equipment to meet the needs of exceptional children.[16]

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[15]American Psychological Association, Inc., The Community and the Mental Health Center (Washington, 1966), p. 10.

[16]Texas Education Agency, Administrative Guide and Handbook for Special Education, 1971 (Austin: Educational Services Center, 1971), p. 2.

"Exceptional children," also referred to as the students of the Special Education Department of the public schools, are children between the ages of three and twenty-one, inclusive, with educational handicaps (physical, mental, emotional, and/or children with language and/or learning disabilities) or specifically defined by the Texas Education Agency as physically handicapped, mentally retarded, emotionally retarded, language and/or learning disabled, pregnant students, speech handicapped and multi-handicapped.[17]

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[17] Ibid., p. 2.

CHAPTER II

REVIEW OF RELATED LITERATURE

Historical Perspective

Consultation in the current mental health effort has emerged, not so much as a tool, but as a whole new direction in the field. Related literature in the field reflects the new direction and the controversy surrounding consultation services.

A survey of the literature about mental health consultation involves a survey of the forces operating in the broad area of mental health activities. Insofar as the theory, practice, and goals of mental health consultation are derived from the practice of psychotherapy, the revolution in therapy that has been occurring over the past fifteen years has been central to the evolution of community mental health practices.

Prior to the mid-1950's, psychotherapy operated within a comfortable orthodoxy. Deviations were viewed tolerantly as modifications to the well-established guidelines that therapists follow in consultation. During the early 1950's, the traditional orthodoxy of Freudian theory, which provided guidelines for the professional therapist, was questioned and found wanting for the solutions to problems of a community-wide scope.[1]

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[1]Franklin McClung and Alastair A. Stunden, Mental Health Consultation to Programs for Children (Washington: National Institute of Mental Health, January, 1970), p. 2.

McClung and Stunden (1970) offered three reasons why mental health consultation had filled the vacuum left when psychotherapy began to be criticized as the only valid form of therapy.[2] First, these men said that no reliable evidence was available to demonstrate that psychotherapy was better than no treatment at all. This assertion reversed a long-standing dedication to the belief that a high correlation exists between psychotherapeutic treatment and recovery rate. The foundation was prepared early by McClung and Stunden for innovators to appear not as rebels but as rescuers. Therefore, we have now therapy, reality therapy, sensitivity training, consciousness expansion, and other forms of therapy developing rapidly. Each of these innovators has attracted dedicated followers and equally dedicated critics.

The second reason for the development of consultation was doctor shortage. The American Psychiatric Association estimated in 1964 that 4.5 million children in the country were in need of mental health consultation. A research effort by Hollingshead and Redlich (1958) substantiated the need for other services, primarily consultation.[3] Either new techniques had to be devised to use more efficiently trained personnel or people without professional mental health training had to be recruited and assigned to work.

A third reason for the development of consultation offered by McClung and Stunden was the socio-cultural pressure to extend mental health services to large populations which had not benefited from the

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[2] Ibid., p. 2

[3] A. B. Hollingshead and F. C. Redlich, Social Class and Mental Illness: A Community Study (New York: Wiley and Sons, 1970), p. 2.

mainstream of treatment. Mentally retarded children and maladjusted teenagers became the object of national concern especially during the early 1960's. Federal, state and local funding became available to local communities to develop consultation services for these children.

Conceptual Literature

Within the field of mental health consultation, there is no distinction in theory or practice between consultation to adults and to children. Administratively consultation is not separated on a child-adult dimension except by agency names. Many mental health agencies spend consultation time primarily with childcare agencies such as schools, probation departments and public health agencies. For these reasons, literature references on all types of consultation are assumed to apply equally to child and adult consultation problems.

Early efforts.--The literature reviewed prior to 1955 followed the medical model of a consultant, usually a senior consultant, discussing a specific case with a junior consultant. The typical situation was a psychiatrist overseeing a group of social workers. Sloane (1936) saw this practice as a means of extending the psychiatrist's role.[4] Coleman (1947) advocated consultation to provide reassurance for the social worker to anticipate problems in treatment, and to explore the patient's feelings toward the psychiatric social worker.[5] There was a status relationship of a superior consultant offering advice to a subordinate consultant. Eventually the mental health model

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[4]P. Sloane, "The Use of a Consultation Method in Case Work Therapy," American Journal of Orthopsychiatry (January, 1970), p. 2.

[5]J. V. Coleman, "Psychiatric Consultation in Case Work Agencies," American Journal of Orthopsychiatry (April, 1927), pp. 533-539.

of consultation evolved to a public health model with colleagues of equal status from different fields resolving a problem of mutual interest. This has become the model of the Bayshore Mental Health Mental Retardation personnel who work with the Goose Creek Consolidated Independent School District Special Education Department.

Basic works on consultation.--One of the most quoted sources in consultation literature reviewed by the investigator was Gerald Caplan. As early as 1961 Caplan placed considerable emphasis upon mutual respect and acceptance by the consultee's expertise in his own field.[6] He also described a shift in emphasis from advising the consultant about a client from the viewpoint of psycholanalysis to a new emphasis of child-client consultation. The mental health worker wanted advice on a problem with a child-client rather than an analysis of his own personality. One of the important contributions of Caplan is his defense of consultation as a legitimate discipline for the mental health profession. Caplan thinks he can reach out to a larger population with consultation than with a one-to-one client relationship.

Caplan (1963) has defined consultation four ways: (1) client-centered case consultation, (2) consultee-centered case consultation, (3) consultee-centered administrative consultation, (4) program-centered administrative consultation.[7] The basic textbook used by the staff psychologist at Bayshore Mental Health Mental Retardation Center for consultation services to the school system is Caplan's book,

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[6]Gerald Caplan, Prevention of Mental Disorders in Children (New York: Basic Books, Inc., 1961), pp. 12-23.

[7]Gerald Caplan, "Types of Mental Health Consultation," American Journal of Orthopsychiatry (July, 1963), pp. 470-481.

The Theory and Practice of Mental Health Consultation (1970).[8] In this book Caplan offered his definition of mental health consultation, describes four categories of consultation types, and made suggestions about philosophy and application of consultation services to community institutions.[9]

The investigation of I. N. Berlin (1965) forms a second basic work on consultation. He focused on the imperative for consultation on the premises where the consultee is actively engaged in the counseling process. He emphasized the value of free expression of the consultee's frustration, guilt, and hostility toward his client. This outflow permits the person whom Berlin is consulting to see the client he is serving in a realistic problem-solving situation. The consultee will not be as defensive about his own feelings; therefore, he can objectively try to determine the needs of his clients. This contribution by Berlin, focusing attention on the need for consultation rather than therapy for mental health personnel, allows an attitude of mutual respect to develop between the consultant and consultee concerning another client.[10] In this mode, any reference to the consultee's private life is strictly avoided.

The question of the amount of time the consultant should have with the consultee's client differs because of definition and philosophy of "consultation." While some define consultation only as a relationship

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[8]Lawrence T. McCarron, interview in his office, Bayshore Mental Health Mental Retardation Center (July, 1972).

[9]Gerald Caplan, The Theory and Practice of Mental Health Consultation (New York: Basic Books, Inc., 1970).

[10]I. N. Berlin, "Mental Health Consultation in the Schools: Who Can Do It and Why?," Community Mental Health Journal (January, 1965), pp. 19-22.

between client-consultant, others define consultation as client-consultee-consultant. How much time the consultant should spend with the client as well as consultee is one of the controversial questions in the field of consultation. Berkovitz recognized the potential danger in a situation where the consultant circumvents the school district's psychologist by seeing the children directly.[11] Such an action often creates ill feelings on the part of the psychologist. But classroom observation is often seen as important. Caplan went beyond the observation level and stated that in the case-conference consultation, where the immediate goal is to help the consultee find the most effective treatment for the client, the consultant may frequently examine a client for diagnostic purposes.[12]

Initiating consultation.--The contractual commitment between the consultant and the consultee agency is the essential element in the preparation for the initial stages of consultation. The needs and responsibilities of both agencies contracting for consultation must be specific and clear. Haylett and Rapaport (1963) suggested that consultation contracts should be renegotiated annually and should include an evaluation of the program. Rapaport said that the agency seeking consultation needs clear understanding between top administrative officials and the consultant in order to prevent covert resistance to the intrusion of the consultant at a later time. The contract should be clear to all parties.[13]

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[11]I. H. Berkovitz, "Consultation for School Personnel" (Washington: American Psychiatric Association, 1967), p. 4.

[12]Gerald Caplan, "Types of Mental Health Consultation," American Journal of Orthopsychiatry (July, 1963), p. 473.

[13]C. H. Haylett and L. Rapaport, "Mental Health Consultation" Handbook of Community Psychiatry (New York: Grune and Stratton, 1963), p. 15.

Brown (1967) offers the most elaborate discussion of the process of introducing consultation to the administrators of an institution. He suggests eight steps:

(1) Identify the consultee groups.

(2) Mutually agree on the time and goals of consultation.

(3) Examine the relevance of the consultee's needs to the professional skills of the consultant.

(4) Clarify the limits of help the consultant can provide.

(5) Develop an awareness of the effect of the consultant's relationship to consultee on other groups.

(6) Develop an awareness of power and authority relationships in an agency.

(7) Explore the consultee's previous experience with mental health personnel.

(8) Establish a means for evaluation of the consultation program.[14]

Consultation to schools.--Public schools are recipients of a major part of consultation services.

Three areas of concern about public school consultation were predominate in related literature: (1) the amount of time a consultant should spend with teachers, administrators and children, (2) the amount of consultation that should be required of teachers, (3) the emotional feelings of teachers and administrators about consultants.

Berkovitz (1968) described the consultation services provided by the Los Angeles County Mental Health Department to large and small

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[14]J. W. Brown, "Pragmatic Notes on Community Consultation with Agencies," Community Mental Health Journal (March, 1967), p. 400.

school districts in the greater Los Angeles area. His basic proposal was to divide consultation equally among three groups: administrators, specialized remedial children, and teachers.[15]

One warning was echoed repeatedly throughout the literature. Many consultation demands are imposed upon teachers who are untrained in the field. Such demands create undue stress for the teachers and lessen the probability of their co-operation and valid contributions to the consultative process.

Berlin (1965) stressed the need for the consultant to be aware of the fearfulness of teachers and the guardedness of administrators and to proceed carefully, letting the needs of the consultees develop gradually in as non-threatening a way as possible.[16]

Analysis of Existing Models

Psychological Consultation in the Schools by Ruth Newman (1967) is a recent book offering guidance in the emerging field of consultation, especially with children.[17] The conclusions came out of a study conducted 1955-1960 with extremely hyper-aggressive, disturbed children in residence at the National Institute of Mental Health at the Child Research Branch in Washington, D. C. Consultation methods learned in this clinical experiment were used in a variety of schools. Newman used regular and continuous consultation rather than crisis consultation, after observing the interplay between the teacher and bureaucracy,

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[15]Berkovitz, "Consultation for School Personnel," p. 5.

[16]I. N. Berlin, "Mental Health Consultation in the Schools--Who Can Do It and Why?," Community Mental Health Journal (January, 1965), p. 20.

[17]Ruth Newman, Psychological Consultation in the Schools (New York: Basic Books, 1967), p. 10.

between the student and the teacher, and between the teacher and the parent. The book provides pragmatic advice about making a consultation program succeed: what procedures are helpful, what pitfalls to watch, what training for teachers. Newman concluded:

> We firmly believe that, for consultation to be successful over the long run, it must include a concept of continual, on-the-spot service by trained people, sufficiently flexible to change procedures, though not principles, as the personnel or conditions of a school demand.[18]

Teaching Disadvantaged Children in the Infant School, edited by T. Cox and C. A. Waite (1970), describes a three and one-half year research and development project by the University College of Swansea in England. The purposes of the project were: (1) to provide screening techniques to identify children in need of compensatory education, (2) to make longitudinal studies of children's emotional development and response to schooling, (3) to develop teaching programs for culturally deprived children.[19]

One chapter describes five programs of consultation. The authors of the book offered the following conclusions: (1) tremendous effort is being made to tackle problems of disadvantaged children, (2) research is extensive concerning practical programs, (3) expert help has been offered by clinicians and consultants to teachers and children.[20] Programs studied by the research team had consultation services as part of their total effort to help disadvantaged children. Emphasis was given to taking a broad view of education that involves

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[18] Ibid., p. 10.

[19] T. Cox and C. A. Waite, Teaching Disadvantaged Children in Infant School (Swansea, England: Crown Printers, 1970), p. 4.

[20] Ibid., p. 22.

the training of emotions and the development of personality. Consultation services to the school were a vital part of the program for these disadvantaged children.

A recent issue of Exceptional Children, the official journal of the Council for Exceptional Children, contained an interview with George Shepard, Director of Research and Demonstration Center in Early Childhood Education at the University of Oregon. He described the program in detail by using the method of questions and answers in the interview. Consultation services to teachers, parents and children are an integral part of his program. Shepard said:

> As you can see, it is a very diversified group of people--psychologists, medical people, educators--who are lending their abilities, their knowledge, their skills to develop our center.[21]

The Joint Information Service, which combines the interests of the American Psychiatric Association and the National Association for Mental Health, made a study of 234 comprehensive mental health centers in 1964. Eleven of these 234 programs were selected for site visitation and research. The study revealed that each center had some excellent features, all lacked the ideal of comprehensiveness, and most centers lacked integration of the mental health program with psychiatric facilities in the local community. Ten of the eleven programs contained all five of the essential elements of a comprehensive mental health program delineated in the federal regulations: evaluation and research, hospital care, emergency service, outpatient care, and consultation services. All eleven centers provided consultation services. None of the eleven

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[21]Evelyn Blum, "An R & D Center Focuses on Early Childhood Education," Exceptional Children, Vol. 37, No. 9 (May, 1971), p. 680.

centers met the enormous needs of emotionally disturbed children.[22]

An article from Mental Health Digest defined three categories of disturbed children, offered suggestions for early recognition of emotional difficulties, and described possible therapy. Four of the six suggestions for therapy relate to the Bayshore Mental Health Mental Retardation Center for the school district: (1) professional evaluation of the child, (2) provide facilities available to school personnel for early assessment of any child who exhibits deviant behavior, (3) develop classes for emotionally disturbed children within a controlled environment, less demanding and less exciting, (4) develop specialized teacher training.[23]

The National Institute of Mental Health staff made a survey of services provided to children on one day, November 15, 1967, by the Community Health Centers. A total of 133 centers responded. On that one day 7,598 persons were served, of whom 1,302 were under eighteen years of age. There were three times as many boys as there were girls served on this one day.[24]

The Amsterdam Mental Health Service inaugurated a community mental health center in the 1930's. Workshops, first-aid programs, foster homes, and co-operation with police, courts, social services, and schools were used as tools to reduce the number of patients in mental

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[22]Raymond Glasscote, "Eleven Programs - A Summary and Comparison," The Community Mental Health Center--An Analysis of Existing Models (Washington: Joint Information Service, 1964), p. 26.

[23]Helen Metzger, "Early Recognition of Emotional Difficulties," Mental Health Digest (July, 1968), p. 19.

[24]Ibid., p. 2.

hospitals in Amsterdam, Holland. This activity shifted the responsibility for the mental patient from the hospital to the community.[25]

Leonard Goodstein's article in Hospital and Community Psychiatry (June, 1972), "Organizational Development as a Model for Community Consultation," encouraged the establishment of good procedures and good climate to nurture problem-solving consultation. He said that training in understanding individual psychodynamics should be a part of all training for effective change. Goodstein suggests diagnosing problems of an organization, observing the organization in action, and administering a questionnaire to identify problem areas. Lack of clear purpose, poor internal and external communication, inadequately trained staff, ineffectual leadership, and personal psychological stresses, are some problem areas that create misunderstandings when consultants enter a new organization to provide consultation services.[26]

Summary.--The community mental health center movement is the mid-twentieth century's response to needs of the mentally ill. It represents a shift to the community as a more appropriate base of treatment, away from the large mental institution that had been the main treatment base during the nineteenth century.

Consultation is one of the five services required by federal legislation. Consultation is basically a problem-solving service while education is its knowledge-building twin. Prevention of illness and promotion of health is the purpose of consultation in community

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[25]Arie Querido, "The Shaping of Community Mental Health Care," International Journal of Psychiatry, Vol. 7, No. 5 (May, 1969), p. 300.

[26]Leonard Goodstein, "Organizational Development as a Model for Community Consultation," Hospital and Community Psychiatry, Vol. 23, No. 6 (June, 1972), p. 165.

institutions such as schools.

Literature examined in the field of consultation services provides resources from which the investigator concluded the following: (1) consultation services to schools by community mental health centers is growing, (2) stress occurs within school administrators when an outside agency enters a school for consultation with teachers, (3) the mental health movement operates on a new philosophy of the comprehensive community health center.

CHAPTER III

RESULTS OF CO-OPERATION BETWEEN THE MENTAL HEALTH CENTER OF THE SCHOOL DISTRICT SPECIAL EDUCATION DEPARTMENT

Historical Influences of Mental Health Movement

National Association for Mental Health - How they serve.--The National Association for Mental Health is a national voluntary citizens organization which is leading the fight against mental illness. Currently focusing on serious mental illness, the National Association for Mental Health is committed to help the mentally ill, their families and the community.

To concentrate attention on the needs of the seriously mentally ill, the national association has chosen four areas of need for programs: (1) improved care and treatment for mental hospital patients, (2) aftercare and rehabilitation services, (3) treatment, education and special services for mentally ill children, (4) community mental health services.[1] Two of the four areas of need are related to local schools and to local mental health units. One reason for the program emphasis on treatment, education and special services for mentally ill children is the presence of large numbers of them in regular classrooms. These children are often denied adequate treatment and education because of the difficulty in meeting the needs of normal children as well as exceptional children in

[1] National Association for Mental Health, Inc., The NAMH Program, How They Serve (Washington: National Association for Mental Health, Inc., 1970), p. 5.

the same classroom. Other children with mental or emotional problems are committed to state institutions away from local mental health services.

The National Association believes such children should be treated and educated in their home communities when this is in the best interest of the child, his family and the community. To this end, the National Association encouraged communities to develop a comprehensive mental health program. The National Association believes that every child has a right to an education suited to his needs and that such education should be provided within the framework of public school systems.

These beliefs are explained as follows:

> The provision of adequate services for diagnosis, treatment, education, and rehabilitation of mentally ill children is a community responsibility and an obligation of the appropriate public authorities, local, state and federal. No child should be denied services because of his inability to pay.[2]

Armed with an overview of the need for mental health consultation for children in public school and committed to a philosophy of helping these children, the National Association began an educational and lobbying program to encourage the passage of legislation. The influence of this organization, coupled with the influence of President Kennedy, led to the passage of legislation for the purpose of establishing and funding mental health centers throughout the United States.

Public Law 164, passed October 31, 1963, by the Congress of the United States is the most influential piece of legislature in the field of mental health. The purpose of the legislation is defined as follows:

> The purpose of this legislation is to provide assistance in combating mental retardation through grants for construction of research centers and grants for facilities

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[2]Ibid., p. 13.

> for the mentally retarded and assistance in improving mental health through grants for construction of community mental health centers and for other purposes.[3]

The law authorized the appropriation of twenty-six million dollars for the fiscal years 1964 through 1967. This money was used for project grants to construct facilities and to develop research projects relating to the causes and prevention of mental illness and mental retardation.

Section 131 of Senate Bill 1576, passed in 1963, was amended by the Ninety-first Congress of the United States to authorize grants for construction of mental health centers and programs through June 30, 1973. This amendment added 295 million dollars for the construction of facilities and for the development of mental health programs.

> For the purpose of assisting in the establishment and initial operation of facilities for the mentally retarded providing all or part of the program of comprehensive services for the mentally retarded principally designed to serve the needs of the particular community or communities in or near which the facility is situated, the secretary, in accordance with the provisions of this part, may grant, for the temporary period specified in this section, a portion of the cost (determined pursuant to regulations under section 144) of compensation of professional and technical personnel for the initial operation of new facilities for the mentally retarded or for new services and facilities for the mentally retarded.[4]

The appropriations provided by Public Law 164, passed by the Eighty-eighth Congress in 1963, is one indication that the Congress of the United States has a great interest in mental health and mental retardation programs and facilities. The legislation described above has had a significant impact on state and local mental health programs. The influence of the legislation created a mood in the State of Texas that led to the Mental Health Mental Retardation Act of 1965.

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[3]Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, 77 Stat. 282 (1963), 88 U.S.C. sec. 164 (1963).

[4]Ibid.

Texas Plan for Mental Health.--The Texas Plan for Mental Health services resulted from the work of a statewide citizens committee for mental health planning and was presented on December 1, 1964, to the Governor and the administrative officials of the State of Texas. The study began with the question, "What will Texas do about mental illnesses?" The resulting publication constitutes the thinking of the planning committee for comprehensive statewide and community mental health services and what should be done to provide a mental health program for Texas citizens. A new philosophy for the treatment of mental illness and special education problems was recommended to the people of Texas. The report states that mentally ill citizens deserve something better than isolation in state mental hospitals, far from loved ones, from home and familiar surroundings often after the damage is beyond repair. The report further states that prevention, early detection and care in the local community are more effective, and therefore, more desirable than waiting until the patient is placed in a distant institution.[5]

The changing philosophy for the prevention and treatment of mental illness has been followed by new methods and new laws. The recommendations of this citizens' committee created a climate for improved mental health care in the State of Texas during the administration of Governor John Connally. Mental health problems in Texas became the concern of Texans as it has been the concern of national leaders.

The 116 citizens who were involved in the preparation of the Texas Plan were selected because of their concern, their capabilities, and their leadership. As a result of their work, the Mental Health

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[5]Statewide Citizens Committee for Mental Health Planning, The Texas Plan for Mental Health Services (Austin: Office of Mental Health Planning, 1964), p. 13.

and Mental Retardation Act of the State of Texas was enacted by the Fifty-ninth Legislature and amended by the Sixty-first Legislature, providing funds and guidelines to develop a program for Texas Children.

According to the 1960 census, there were 3,638,656 children in Texas who were under eighteen years of age. One study has indicated that four out of every one hundred school-age children can be diagnosed as emotionally disturbed.[6] As the child population increased annually in Texas, the number of children with special problems increased proportionally. The problem of expanding resources to keep pace with the population growth became complex. Furthermore, prior to 1965, out of the 254 counties of Texas, only fifteen mental health centers existed for diagnosis, evaluation and treatment of children and only eight were staffed by specialized professions. In a study of mental health resources in various communities in the country, sixty-one of the lowest ranking ninety-four counties in the nation were in Texas.[7] The Texas Plan contained the information about mental health needs. As citizens of Texas became aware of the acute needs, groups and individuals initiated steps to develop community mental health centers for education and consultation services.

The Texas Plan was not the first effort in Texas to develop a program of mental health prevention and treatment. The initial step was taken by the federal government in 1946 with passage of the National Mental Health Act. The states responded to the program, and Texas

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[6]Fred R. Crawford, "A Mental Health Need," Texas Health Bulletin, (August-September, 1961), pp. 9-10.

[7]Reginald Robinson, David F. DeMarche, and Mildred K. Wagle, Community Resources in Mental Health (New York: Basic Books, Inc., 1963), p. 334.

established the Mental Health Division within the Texas Department of Health in 1947. As the scope of the problem was identified, the need for wider understanding became apparent.

In 1955 Congress passed the National Mental Health Study Act. The committee report revealed the necessity for expanded action. The medical profession and the state governments continued the new emphasis on mental health prevention with large scale education programs aimed at the identification, treatment and prevention of mental disorders. In addition, Congress authorized grants for the construction of community mental health facilities.

Throughout the fifteen years following 1946, the Division of Mental Health sought to have a complete community health program in the State of Texas. The goals of the division were to preserve and protect an individual's mental health when well, and provide an early diagnosis, care, rehabilitation and early return to social and physical well being when the individual became mentally ill. To accomplish this end, the division worked with local communities to establish mental health programs as accessible to the individual's home as possible. The value of community treatment was recognized by the legislature in 1957 with the authorization for the Board of Texas State Hospitals and special schools to establish out-patient clinics for the mentally ill as the board thought necessary and as funds became available.[8]

During this period of development of mental health services in Texas, nothing was said about public schools. The Texas Plan primarily related to persons with severe mental illness needing institutional help. The concern for consultation services on a local level to prevent and

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[8]Citizens Committee, Texas Plan for Mental Health Services, p. 11.

treat mental illness and mental retardation developed at a later time. This state plan eventually filtered into the county level.

Harris County Mental Health Mental Retardation Program.--On Thursday, December 9, 1965, County Commissioner's Court of Harris County approved a recommendation appointing a board for the development of a comprehensive mental health and mental retardation center for Harris County. The recommendation was as follows:

> Moved by Commissioner Ramsey, seconded by Commissioner Chapman, duly put and carried, it is ordered that the following named persons are hereby appointed, effective November 19, 1965, as Trustees on the Board of Trustees of Harris County Mental Health and Mental Retardation Board: Dr. George G. Alexander; Dr. Spencer Bayles; Dr. Moody C. Bettis; Rev. Harold Bomhoff; Dr. John Flannigan; Mrs. I. H. Kempner; Dr. Samuel Nabrit; Mr. Robert U. Parris; and Mrs. William J. Selman.
>
> The above and foregoing have been omitted from the minutes of November 19, 1965, be and the same is here now entered NUNC PRO TUNC.[9]

The Harris County Mental Health Mental Retardation Center is a public agency dedicated to the development of community-based, locally-controlled programs for the prevention and treatment of mental disabilities.[10]

The center is governed by a nine-member board of trustees appointed by the Harris County Commissioner's Court under provisions of the Texas Mental Health Mental Retardation Act of 1965. The board sets the goals and objectives of the center, develops policies, and appoints an executive director to administer the program. It also appoints advisory committees, medical committees and other committees to advise it

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[9]Harris County Mental Health Mental Retardation Center, Report of the Board of Trustees, Plan of the Harris County Mental Health and Mental Retardation Center (Houston, 1970), p. 25.

[10]Harris County Mental Health Mental Retardation Center, "Programs for the Prevention and Treatment of Mental Disabilities," p. 1.

on matters relating to the administration of local services.

The purpose of the center is to conserve and restore the mental health of Harris County residents, prevent retardation and help the mentally retarded of the community achieve their maximum potential. To meet this purpose the center has developed a flexible, long-range plan which provides for the establishment of area service centers and the development of some specialized services on a county-wide basis. Services are decentralized geographically into eleven areas to insure maximum accessibility and availability at all times to all persons living in the county.

Priorities for the development of area centers are based on the relative needs of the area to be served. Social, cultural and economic factors of the population of each area are taken into account. Advisory councils, made up of residents of each center area, help in effectively relating area programs to the needs of each area.

The center coordinates local programs and planning with the Texas Department of Mental Health and Mental Retardation. Under state law, the department provides assistance, advice and consultation in the planning, development and operation of community centers. The center strives for effective working relationships with the state operated hospitals, schools, mental health clinics, and centers for human development.

Funds for operating and staffing the center come from the state and federal grants, local tax appropriations, United Campaign funds, service fees and gifts. Grants-in-aid are received from the Texas Department of Mental Health and Mental Retardation. The center also receives staffing grants from the United States Department of Health, Education and Welfare through the National Institute of Mental Health,

Education and Welfare and the National Institute of Mental Health and the Social Rehabilitation Administration. The Mental Health Mental Retardation Center receives grant funds from the city of Houston Model City Department for Model Cities Mental Health and Mental Retardation services.

The comprehensive plan includes twenty-seven mental health services and ten mental retardation services provided by the staff located at eleven mental health mental retardation centers in Harris County. Each of these eleven centers is governed by an advisory board on the local level, thus offering individualized mental health services to the local communities. The Bayshore Mental Health Mental Retardation Center is one of the eleven area centers in the Harris County master plan.

Bayshore Mental Health Mental Retardation Center.--Interest in a community mental health center in Baytown dates back to 1960, five years prior to the passage of House Bill 3 in the Texas Legislature. Harold Bomhoff has been associated with efforts to develop a community mental health center in Baytown most of this time. In an interview with Bomhoff, he noted the following historical development of the Baytown center:

> Baytown mental health was organized first on a community center basis. This was done after a two-year study in which an attempt was made to combine all mental health services in one building. The Baytown Opportunity Center and the Cerebral Palsy Center, at that time, would not participate in the community effort in one building. There is effort at the present time to place the public welfare, cerebral palsy, mental retardation, opportunity center, mental health and mental retardation staffs in one building. The other mental health agencies of the community have chosen not to participate in this activity.
>
> Don Marler was invited to serve as executive secretary and administrative director of the Bayshore Mental Health Mental Retardation Center. Immediately after he came to

> the center, he was contacted by Goose Creek School District to assist in the evaluation of students with special education problems. This occurred in the spring of 1968. The whole idea of the ten-year mental health program in Baytown is early diagnosis and prevention rather than treatment.[11]

The Bayshore Mental Health and Mental Retardation Center began operation March 12, 1968. The center was planned according to the new philosophy advocated by the Texas Plan submitted to Governor Connally on December 1, 1964, by a citizens committee. Recognition, prevention, and treatment of mental illness and mental retardation at the local level was the philosophy behind the new program.

Administration of the Bayshore Center is a function of the Harris County Mental Health Mental Retardation Board of Trustees.[12] An area Advisory Board advises the Harris County Board and works toward the development of the local center.

The Advisory Board from Area 2 was established in 1966. This council worked directly with the Harris County Board of Trustees and the executive director of the board. In 1967, a program developer was hired to assist in solidifying the plans for a center in Baytown. Individuals and community groups, including the school board, offered expressions of interest for the center. In March, 1968, the center opened with a limited staff financed by state grant-in-aid. A request for federal staffing grant was submitted.[13] Approval of the grant was anticipated by the local mental health staff and the Advisory Board.

A federal grant of $103,000 for mental health staffing was secured

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[13]Harold O. Bomhoff, interview held in his home, January 14, 1972.

[12]Don Marler, History of Bayshore Mental Health Mental Retardation Center, p. 1.

[13]Ibid., p. 2.

September 1, 1968, to cover 75 per cent of all staff costs. The remaining 25 per cent of personnel and operating costs were borne by state grant-in-aid funds. The East Harris County Community Chest granted $5,000. Other amounts came from patient fees and state grant-in-aid monies.[14]

A federal grant for mental retardation staffing was approved September 1, 1969. This grant of $48,000 covered 75 per cent of the staff costs for one year. The remaining staff operating costs came from patient fees and from state funds for a contract with Goose Creek Consolidated Independent School District for $6,500 for the purchase of evaluations.[15]

Since the Bayshore Mental Health Mental Retardation Center opened in March, 1968, the staff has increased from a total of fourteen in 1968 to a total of twenty-two in 1972. The following tables provide an overview of present personnel.

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[14]Harris County Mental Health Mental Retardation Board of Trustees, "Application to Federal Department of H.E.W. for Staffing Grant for Bayshore Mental Health Center," (Baytown, 1969), p. 1-8.

[15]Harris County Mental Health Mental Retardation Board of Trustees, "Application to Federal Department of H.E.W. for Staffing Grant for Bayshore Mental Retardation Center," (Baytown, 1969), p. 1-8.

TABLE 1

BAYSHORE MENTAL HEALTH STAFF - 1972[a]

Position Title	Hrs. Per Wk.	Current Year	Continuation Year	Estimated Distribution of Hours per Week by Service					
				Patient In	Patient Out	Partial Hosp.	Emergency	Consultation & Educ.	Total Hrs.
Administrative Director	40	17,754	18,642	2	20	2	2	14	40
Medical Director	40	26,700	28,700	6	20	8	2	4	40
Secretary II	40	6,000	6,300	4	20	10	2	4	40
Clerk-Typist I	40	4,608	4,838	4	20	10	2	4	40
Chief Social Worker	40	14,148	14,855	2	18	2	2	16	40
Social Worker	40	11,616	12,197	2	32	2	2	2	40
Mental Health Worker	40	5,808	6,098	0	0	40	0	0	40
Psychiatrist	40	12,408	13,028	2	32	2	2	2	40
Psychiatric Nurse	40	9,528	10,004	4	0	28	2	6	40
Rehabilitation Therapist	40	8,916	9,362	4	0	32	0	4	40
Social Worker	40	11,232	11,794	2	30	2	2	4	40
Speech Therapist	20	3,710	3,896	0	20	0	0	0	20
Social Worker	40	9,216	9,677	2	34	0	2	2	40
Records Clerk	40	5,436	5,708	4	16	12	2	6	40
Child Psychiatrist	3	2,824	2,500	0	2.4	.3	.3	0	3

[a]Calculated from: Harris County Mental Health Mental Retardation Board of Trustees, "Application to Federal Department of H.E.W. for Staffing Grant for Bayshore Mental Health Center," (Baytown, 1972), p. 24.

TABLE 2

BAYSHORE MENTAL RETARDATION STAFF - 1972[a]

Position Title	Qualifications of Position	% Time In Each Service in 40-Hr. Work Week	Full Time	Part Time	Annual Pay
Medical Director	M.D. Degree	10% 10% 20%		X	12,650
Coordinator Social Worker	ACSW, 5 yrs. experience, 1 yr. in administration or supervisory position	50% 25% 25%	X		16,212
Clinical Social Worker	MSW, 1 year experience, preferably with mentally retarded	75% 25%	X		12,053
Chief Psychologist	Ph. D. Degree	25% 75%	X		18,975
Clinical Psychologist	Deleted				
Speech Therapist	B.A. Degree in Speech	10% 30% 10%		X	4,915
Nurse	R.N. Degree	50% 50%	X		10,915
Secretary	High School diploma, courses in business, stenography, typing, receptionist experience & knowledge of med. & psychological vocabulary necessary.		X		6,877

[a]Calculated from: Harris County Mental Health Mental Retardation Board of Trustees, "Application to Federal Department of H.E.W. for Staffing Grant for Bayshore Mental Retardation Center," (Baytown, 1972), p. 23.

The primary reason for increases in staff is the increase in the total budget for the Bayshore center. The following tables indicate the budget for the fiscal years 1971 and 1972 and the proposed budget for 1973 for the Bayshore Mental Health Mental Retardation Center. The growth pattern demonstrated by budget increases has been consistent since 1968 when the center opened for mental health mental retardation services to the community.

TABLE 3

BUDGET ALLOCATIONS FOR BAYSHORE MENTAL HEALTH CENTER[a]

	1971	1972	1973
Local Funds	48,761	38,375	46,000
State Grants	77,207	125,620	176,300
Federal Grants	87,030	99,730	67,800
Total	231,371	263,725	290,100

[a]Calculated from: Harris County Mental Health Mental Retardation Board of Trustees, "Application to Federal Department of H.E.W. for Staffing Grants for Bayshore Mental Health Center," (Baytown, 1971, 1972, 1973).

TABLE 4

BUDGET ALLOCATIONS FOR BAYSHORE MENTAL RETARDATION CENTER[a]

	1971	1972	1973
Local Funds	13,500	17,200	18,100
State Grants	32,396	50,630	68,515
Federal Grants	43,860	29,520	19,685
Total	89,756	97,350	106,300

[a]Calculated from: Harris County Mental Health Mental Retardation Board of Trustees, "Application to Federal Department of H.E.W. for Staffing Grant for Bayshore Mental Health Center," (Baytown, 1972), p. 24.

The increase in budget and staff has provided the Bayshore Center with resources to develop a diversified program that complies with federal laws regulating the grants. The Mental Health Center offers five basic services: (1) inpatient care at San Jacinto Methodist Hospital, (2) outpatient care at 1410 Louisiana, Baytown, (3) emergency care, (4) day treatment, (5) consultation and education.

The Mental Retardation Center offers three services: (1) diagnosis and evaluation, (2) treatment and counseling for the retardate and his parents, (3) consultation and education.

Consultation and education services conform to the Harris County Mental Health Mental Retardation Center guidelines prepared in 1970. Guideline No. 3 is as follows:

> To recognize that the system of services which will most effectively accomplish these mental health mental retardation program ends cannot exist separate and apart, but must interlock with other sub-systems--government, education, welfare, health, etc.--of the larger social system.[16]

Summary.--This historical summary places the Bayshore Mental Health Mental Retardation Center in the perspective of a national mental health movement. The center is the end result of federal, state, and county interest in the field of mental health services on a local level. Mental health consultation is now interlocked with the school system.

Historical Influences Shaping Special Education

Goose Creek Counseling Program.--Guidance services in the Goose Creek Consolidated Independent School District are planned as an integral

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[16]Harris County Mental Health Mental Retardation Center, Report of the Board of Trustees, Plan of the Harris County Mental Health and Mental Retardation Center (Houston, 1970), p. 5.

part of the educational program to help each pupil make sound adjustments, choices and plans. To accomplish this task the school administration personnel encourage counselors to use community resources. One of the guidelines for accreditation used in evaluating the guidance program stated that the purpose of the program was to encourage every pupil to make satisfactory educational, social and personal adjustments and to broaden the guidance program through the coordination of school and community resources.[17]

Another statement pertaining to the total educational program as it relates to the community offers some insight into the developmental process between the school system and the mental health unit of Baytown:

> A good guidance program helps the school further in that it is developed from a knowledge of students, their differences, their talents, their limitations, their dreams, and the hard facts of reality they will need to face, the same factors with which the school must deal in educating these students. Their parents, their homes and their environments, play a large part in this program. The program gives a familiarity with guidance literature, educational measurement, psychology, personality traits, occupations, careers, employment opportunities and public relations interest. It helps in interpreting pupils' needs to the staff and administration.[18]

Stronger encouragement to use community resources for solving special problems is offered by the school personnel:

> Problems of emotional tensions and resulting frustrations may be dealt with in a fairly non-directive manner, the student being encouraged to talk at will in reality to "talk out" his problem. The counselor in this case should be a professional listener affording a sounding board for the student. During this kind of interview, the counselor must at all times remember that he may wish to refer the student to another

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[17]Goose Creek Consolidated Independent School District, Accreditation Evaluation Report to the Texas Educational Agency (Baytown, 1968), p. 38.

[18]Goose Creek Consolidated Independent School District, Guidance Program Grades One through Twelve (Baytown, 1956), p. 10.

> teacher, counselor, administrator or some person in the community who may be better able to help this student.[19]

The accreditation manual emphasized that the basic responsibility assigned to counselors was multiple, including recognition and referral procedures related to special education problems: (1) make use of community agencies such as Welfare, Probation Clinic, Sight Conservation and Hearing Clinic; (2) recognize symptoms of emotional problems which may need services of a specialist. Confer with parents and refer cases to a psychologist or a psychiatrist when symptoms indicate that treatment is needed; (3) assist in identifying students for special education.[20]

In a special report January 31, 1964, by a committee in the school system for suggested improvements in the current guidance program, the following idea was presented: "We need to have some students in special education before they enter Junior High School. Early detection of slow learners should be made while in elementary school. Special aid is a must in Junior and Senior High Schools. We must be able to take care of slow learners."[21]

W. C. Herring, Assistant Superintendent responsible for curriculum and guidance in the Goose Creek Consolidated Independent School District, reviewed a new philosophy regarding special students. He said:

> The present philosophy is to get students back into the mainstream of education in Junior School (sixth, seventh and eighth grades); this means the counselor will be in touch with the Special Education Department from the very beginning of the

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[19] Ibid., p. 24.

[20] Goose Creek Consolidated Independent School District, Accreditation Evaluation Report, p. 41.

[21] Goose Creek Consolidated Independent School District, "Suggested Improvements for Present Guidance Program" (Baytown, January 31, 1964), p. 7 (Mimeographed).

> student's life in the school system. There is no attempt to isolate special education students from the mainstream of education, but to work them back into the regular channels of the school as soon as possible.[22]

Texas Education Agency Plan for Special Education.--Texas schools are committed to the principle of education for all children regardless of variance and ability. The basis for special education is the belief that every child is entitled to full recognition of his right to educational opportunities, consistent with his ability to learn.

The intent for a statewide special education program is:

1. To carry out fully and effectively legislative intent expressed in the Foundations School Program Act, " . . . to guarantee to each child of school age in Texas the availability of a foundation school program . . ."

2. To develop further the intent in Senate Bill 230, 61st Legislature, regular session, ". . . to provide for a comprehensive special education program for exceptional children in Texas . . ."

3. To provide for full implementation of all legislation relevant to the education of exceptional children.

4. To furnish leadership and guidance to local school districts in the establishment, operation, and development of comprehensive program of speech education for exceptional children in Texas.[23]

A management services group in Austin conducted a comprehensive study of special education in Texas. Its 1968 report influenced a legislative study leading to Senate Bill 230.[24] This was a trend away

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[22]W. C. Herring, interview held in public school administration building, March 16, 1972.

[23]Texas Education Agency, Administrative Guide and Handbook for Special Education, 1971 (Austin, Texas: Educational Services Center, 1971), p. 1.

[24]Management Services Associates, Special Education in Texas (Austin, Texas: Education Agency, 1968), pp. 1-20.

from the previous special education philosophy of student isolation toward a new philosophy of student integration into the mainstream of education. This study, known as the Mallas report, contained specific proposals that were incorporated into Senate Bill 230.

Senate Bill 230 was signed into law by Preston Smith, June 21, 1969, thus establishing the current special education funding.[25] This bill created a new plan for special education programs in Texas, called Plan A. The old plan for special education programs was called Plan B.

Plan A is the program of comprehensive special education for exceptional children.[26] The new law requires that all accredited local schools approved by the Texas Education Agency for Foundation Program School Funds for special education programs must provide a comprehensive special education program for handicapped pupils between the ages of three and twenty-one by the school year starting September 1, 1976. The formula used for funding is based on the local school district's total average daily attendance (ADA) for pupils from six through twenty-one years of age for the preceding school year. This is the greatest difference between the old and the new plans for special education. Under the new program, Plan A, the school requests funding according to average daily attendance records. This procedure has increased funds available for staffing, thus greatly increasing Special Education Department staffs.

Plan B is the program based on Identified Handicapped Pupils.[27] This plan is in operation until September 1, 1976, or until accredited

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[25]Comprehensive Special Education Act of 1969, Art. 2654, Vernon's Civil Statues, Senate Bill 230, 61st Texas Legislature, 1969.

[26]Administrative Guide for Special Education, p. 37.

[27]Ibid., p. 42.

school districts make application and receive approval for comprehensive special education programs under Plan A. The formula for allocating instructional unit personnel is based on the number of handicapped pupils identified by type of disability for whom the school district plans to provide special education services.

Goose Creek Special Education.--Senate Bill 230 provided large increases in funds for a comprehensive special education program. The school district has provided a program for exceptional children since the school year 1962-1963. Nine staff members carried out the work under the old program called Plan B. During the first year that the school district worked the new program, Plan A, the staff increased to forty-nine.[28] The following table provides a comparison of staff members under Plan A and Plan B in Goose Creek Consolidated Independent School District.

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[28]W. T. Thomas, interview held in Goose Creek Consolidated Independent School District Special Education Department (February 17, 1972).

TABLE 5

STAFF ANALYSIS OF SPECIAL EDUCATION IN GOOSE CREEK CONSOLIDATED[a] INDEPENDENT SCHOOL DISTRICT

1962-63*	1970-71+
1 - Director	1 - Director
2 - Speech Therapists	8 - Speech Therapists
1 - Teacher Physically Handicapped	1 - Teacher Physically Handicapped
1 - Teacher Educable Mentally Retarded	9 - Teachers Educable Mentally Retarded
2 - Teachers Trainable Mentally Retarded	1 - Secretary Full Time
1 - Teacher Aid	1 - Early Childhood Supervisor
1 - Secretary giving 1/2 time	1 - Education Diagnostician
9 - Total Staff	1 - Counselor
	8 - Early Childhood Teachers
	1 - Musical Teacher
	3 - Homebound Teachers
	10 - Teachers of Minimally Brain Damaged
	4 - Teachers of Emotionally Disturbed
	49 - Total Staff

[a]Calculated from: Goose Creek Consolidated Independent School District Special Education Department, "Application to Texas Education Agency for Staffing Grant," Baytown, 1962-63 and 1970-71.

*First year for full-time director.

+First year under Plan A.

The projection for special education staff will increase. The following table provides information for a five-year projection for the school district:

TABLE 6

STAFF FOR FIVE-YEAR PLANNING[a]

Type of Information	1961-72 Entitlement	1972-73	1973-74	1974-75	1975-76	1976-77
Instructional Units (3-5)	20	20	20	21	21	21
Instructional Units (6-21)	80	80	80	86	86	86
Teacher Aid Units	35	35	35	38	38	38
Supportive Professional Service Units						
Supervisor	5	5	5	5	5	5
Visiting Teacher	2	2	2	3	3	3
Counselor	3	3	3	3	3	3
Educational Diagnostician	3	3	3	3	3	3
School Psychologist	1	1	1	1	1	1
Assoc. School Psychologist	1	1	1	1	1	1
TOTALS	150	150	150	161	161	161

[a]Calculated from: Private files of W. C. Herring during private interview held in public school administration building, March 16, 1972.

Since Senate Bill 230 created Plan A in Texas education, the number of students served in special education units in Goose Creek School District has increased. In the school year 1970-71, there were 847 special education students in the Goose Creek Consolidated Independent School District.

During the year, 1098 students were categorized for special education services. Re-entry into the regular school system and mobile families caused a net 847 students reporting for special education during the year. In 1971-72 school year, the membership report at the beginning of the year was 960 in special education.[29]

[29]W. T. Thomas, interview held in Goose Creek Consolidated Independent School District Special Education Department, February 17, 1972.

Co-Operation Regarding Consultative Services

Introduction.--Co-operation between Bayshore Mental Health Mental Retardation Center and Goose Creek Consolidated Independent School District regarding consultation services developed in three stages: (1) Pre-Plan B Funding, (2) Plan B Funding, (3) Plan A Funding.[30]

Stage One: Pre-Plan B Funding.--Counseling services to determine individual needs evolved in the Goose Creek School District over a long period of time. The first official book to guide counselors was published in 1956. This book, Guidance Programs Grades One Through Twelve, remains the official guide for counselors in 1972, although it is now in the process of being revised. This handbook describes six traditional areas of guidance services that are offered by the Goose Creek School District. These six services are: individual inventory, counseling, occupational and educational information, orientation, placement, and follow-up. Prior to Plan B funding, the guidance program counselors of the school district determined students needing special education attention through individual inventories, primarily the I.Q. test scores.[31] Special education students were referred to psychiatrists, to state schools in other areas in Texas, or were assisted by regular classroom teachers. Administration officials recognized the needs of individual students, but the officials did not have resources necessary for special education programs.

Stage Two: Plan B Funding.--The second stage of co-operative development began when the school district hired a full-time Director of

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[30]Mike Madison, interview held in his office (January, 1972).

[31]Ibid.

Special Education during the school year 1962-63. The new director developed a program from special education legislative guidelines and Texas Education Agency programs guidelines.

The Bayshore Mental Health Mental Retardation Center provided a needed service to the school district under the Special Education Plan B in the form of consultative services. In a paper by Don Marler in 1971,"What Mental Health Consultation Can Do for the Schools," the director of the mental health unit made the following statements about consultation services for the Goose Creek Consolidated Independent School District:

> There are two kinds of mental health consultation: case consultation and program consultation. Program consultations may involve a mental health professional in planning for testing and evaluation services, special education curriculum, in-service training and other specific needs.
>
> The broad aim of mental health consultation is to assist the teachers in doing their job with disturbed children at less expense of energy to the teacher, and through better prepared teachers, prevent problems from growing into crises situations. Measurement of the results of mental health consultation is very difficult. The results are often not tangible nor demonstrable in the short run, but it is the opinion of most mental health professionals and some educators that mental health consultation can be one more helpful resource to overworked teachers.[32]

The following table provides a summary of case studies of consultation services provided by Bayshore Mental Health Mental Retardation Center to Goose Creek Consolidated Independent School District Special Education Department:

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[32]Letter from Don Marler to W. C. Herring, Goose Creek Consolidated Independent School District (Baytown, Texas, November 12, 1971).

TABLE 7

STATISTICS ON BAYSHORE MHMR WORK[a]

Year	Budget	Staff Members	New Cases Harris County	*All School Evalua. Cases
(3/68-12/31/68)	$ 40,494	11	299	47
1969	133,357	11	317	68
1970	231,957	20	569	247
1971	306,968	21	626 (Through 4/30/72)	241 (Through 4/30/72)

[a]Calculated from: "History of Bayshore Mental Health Mental Retardation Center, Baytown, Texas, 1972."

*Approximately 2/3 of school evaluation in the past has come from Baytown schools.

When Don Marler requested funds for the new 1971-72 school year, he provided further information about consultation work with the school district by stating:

> The Bayshore Mental Health Mental Retardation Center, which began their program in 1968, assisted 247 persons during the previous year, of whom 186 were children under 16 years of age. More than 650 hours of consultation services were provided to persons in the school and community agencies.[33]

The drop in consultation cases for the school district from a high of 247 in 1970 to a low of thirty through April 30, 1972, resulted from two changes: (1) shift of emphasis in the philosophy of the Special Education Department, (2) the addition of staff psychologists to the school system because funds were provided in Plan A for new staff personnel. This trend is expected to continue as long as Plan A is the basis for special education services in Texas.[34]

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[33]Letter from Don Marler to Budget Committee of Baytown Community Chest (Baytown, Texas, June 9, 1971).

[34]Interview with W. C. Herring (March 16, 1972).

Stage Three: Plan A Funding.--Senate Bill 230 passed on May 6, 1969, added a new dimension to special education in Texas, thus affecting the Goose Creek Special Education Department. This bill began Stage Three of co-operation between Bayshore Mental Health Mental Retardation Center and Goose Creek Consolidated Independent School District. The staff of the Goose Creek Special Education Department increased from nine in 1962-63 to forty-nine in 1970-71, with a projected increase to 161 in 1976-77 (Table 5). This staff increase includes a school psychologist, educational diagnostician and special education counselors. Since the arrival of the school psychologist, the Bayshore Mental Health Mental Retardation Center consultations have decreased.[35]

Once special education students were helped by school counselors in the regular guidance program in Goose Creek School District. When a full-time director was hired for the school year 1962-63, special education consultation increased under Plan B because provisions for funds were based on the number of identifiable exceptional children in the school.

Future co-operation.--The Goose Creek Consolidated Independent School District, the Baytown Police Department, the Harris County Juvenile Probation Department, and the Bayshore Mental Health Mental Retardation Center have made a joint application for funds to support a psychologist, a director and a secretary to work in the School-Community Guidance Center.[36] The psychologist will be responsible for counseling

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[35]Interview with Don Marler held in his office, March 15, 1972.

[36]Harris County Mental Health Mental Retardation Board of Trustees, "Application to Federal Department of H.E.W. for Staffing Grant for School Community Guidance Center," (Baytown, 1972), p. 1-9.

parents and students in order to prevent delinquencies, dropouts, and truancy. These co-operative agencies seek budget support for $92,802 for this service for three years.

If the request for a grant is approved, a well-trained, experienced psychologist will be hired by the Bayshore Mental Health Mental Retardation Center. Supervision, fiscal, administrative and personnel responsibility will rest with the Bayshore Center. The psychologist will be housed in the School-Community Guidance Center, and will work exclusively with cases in that center. Records will be kept in conformity with Bayshore Mental Health Mental Retardation Center practices. The Bayshore Center professional staff will be available for back-up services and for consultation to the Guidance Center worker. In cases needing mental health and mental retardation services beyond the scope of the Guidance Center, a referral can be made to the Bayshore Center. The director will serve also as school attendance officer for the School-Community Guidance Center. He will devote one-fourth of his time to this duty.

During the second year the four co-operating agencies will be asked to plan to assume equal shares of the cost of this project beginning with the fourth year of operation.

The Guidance Center was established in 1971 to coordinate the total efforts of the schools, the community, the city, and the county agencies in meeting the needs of truant, dropout or delinquent students. During the first three months of operation, September 1, 1971 to November 31, 1971, the center had direct contact with three hundred families.[37]

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[37] Ibid., p. 6.

CHAPTER IV

SUMMARY AND CONCLUSIONS

Consultation and education are dual services of public institutions designed to work best in close harmony. Educators have endeavored for years to provide adequate facilities, instructional media, and well-trained teachers to assure the best quality education possible for the total scholastic population. The general public, however, has been less aware and less accepting of therapeutic or diagnostic education. This attitude is apparently changing. During the last decade public awareness of the need for professional assistance in mental health and special education problems increased, due in part to federal programs begun in the sixties under the influence of President Kennedy. A significant part of the programs is the establishment of comprehensive community mental health centers located in strategic cities.

Increased funding and staffing in both mental health centers and special education departments caused these two institutions to converge in local communities to co-operate on special education department problems. Consultation services provided by mental health centers to school districts were helpful in two ways. First, these services provided assistance to administrators and teachers in evaluating exceptional children. Also these services better equipped administrators and teachers to solve future problems related to these children and their families.

The convergence of mental health centers and special education

departments to assist exceptional children came at approximately the same time that new trends became noticeable in both types of institutions. First, in the area of special education changes in methods and philosophy have occurred. The aim of special education remains the same since the department was created in 1949 by the Texas Education Agency - to provide services additional to, or different from, those provided in regular classrooms to meet needs of exceptional children. However, since the passage of Senate Bill 230 which funded Plan A for special education, the trend has been to integrate these children into the regular classroom as soon as possible. Such an effort requires evaluation and consultation services to determine which pupils return to the regular classroom and how best to teach them. Most schools did not have school psychologists to perform this evaluation until funds became available through Plan A. Therefore, mental health centers which had personnel available for consultation and evaluation were used for the services.

Second, the mental health centers provided consultation as one of five general services included in a comprehensive community health center. Formerly looked upon as only a tool of counseling, consultation today is projected as one of the major directions of mental health work. Leaders in the field state that traditional diagnostic and treatment services only meet the most critical needs of mental health or special education cases. Professionally trained staff members of mental health centers need allies to provide extensive preventive services. These allies include teachers and school counselors who can move into the problem-solving situations requiring psychological evaluation and consultation.

Problem and design.--Consultation and evaluation services were provided to the Special Education Department of the Goose Creek Consolidated Independent School District by the Bayshore Mental Health Mental Retardation Center at a critical time when the school's staff was inadequate to handle evaluation of special education cases. The purpose of this study was to describe the mental health movement and the special education movement particularly as these movements have influenced local mental health and local Baytown public schools. The emerging field of consultation has been the focal point of study because it is the trend and method that brought the two institutions into a co-operative endeavor.

The problem was placed in perspective in Chapter I, defining the historical and theoretical framework in which the investigator worked. A review of literature related to the subject of this paper was investigated. Two categories of literature are summarized in the second chapter: (1) conceptual literature dealing with theory and philosophy of consultation, (2) literature related to existing models of consultation, especially consultation for public schools. The longest section of the paper described results of the co-operation that existed between the two institutions. The design is deliberately historical and descriptive rather than statistical. The investigator--through interviewing, researching of historical data related to the two institutions, reading of related literature in the area of consultation, and studying legislation affecting the mental health movement and the special education movement--began to summarize the growth of both institutions and the manner in which they co-operated.

Findings.--A review of related literature quickly revealed that consultation is much more than a technique or tool for counselors. It is a new philosophy in mental health services, consultation being one of the five basic services required by federal government specifications before funding is given to community mental health centers. Caplan of Harvard has encouraged a wider definition of consultation in order to help more persons. Sophistication of psychological evaluation has increased the mental health consultant's ability to diagnose problems. The expanding population and increasing mental health problems, including those of exceptional children, also increases the number of persons needing help. Consultation by a psychiatrist or psychologist for teachers, school counselors and administrators increases the number who can be helped.

The second discovery was that government agencies are concerned with the problem of mental health, both curative and preventive. Two pieces of legislation, Public Law 164 on the federal level and Senate Bill 230 on the state level, provided funds for increased staff and facilities for comprehensive mental health centers and special education departments. Funds for federal and state sources made it possible to increase the staff of the Goose Creek Special Education Department from nine in 1962-63 to forty-nine in 1970-71. Federal grants and local Community Chest support have provided enough money for the Bayshore Mental Health Mental Retardation Center to increase its staff from fourteen in 1968 to twenty-two in 1972. These staff increases in both institutions precipitated an increase in case work loads and an upgraded program. A major incentive in the increase in staff and program has been federal funding for mental

health mental retardation purposes and special education purposes.

A third finding was that Bayshore Center provided consultation and evaluation at a critical time in the life of Goose Creek Special Education Department. When consultation services began in 1969, the local school district received funding from Plan B of the Texas Education Agency. This funding is based on identifiable exceptional children rather than the new base of funding for Plan A which is calculated on average daily attendance. The difference in the basis of funding means that for Plan B fewer dollars were available for special education than under Plan A. Therefore, the staff was much smaller in the Goose Creek Special Education Department. No psychologist was available for evaluation of special education students. The Mental Health Center had the necessary staff to perform the tasks requested by the school system on a contract basis of $75.00 per evaluation. The two institutions worked closely until Plan A funding provided enough money to hire a school psychologist and education diagnosticians.

Implications.--Three implications were concluded by the investigator: (1) Positive contributions were made by the Bayshore Mental Health Mental Retardation Center to the Special Education Department of the Goose Creek Consolidated Independent School District. (2) Problems were encountered by both institutions in the development of the consultation program. (3) Certain recommendations are in order.

A major contribution of the Mental Health Center to the school district was the provision of consultation help when it was needed most. One example from Table 7, "Statistics on Bayshore MHMR Work," is that the Mental Health Center provided 650 hours of consultation

on 247 cases in the area in 1970. Two-thirds of these cases were in the Goose Creek schools. This consultation upgraded the program at a critical time for the school district, because the Special Education Department did not have the staff to do this consultation at the time. These services could have been obtained from private psychiatrists or psychologists in Houston, but only at the expense of time and money by families travelling to the city for consultation for their exceptional children.

The initial contracts have diminished in number, but consultation is still available from Bayshore Mental Health Mental Retardation Center for difficult cases. The center includes the parents in the counseling process, thus making it a family counseling situation. The opportunity is available for future co-operation between the two institutions.

Both institutions have increased their staffs as funds have been available. No research is available on the manner in which attitudes have changed, but it is possible that the Mental Health Center personnel influenced the school to seek professionally trained psychologists and educational diagnosticians for the Special Education Department. Consultation to teachers through in-service seminars developed more competent teachers in the area of special education.

Problems encountered were fewer than the investigator expected. One of the major difficulties was the lack of a clear understanding of Plan A philosophy and programs by mental health personnel. Also, when the number of evaluations by the Mental Health Center for the Special Education Department dropped, there was some concern in the center that the students would not receive

proper consultation. However, the hiring of a school psychologist provided a staff member who could evaluate, consult and design curriculum needs for the exceptional child. A final weakness was the fact that the staff at the Mental Health Center was generally unfamiliar with the instructional curriculum of the Special Education Department of the school district.

The investigator suggests four recommendations for future research and co-operation by the two institutions. First, administrators and consultation personnel of both institutions need to explore the new philosophies of consultation and special education. A series of group sessions would be beneficial to clarify the past experiences together. Second, the guidelines for referral of extreme cases of Special Education Department exceptional children and families are not clear. Some policy to determine at what point referral is to be made would be helpful. Third, public relations is a continuing problem in the mental health and special education fields. Both institutions can provide more positive public relations material to the citizens of Baytown, informing them of the philosophy and program of the institutions and the way in which the two groups work together. Fourth, plans for the new School Community Guidance Center offer an opportunity for continued co-operation between the Mental Health Center and the school district.

APPENDIX I

PROCEDURE FOR EVALUATIONS[1]

The Goose Creek Consolidated Independent School District has contracted with the Bayshore Mental Health Mental Retardation Center for comprehensive evaluations of school-age children in the district who present special problems in the academic setting.

The purpose of the following information is to set forth the method by which the contract between the Goose Creek School District and the Bayshore Center will be fulfilled.

I. Types of Special Education Classes Available and Eligible Children

Emotionally Disturbed

Visually Handicapped

Auditorially Handicapped

Physically Handicapped

Homebound (including girls who are pregnant)

Minimal Brain Injured

Speech Handicapped

Educable Mentally Retarded

Trainable Mentally Retarded

A description of these classes and eligibility may be found on pages 1 through 6 of the "Handbook for Teachers and Principals" provided by the Goose Creek Consolidated Independent School District.

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[1]Bayshore Mental Health Mental Retardation Center, "Procedure for Evaluations," Baytown, 1969, p. 1. (Mimeographed.)

II. Students Ineligible for Special Education Classes

Certain children who display traits of the child who falls in the above categories may not be eligible for special education. Unless a comprehensive appraisal establishes an emotional, physical or mental disorder, there is no legal basis for enrollment in special education. Some of these are classified as habitual truants, discipline problems, delinquents (have been handled by juvenile authorites), slow learners, bilinguals, and profoundly retarded.

III. Procedures for Referral:

The following steps must be taken by the school prior to referral to Bayshore Center:

A. Teacher-Principal conference regarding child.

B. Teacher-Parent-Principal conference regarding child

C. Agreement for appraisal

1. Complete school form (half page with name of child, birthdate, school attending, and name, address and telephone number of parents or guardian).
2. Complete Bayshore Referral Form
3. Both forms are to be sent to the Director of Special Education.
4. Referral forms are reviewed and the following course of action may be taken:
   a. Referral returned to referring school because it is inappropriate or incomplete.
   b. Additional screening by school counselor and/or school psychologist.

c. The office of the Director of Special Education acknowledges receipt of all referrals by school mail.

d. Referral is sent to Bayshore Center for evaluation.

IV. Procedure to be used by Bayshore Center in Servicing School Cases:

A. Screening

All school referrals go to one person at Bayshore Center for screening. This person makes decision as to whether or not the referral is appropriate and whether or not the MH Unit or the MR Unit will do the evaluation. Parents are then notified by letter as to whom they should contact for their first appointment. Follow-up on those cases who do not contact the Center for first appointment includes a telephone call to parents, and a report to the Special Education Office regarding failure of parents to follow thru. This is the responsibility of the intake worker.

B. Diagnosis and Evaluation

1. Intake - Gathering of social, developmental and medical history

2. In addition to the above social evaluation, one or more of the following evaluations may be done:

a. Psychological, or review of recent psychological

b. Neurological (mandatory for MBI class only). When possible refer back to family for this.

c. Speech

d. Psychiatric

e. Physical (mandatory for any child placed in Special Education.) When possible refer back to family doctor for this.

f. Medication evaluation

C. Staffing - Will include the following:

1. All persons from Bayshore involved in diagnostic process.

2. Referring principal

3. Referring Teacher

4. Director or Supervisor of Special Education

D. Reporting

1. Presentation of recommendations to parents is made by Bayshore Center. (Intake worker makes this presentation unless staff designates otherwise.)

2. Complete written report is sent to Special Education prior to, or no later than, date the school is billed for the case.

E. Follow-up or Consultation

This may involve follow-up by telephone regarding recommendations, and teacher observations regarding children or medication.

F. Treatment

This will be available to these children or their families through Bayshore Center. However, it should be clearly understood that there will be the usual fee assessed for this service.

APPENDIX II

BAYSHORE MENTAL HEALTH AND MENTAL RETARDATION CENTER REQUEST FOR EVALUATION OF BEHAVIOR AND/OR LEARNING DISORDERS[1]

One of your students is to be referred to the Bayshore Mental Health and Mental Retardation Center. Your observations about this student's behavior, achievement, and personality are an essential part of our assessment and will be most helpful to us. Please give as much information as possible. Feel free to use the back of the page.

Name of Child_____ Birth Date_____

School_____ Grade_____

School Address_____ Phone_____

Father's Name_____ Mother's Name_____

With Whom Does Child Live?_____

Address_____ Phone_____

Name of Person Completing Questionnaire_____

Position_____ Date Completed_____

1. Reason for Referral:

2. Child is in what type of class? regular___; accelerated___; slow____; special education (describe briefly):

3. Has child ever been in a different type class from the one he is in at present?

   What type was he in and under what circumstances was he moved to his present class?

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[1]Bayshore Mental Health Mental Retardation Center, "Request for Evaluation of Behavior and/or Learning Disorders," Baytown, 1969, p. 1. (Mimeographed.)

4. Has child ever shown a marked change in grades or behavior?____If so, please describe, giving age and grade of child, what seemed to cause this and how it was handled.

5. List subjects child is currently taking and grade at last grading period.

Subject	Grade	Describe any particular difficulties

6. Please list all standardized IQ, Achievement, Aptitude, and other Psychological tests (for all grades) and if possible attach recent profiles.

Name of Test	Date Given	Scores

7. Health Information:

Doctor's Name_____ Address_____

VISION	HEARING
Test Results:	Test Results:
Date:_____	Date:_____

Describe any significant medical problems and/or abnormalities:

Comments:

8. Please describe this child's strengths and assets:

9. Describe this child's behavior and adjustment in the classroom:

10. How does this child get along with other students?

    Does he have any special friend or friends?

    How does he get along with teachers?

11. What methods have teachers used in coping with this child?

    Methods most effective?

    Methods least effective?

12. What are your observations about this child's parents and home life?

What has been the extent of your work with the parents?

How able or willing are they to carry out suggestions?

3. What questions would you like answered by our evaluation?

Date_____

I am aware that _____, a student at _____, has been referred to the Bayshore Mental Health and Mental Retardation Center or the Harris County Department of Education for evaluation.

_____
Parent or Guardian

_____
Signature of Person responsible for Referral

_____
Title

APPENDIX III

GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT
DEPARTMENT OF SPECIAL EDUCATION
OBSERVATION GUIDE[1]

School _____

Teacher _____

Supervisor _____

Date _____

This guide is meant to be used for conferences between teachers and supervisors concerning decisions for instructional guidance of special education students. A consistent, structured approach to this task will be most beneficial to all concerned. The observer may not complete every item at each visit, therefore, several observations will be necessary for an overall view of teacher/pupil involvement in the classroom. Observations should be objective. By taking notes related to particular rations on the scale, clarification for follow-up conference may be provided.

1. Classroom Management

	Not at all					To a great extent
a. Arrangement of the furniture meets the needs of individualized instruction.	/ 0	/ 1	/ 2	/ 3	/ 4	/ 5
b. Materials are easily accessible for instructional tasks.	/ 0	/ 1	/ 2	/ 3	/ 4	/ 5
c. There is flexibility in room arrangement.	/ 0	/ 1	/ 2	/ 3	/ 4	/ 5
d. Room arrangement provides for the physical comforts of the students.	/ 0	/ 1	/ 2	/ 3	/ 4	/ 5

[1]Three excerpts from the Texas Education Agency Visitation Instrument were modified for use in this observation guide. Other material was developed by Goose Creek Consolidated Independent School District Special Education Staff for consultation purposes, January 10, 1972.

	Not at all					To a great extent
e. There is maximum use of instructional materials	0	1	2	3	4	5
f. The teacher maintains control and handles his own routine discipline problems.	0	1	2	3	4	5
. Is firm and consistent, but friendly.	0	1	2	3	4	5
. Is self-confident in the management of pupils	0	1	2	3	4	5

2. Preparation and Planning

a. The teacher provides for the purposeful use of each pupil's time throughout the teaching block.	0	1	2	3	4	5
b. There are long term and short term objectives for each child.	0	1	2	3	4	5
c. These objectives emphasize sequential development of fundamental skills.	0	1	2	3	4	5
d. The teacher keeps a daily record of the child's progress.	0	1	2	3	4	5
e. Educational plans, either teacher formulated or computer programmed for individuals are being implemented.	0	1	2	3	4	5
f. The teacher exhibits understanding of socioeconomic differences and how these influence learning.	0	1	2	3	4	5
g. Materials are used to meet individuals needs according to instructional plans.	0	1	2	3	4	5
h. Teacher-made materials are in use.	0	1	2	3	4	5
i. An orderly arrival/dismissal of the class is evidenced.	0	1	2	3	4	5
j. A form of positive reinforcement is demonstrated.	0	1	2	3	4	5

3. Pupil-Teacher Relationships

a. The teacher is fair and impartial. / / / / / / 0 1 2 3 4 5

. Teacher comments are based on fact. / / / / / / 0 1 2 3 4 5

. The confidence of the pupils is maintained through the appropriate teacher comments. / / / / / / 0 1 2 3 4 5

b. The teacher sets an example and encourages socially acceptable behavior; e.g., dress, correct usage of speech, and manner. / / / / / / 0 1 2 3 4 5

c. The teacher maintains an atmosphere conducive to freedom of thought and creative expression, and shows respect for pupil opinions and suggestions. / / / / / / 0 1 2 3 4 5

d. The teacher recognizes and fosters each pupil's worth and dignity. / / / / / / 0 1 2 3 4 5

e. A balance of teacher-pupil interaction appropriate to short-term objectives is evidenced. / / / / / / 0 1 2 3 4 5

f. The teacher handles behavior problems without emotional extremes. / / / / / / 0 1 2 3 4 5

4. Autonomy, Learner Involvement

a. The student exhibits interest in the classroom proceedings. / / / / / / 0 1 2 3 4 5

b. Each student seems aware of the purpose of his instructional programming and how he fits into the plan. / / / / / / 0 1 2 3 4 5

c. Each student demonstrates the ability to use instructional materials. / / / / / / 0 1 2 3 4 5

d. Some learning activities are student initiated. / / / / / / 0 1 2 3 4 5

e. Students are involved in group discussions. (If appropriate) / / / / / / 0 1 2 3 4 5

f. Students are free to move about in the classroom while working.

g. Students are working independently.

h. The students score their own work then experience follow-up conferences with the teacher regarding the scoring and pupil progress.

i. The students work in small groups based on individuals needs.

5. Pacing

a. Each student is proceeding at his own rate.

b. Each learner apparently succeeds at what he is doing before he enters a new activity.

c. The assistance and support given by the teacher appears to be appropriate to the learner's need.

d. Different activities are provided for each student.

6. Differentiation of Assignment

a. Students are working on different tasks.

b. Students are working with different materials.

c. There are opportunities to recycle tasks where student's understanding is insufficient to go on to new material.

d. The teacher's expectations seem to be based upon ability and previous practice of each student.

e. The teacher varies directions and assistance for different students.

f. Students in the same program are pursuing individual objectives. 0 1 2 3 4 5

g. Activities appear to be geared to each student. 0 1 2 3 4 5

h. Some learning activities are student selected. 0 1 2 3 4 5

7. The Team

a. The resource teacher and the regular classroom teacher plan together the instructional objectives for the pupils. 0 1 2 3 4 5

b. The special education teacher works closely with the principal and keeps him informed of progress. 0 1 2 3 4 5

c. An aide works regularly with students in the special education room. 0 1 2 3 4 5

Additional Comments:

Follow-up Conference:

Date

Participants

Comments

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VITA

Charles Gary Bonner was born in Shreveport, Louisiana, on March 5, 1937, the son of Flossie Jewel Bonner and Curtis G. Bonner. After graduating from Springhill High School in Springhill, Louisiana, in 1955, he entered Baylor University. In May, 1959, he received his Bachelor of Arts degree with majors in history and education and a minor in religion. He entered Southwestern Baptist Theological Seminary in Fort Worth, Texas, in 1959, receiving the Bachelor of Divinity degree in 1963. He pastored First Baptist Church in Schulenburg, Texas, 1963-1965. For the next four and one-half years he served as an associate pastor, first at Highland Park Baptist Church in Austin, then at First Baptist Church in Abilene. In November, 1969, he assumed his present duties as pastor of First Baptist Church, Baytown, Texas.

In June, 1959, he married Ann Harper of Springhill, Louisiana. The couple are parents of two children, Christopher and Andrea. Ann is a teacher in the public schools of Baytown.

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