DOCUMENT RESUME

ED 215 842 RC 013 348

AUTHOR Andrade, Sally J., Ed.
TITLE Representation on Mental Health Boards and Advisory Councils in Texas: Implications for Services to Mexican Americans.
INSTITUTION Intercultural Development Research Association, San Antonio, Tex.
SPONS AGENCY National Inst. of Mental Health (DHHS), Rockville, Md.
PUB DATE 81
GRANT MH-31212-02
NOTE 186p.; For related documents, see RC 013 347-351. Tables D-1 through D-59 may not reproduce clearly.
AVAILABLE FROM Intercultural Development Research Assoc., 5835 Callaghan, Suite 350, San Antonio, TX 78228 ($10.95).

EDRS PRICE MF01/PC08 Plus Postage.
DESCRIPTORS *Advisory Committees; Blacks; *Citizen Participation; Citizen Role; Delivery Systems; Federal Regulation; *Governance; Governing Boards; Group Membership; *Institutional Administration; Literature Reviews; Mental Health Clinics; *Mental Health Programs; *Mexican Americans; Participant Characteristics; Public Health Legislation; State Legislation
IDENTIFIERS Community Mental Health Centers; *Texas

ABSTRACT

Focusing on community mental health centers (CMHCs), governance within the Texas mental health service delivery system and how representation on boards and advisory councils relates to services for Mexican Americans are addressed by reviewing existing conceptual analyses of the governance function in community mental health and the citizens' role in governance; surveying federal and state statutes; and compiling rosters of board and council members at the Texas Department of Mental Health and Mental Retardation (TDMHMR) and CMHCs. Tabular data on the ethnicity, sex, and occupation of 1981 board members demonstrate the historical lack of Mexican American and Black representation on the TDMHMR Board of Trustees and CMHC boards. The monograph includes discussions on the role of boards and councils in the TDMHMR: the federal intent and public law; the context: mental health in Texas; specific cases of citizen representation on mental health boards and councils; the issue of "representation vs. representativeness" for Mexican American communities; and recommendations for expanded citizen participation in the governance of mental health programs. Appendices include a model board of citizen governance; an annotated chronology of federal and state mental health activity; and rosters of 1979 and 1981 state boards, advisory groups, and CMHC boards. (Author/NQA)

Representation On Mental Health Boards and Advisory Councils In Texas: Implications For Services To Mexican Americans

by
Sally J. Andrade, Editor

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Front cover design by Sharon Sepúlveda-Hassell and David G. Ramirez

This publication was produced with funds from a grant (MH 31212-02) made to the Intercultural Development Research Association (IDRA), by the National Institute of Mental Health (NIMH). However, the opinions expressed herein are solely those of IDRA and do not necessarily reflect the position or policies of NIMH, and no official endorsement should be inferred.

REPRESENTATION ON MENTAL HEALTH BOARDS AND ADVISORY COUNCILS IN TEXAS: IMPLICATIONS FOR SERVICES TO MEXICAN AMERICANS

Sally J. Andrade, Editor

Abstract

This monograph addresses the issue of governance within the mental health service delivery system in the State of Texas, focusing specifically on community mental health centers (CMHCs), in terms of how the issue of representation on boards and advisory councils relates to services for Mexican Americans. The study was developed through reviews of existing conceptual analyses of the function of governance in community mental health and the role of consumers or citizens in governance, a survey of federal and state statutes, and the compilation of rosters of board and council members at the State mental health authority and CMHCs in Texas.

Following the introductory chapter, the second chapter is a review of the literature on citizen participation in community mental health center governance by Sally J. Andrade. The third provides background information on the role of boards and councils in the Texas Department of Mental Health and Mental Retardation. Written by Bernadette A. Brusco, the section reviews the federal intent and public law and discusses the context of mental health in Texas.

The fourth chapter by Andrade discusses specific cases of community or citizen representation on mental health boards and councils in Texas. It includes tabular presentations of the ethnicity and sex of members in 1981, as well as their occupation. The data demonstrate the historical lack of representation of Mexican Americans (and Blacks) on the TDMHMR Board of Trustees and the boards of the 30 CMHCs in Texas. Also documented is the dominance of the governance function by men, and by men in business and professional occupations.

Particularly underrepresented are Mexican American and Black women. A recent trend is the increased representation of minorities, especially Mexican American men, in an advisory role (i.e., service on the Texas State Mental Health Advisory Council). Andrade discusses the issue of "representation vs. representativeness" for Mexican American communities and in the final chapter presents conclusions and recommendations for expanded citizen participation in the governance of mental health programs in Texas.

The Appendices include a model board for citizen governance, an annotated chronology of federal and state mental health activity, the rosters of state boards and advisory groups and CMHC boards for 1979 and 1981, and a list of references.

MENTAL HEALTH RESEARCH PROJECT OF THE INTERCULTURAL DEVELOPMENT RESEARCH ASSOCIATION

The Intercultural Development Research Association's Mental Health Research Project (MHRP), funded by the National Institute of Mental Health, seeks to improve mental health delivery systems for Mexican Americans in the state of Texas.

The MHRP's major goals include: 1) a preliminary analysis of the effectiveness of the state mental health service delivery system and subsystems in providing services to Mexican Americans; 2) an assessment of the community mental health center concept as it relates to the Mexican American population; 3) the design of a bilingual/multicultural human service delivery model relevant to the mental health needs of Mexican Americans in Texas; and 4) the development of policy and programmatic alternatives to enhance the utilization of the state mental health service delivery system by Mexican Americans.

The MHRP has established a Texas Advisory Committee which consists of mental health service deliverers, professionals/academicians and consumer representatives from the five major geographical regions of Texas. The committee members serve as conduits for information dissemination and collection. To ensure maximum generalizability of the process and products of the MHRP, six nationally recognized professionals in the area of mental health and service delivery systems serve as consultants to the MHRP in the form of a National Advisory Committee.

The goal of the IDRA Mental Health Research Project is improved services for Mexican Americans in the state of Texas. Because a lack of agreement has existed in Census surveys and social science research as to the definition of a "Mexican American," potential problems emerge in attempting to compare data sources across regions or time frames. Terms encountered historically to identify this ethnic group include: Mexicans,

Mexican Americans, Spanish-surnamed, Spanish-speaking, Latin Americans, Spanish Americans, Hispanics, etc. The term "Mexican Americans" is used consistently by the Mental Health Research Project to refer to this population, indicating those residents who are of Mexican origin or descent. References to specific data sources may at times utilize the exact label cited therein (e.g., "Spanish Americans"); it is assumed by the project that the overwhelming majority of any such individuals in Texas are of Mexican origin.

Mental Health Research Project Staff

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FOREWORD

The goal of IDRA's Mental Health Research Project (MHRP) is to document the status of the mental health service delivery system in Texas and to explore ways of making this system become more responsive to the needs of Mexican Americans. The MHRP was the outgrowth of an awareness and concern on the part of many key mental health advocates in Texas and at the National Institute of Mental Health that the inaccessibility of appropriate services for Mexican Americans needed to be remedied. In order to change a system's responsiveness to a particular population, one must impact its policies and programmatic decision-making process. This particular monograph, possibly more directly than any of the others produced by the MHRP, focuses on Mexican Americans' access to and involvement in the policy arenas that shape the current mental health system. The general conclusion drawn in this study is that for minorities and women in Texas there has been little, if any, avenue for input and participation in the formulation of policy for mental health services.

Community psychologists have long argued that human services are more successful when community residents develop a sense of ownership over those services. In order for this sense of ownership to emerge, members of the community must be assured that they have a voice in the policies and procedures of the service facilities. In the ideal sense, services should match local needs. Indeed, the new era of Reagan economics is in some respects founded on the concept of local control and on the idea that communities will politically and financially support that which they control. With federal funding for human services diminishing, the commitment of states and municipalities to such services will be severely tested in the coming years. This monograph is thus written at a timely moment in the history of the community mental health movement, as the future of services established by this movement may soon be dependent on whether or not communities believe these services are necessary, effective and, most of all, responsive to their input.

This monograph would not have been possible without the courteous assistance of many individuals working in the mental health service delivery system of Texas. Particular thanks are due to Juda B. Cloud, Secretary to the Texas Board of Mental Health and Mental Retardation, to Flo Sharples in the Division of Planning and Resource Development of the Texas Department of Mental Health and Mental Retardation, and to the executive directors and their administrative assistants at the 30 community mental health mental retardation centers located throughout the state of Texas. The staff of IDRA Mental Health Research Project wishes to express its appreciation for their responsiveness and interest in helping to analyze the process of mental health governance in our state. We also want to thank Rosario H. Trejo, the MHRP Secretary, for her masterful handling of the complex material in this monograph.

David G. Ramirez
Principal Investigator
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CHAPTER I
INTRODUCTION

Sally J. Andrade

In 1979, the IDRA Mental Health Research Project compiled the rosters of the Board of Trustees which governs the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the agency's two Advisory Councils (Brusco, 1979a). The author stated that the data had never been compiled before and that they were difficult to retrieve, being collected by analyzing past minutes of the Board and annual reports of the Councils. Also included in the monograph were rosters of the boards of trustees of the existing 29 community mental health mental retardation centers (CMHCs) in Texas. The author reported that no complete roster of CMHC board members existed. She conducted interviews with each center's liason officer from TDMHMR and with center staff in order to compile the rosters. Data on board members were usually collected from the secretary to the executive director, the executive director, or the board secretary. Again, according to Brusco, there is no standardized procedure for regularly reporting board membership, and no agency has been designated as a depository for such information. The MHRP monograph thus constituted an initial attempt to document the individuals who govern and advise the administrators of the mental health service delivery system in Texas.

Although welcomed by many readers, the rosters also generated criticism and suggestions for improvement. The straightforward presentation of the members' characteristics without any interpretation made it difficult to discern patterns. There was also support for the concept of an annual update in order to examine the issues of rapid turnover and of self-perpetuating memberships. Frustration was expressed due to the ambiguity of ethnic categories (Spanish Surname, Black and Other).

This monograph is the result of the IDRA Mental Health Research Project's decision to undertake a more systematic review of mental health trustees and advisors in the state in order to expand Brusco's original groundbreaking study. The second chapter by Andrade is a brief review of the literature on governance and citizen participation in the field of mental health, with particular attention to community mental health centers. Chapter Three encompasses slightly revised background information originally compiled by Brusco on the role of boards and councils in the TDMHMR system. She outlines key federal legislation as it has effected governance issues in Texas. In Chapter Four, Andrade analyzes the characteristics of mental health trustees and advisors at both the state and local levels. She questions the definition of representation with respect to race/ethnicity, sex and occupation. The final chapter by Andrade outlines conclusions and recommendations for expanded citizen participation in the governance of mental health programs in Texas, focusing particularly on Mexican American interests. It notes the essentially political nature of many appointments and speculates about possible trends for the future.

The appendices provide valuable resource material for individuals interested in mental health governance. Appendix A provides an outline of a model CMHC board developed by Ragland and Zinn with support from the National Institute of Mental Health. Brusco's Annotated Chronology of Federal and State Mental Health Activity has been edited and is included as Appendix B. The TDMHMR rosters of the Board of Trustees and the three advisory groups have been edited and updated and are presented in Appendix C. Both the original 1979 and the 1981 rosters of CMHC boards of trustees are published in Appendix D. The 1979 rosters have been edited. References for the monograph are included as Appendix E.

The IDRA Mental Health Research Project staff hope that this publication will stimulate more vigorous dialogue about who governs in mental health. The most important factor may be the

urgent need for renewed alliances and cooperation between community representatives and mental health administrators. In a time of growing societal concensus about the utililization of cost-effective approaches to the delivery of human services, community mental health is extremely vulnerable.

CHAPTER II

THE ROLE OF CITIZENS IN THE GOVERNANCE OF COMMUNITY MENTAL HEALTH CENTERS: A REVIEW OF THE LITERATURE

Sally J. Andrade

The goal of this chapter is to present a brief review of the literature on citizen participation in the governance of community mental health centers (CMHCs) in the United States. Because a number of comprehensive annotated bibliographies are all ready available on this topic (e.g., Hunt, 1973; Ragland & Zinn, 1979), the chapter will highlight major issues rather than attempt an exhaustive compilation of findings. It will serve as the foundation for the background information on the position of mental health boards and councils in Texas, summarized in Chapter Three, and for the discussion of Mexican American representation on those bodies in Chapters Four and Five.

Ragland and Zinn (1979) outline the background of citizen participation in the U.S. governing process as it relates to community mental health. They emphasize that broad-based and effective citizen participation in a governing or advisory capacity enables better answers to community problems because of the greater diversity of creative participants in the problem-solving process. This participatory model places citizens in a decision-making role and technicians in an advisory role. Yet Ragland and Zinn note that until the 1960s, the reverse was more typical of most community programs. It was not until the Kennedy and Johnson administrations that the citizen governance model assumed viability. In spite of confusion and conflict engendered by attempts to implement citizen participation in the governance of social service programs, Ragland and Zinn conclude that:

> ...none of our current social problems can be solved until the instruments of self-government are repaired. After the mistrusts of politicians brought on by Watergate at the top level and local problems at the community level, social action programs need believable governing processes that both appear to be and are in actuality open and accountable to the residents of the community. (Ragland & Zinn, 1980, p. 58)

The Federal Legislative Mandate

The philosophy behind the federal program of community mental health centers was one which postulated that the effectiveness of a CMHC would depend on its responsiveness to the needs and resources of local communities. Thus, a commitment to citizen participation in governance was mandated by the CMHC Amendments of 1975, Public Law 94-63:

> The governing body of a community mental health center shall:
>
> (i) be composed, where practicable, of individuals who reside in the center's catchment area and who, as a group, represent the residents of that area taking into consideration their employment, age, sex, and place of residence, and other demographic characteristics of the area, and (ii) meet at least once a month, establish general policies for the center (including a schedule of hours during which services will be provided), approve the center's annual budget,

> and approve the selection of a director for the center. (PL 94-63, Section 201 (c) (1) (A), 1975)

As Dr. Herbert Pardes, Director of the National Institute of Mental Health, stated in 1979:

> The National Institute of Mental Health has a direct interest in encouraging the active participation of private citizens and voluntary and citizen organizations in the delivery of mental health services in their respective local communities.
>
> Support for local community control and citizen participation in the development, delivery, and evaluation of mental health services continues to be a central component of Federal legislation. That encouragement is based on the assumption that direct citizen involvement in the administration and monitoring of mental health services is likely to produce improved program accountability and responsiveness, as well as qualitative, equitable care to all sectors of the community. (Ragland & Zinn, 1979, p. iii)

In their work on theoretical models of citizen participation, Ragland and Zinn (1979) point out that the purpose of federal guidelines and regulations is to ensure that a basic level of similarity, or homogeneity, exists in the governance of CMHCs. The goal is to avoid an arbitrary local policy-making process which would be opposed to the fundamental intent of the citizen input aspects of the CMHC program. Noting that the basic

federal mandates are loosely drawn, the authors assert that they at least assure a representative citizen board will exist and have some influence on policy:

> State, local and research-based guidelines are usually more specific in their definitions for board structure, function, and authority. The individual States, by exercising the discretionary powers delegated to them by the 1967 and 1975 amendments to the CMHCs Act of 1963, may specify the form that citizen participation takes.
>
> Thus, the form and level of citizen participation are intended to be influenced by both local community factors and State and Federal policies. Guidelines are meant to ensure basic citizen input into the decision-making process, but to allow each community to establish optimal local mechanisms for accomplishing this. (Ragland & Zinn, 1979, p. 23)

A number of studies from the National Institute of Mental Health have analyzed the various laws that fund and regulate community mental health centers (National Clearinghouse for Mental Health Information, 1975; Paschall, 1975), and several works are available which review the legal responsibilities and obligations of CMHC board members (The Citizen Participation Program, 1979; Forer, 1963; Milio, 1974).

Recruitment, Selection and Maintenance of Board Members

A major problem that has confronted community mental health centers is that of how to identify potential board members who will be effective leaders and yet representative of their

community or catchment area. The federal guidelines of P.L. 94-63 specify that the factors of employment, age, sex, place of residence and "other demographic characteristics of the area" must be considered "where practicable." Advocacy groups have focused on the issues of race or ethnicity, language, consumer representation, special mental health problems (substance abuse, autism, etc.) and other handicapping conditions.

The barriers inherent to identifying and recruiting potential applicants are sometimes minimized. Ragland and Zinn (1979) summarize a number of articles on CMHC governance board selection and note that the authors repeatedly suggest that genuine citizen participation must begin by interacting with grassroots community organizations:

> The importance of encouraging native leadership is stressed. . .since the prominent local professionals and businessmen may not be the best leaders to represent the people of the catchment area. It is more difficult, but much more strategic, to locate and recruit people that a majority of CMHC clients would accept as leaders in their local communities. (Ragland & Zinn, 1979, p. 5)

Because of the tendency for some boards to be somewhat uniform in their composition (i.e., white male business leaders or professionals), it is often difficult for such individuals to reach out and diversify their membership. Pinto and Fiester (1979), in a study of five community mental health programs in a southeastern state, surveyed the views of CMHC management staff and governing board members toward three related components of the mandate calling for increased citizen participation participation in general, (b) areas of CMHC program evaluation

where citizen input is likely to be most useful, and (c) individuals who would serve most effectively on center advisory groups.

Their results indicate that CMHC board members and staff closely agreed about the type of citizen most appropriate for appointment to a citizen advisory group, i.e., key informants (or community leaders) and referral agents (professionals in the community who send clients to the CMHC). The board members and staff also agreed on the least acceptable appointees -- high risk people and current clients. Pinto and Fiester suggest that CMHC board members thus favor establishing advisory groups composed of individuals very similar to themselves, while they place potential or existing consumers at the bottom of the list. Although the majority of these CMHC board members would be technically classified as "consumers," they, nevertheless, seem to assume a "provider orientation" in this respect. Thus, it appears to be very difficult to ensure some kind of mechanism to represent the interests of CMHC service users (Pinto & Fiester, 1979).

Robins and Blackburn (1974), in their study of five CMHC boards, also document this tendency. Among their findings, they report that essentially, members of the board felt accountable only to each other, except for fiscal accountability to the governmental funding sources. In the authors' words, they appeared to "reign but not rule," however, in that despite the elitist nature of the boards, the members were very conscious of the limitations of their power over the activities of their centers.

Ragland and Zinn (1979) review a number of works outlining possible solutions to problems of recruitment and selection. For example, Burt (1970) delineates a method for rotating board members in order to obtain a cross-sectional representation of the community, and Brieland (1971) proposes methods for selecting community representatives on a regular basis.

Nonetheless, in a mail survey of 220 community mental health centers in 1978, three years after the passage of P.L. 94-63, Cibulka (1981) reports that most CMHCs did not meet the participation requirements of the law for broad representation of the catchment area in governance or the functional requirements for decision making. He also notes that the CMHC boards did not choose to incorporate other typical approaches to participation, such as outside selection of members, interest group representation, evidence of involuntary turnover or limited terms of office, public communication, and accurate representation on the board of at least half the non-elite groups in the catchment area.

The Effectiveness of Citizen Participation on CMHC Governance

Individuals who agree to serve on the boards of trustees of community mental health centers are faced with amazingly complicated tasks of organizational coordination:

> CMHCs differ from other professional service agencies in that they have the dual responsibility of providing specific services and of ensuring the cooperation and coordination of other agencies with related services. Thus CMHC boards have to work toward internal organizational goals, as well as goals among all their related organizations. (Ragland & Zinn, 1979, p. 59)

Questions as to the effectiveness of citizen governance in community mental health have been prominent since the initiation of community mental health centers. Hunt (1973) concludes that the hopes of the designers of citizen participation have yet to be fully realized. Some of his findings include:

1. Many citizen groups are unaware of what they are expected to do;

2. Often they lack the leadership, consistent membership, and staff support necessary to carry out their function;

3. When they are able to make recommendations to providers of health services, their counsel may be ignored or treated lightly;

4. The conflicts and negotiations discussed above often prevent citizen groups from functioning effectively; and

5. Many groups have lost their necessary link to the community they are said to represent. (Hunt, 1973, pp. 14-15)

However, Ragland and Zinn (1979) suggest that more attention needs to be directed to studying the practical results of strong participation in CMHCs. In their review of the literature, they note a number of studies which point out specific benefits of mediation and coordination achieved by consumer and citizen representatives. In their opinion, a key factor is the increased accessibility and utilization of CMHC programs that are frequently the result of active community boards.

Another important role for CMHC governing boards and/or advisory groups is the assistance in the design and implementation of evaluation projects:

> Since the boards represent the community, and only the community can tell in what ways and to what extent its mental health needs are being satisfied, it seems natural for boards to assume and dominate this role. (Ragland & Zinn, 1979, p. 35)

Evaluation has become a major goal of the federal government, and many state governments are following its lead in requiring systematic evaluations of any publically funded services. The crucial issues are the legislative and administrative priority attached to outcome studies (Schulberg, 1981), the need for more comprehensive and sophisticated training on program assessment (Schulberg & Perloff, 1979), the lack of proper use of available techniques (Bernstein & Freeman, 1975), the importance of culturally sensitive evaluation processes (National Institute of Drug Abuse) and the significance of criteria which are indeed reflective of community goals:

> To be effective, mental health providers must be accountable to the consumers of their services, rather than just to their colleagues, as has been the traditional situation. (Ragland & Zinn, 1979, p. 35)

Consumer and community representatives who serve on the boards and advisory councils of community mental health centers are dependent on such evaluation efforts in order to be effective decision makers. The lack of such input often may hamper citizens in their attempts to be effective governors of community mental health centers. Dinkel, Zinober & Flaherty (1981) comment on the infrequent participation of citizens in CMHC program evaluation, presenting a rationale and suggestions for a different level of involvement.

In spite of the many problems concerning the formation and functioning of citizen advisory boards, Morrison, Holdridge-Crane and Smith (1978) conclude that there is considerable evidence that when accompanied by careful planning and periodic evaluation efforts, citizen boards can be invaluable aides to community mental health centers. Citizen advisory boards are viewed by these authors as an excellent means to foster communication

between the community, clients and center staff. Yet because of the lack of new and creative roles for board members and of careful board assessment studies, the authors suggest that enthusiasm for the concept may be waning before its effectiveness has been fully evaluated.

Representation by Racial/Ethnic Groups on CMHC Boards

A fundamental aspect of the arguments on behalf of community participation and community control of public service programs in the 1960s was the growing conviction of Blacks, Mexican Americans and other racially or culturally distinct groups that the structure of American democracy and majority rule would never address the needs of their groups (Cornely, 1970). This conviction that racial/ethnic representation -- on governing boards and advisory committees and in the administration and staff -- is the only way to ensure quality service programs for racial/ethnic populations has also been applied to community mental health centers (Bolman, 1972; Daniels, 1973; Ruiz & Behrens, 1973).

Because of the high incidence of poverty and its debilitating effects among these groups, Ragland and Zinn (1979) argue that a CMHC must make special efforts to know its community:

> Data concerning the physical and environmental status of minority groups are important for citizen boards to consider, since these often correlate with mental illness and should have an impact on program development. The utilization, resistance, and accommodation to mental health services by minority groups in the community are important considerations in programming and delivering CMHC services. Alienation felt toward

> mental health agencies and services must be recognized among minority groups, if it exists; services of the CMHC should be designed to be attractive, responsive, and viable for all groups. (Ragland & Zinn, 1979, p. 1)

As they point out, however, a major tactical error on the part of many CMHC boards is the application of middle-class models of community mental health centers to poverty area conditions. Ragland and Zinn suggest that it is essential for area residents to assume decision-making responsibilities in order to avoid such conflict. Yet they note that:

> There does not exist, however, good methods for identifying communities, determining the will of a community, or dividing responsibility between the professional and consumer for planning and implementing mental health services. The poor have not been trained to handle options because there have always been so few available. (Ragland & Zinn, 1979, p. 43)

They identify a number of works which provide practical suggestions to develop and administer CMHCs in low-income and/or racially distinct neighborhoods, and they also point out the responsibilities of health professionals to gain some insight into the role of hostility and militancy on the part of minority or low-income individuals who serve on CMHC boards.

Two state mental health administrators in Texas discuss the complex dimensions of accountability faced by CMHC administrators, noting at least eight different constituencies which demand various overlapping levels of accountability from a center:

> There has been a switch from internal accountability to external accountability with no diminution of the demands for internal accountability, while the demands for external accountability have escalated rapidly. (Gaver & Franklin, 1978, p. 8)

They conclude that the practical problems facing CMHC directors are likely to get worse before they get better: Which demands must be met? Which should be met? What is actually feasible? While the authors' analysis included "the public" as one sector or constituency, they did not acknowledge issues of racial and ethnic diversity, a tendency of state administrators often commented on by minority mental health advocates.

Training of CMHC Board Members -- And CMHC Staff

Thus, it seems apparent that many of the citizens who serve on the boards of trustees of community mental health centers are frequently ill prepared for the leadership responsibilities which they are expected to assume. Furthermore, many members report feeling powerless in their governance role, noting that they leave much of the decision-making process to the executive director. There also appears to be a pattern of rapid turnover of board members.

Howell (1979) characterizes the current situation as one in which "citizen boards are not providing the community leadership for mental health services as intended; they are seldom truly representative of the community's population." He notes that board members are generally selected primarily for their influence, power, and prestige, and that the methods of selecting board members are usually self-perpetuating. Howell describes most board members as feeling inadequate as leaders and as attempting to avoid asking questions or make suggestions. He describes board members of community mental health agencies as

essentially passive and noncontributing, in that they only sporadically attend board meetings. The result of this behavioral pattern by CMHC board members is the assumption of agency leadership by the staff.

Pinto and Fiester (1979) also reported such self-doubts on the part of board members. Both trustees and staff agreed that most citizens do not know enough about community mental health centers to make useful suggestions for change in services, but the governing board felt even more strongly than the staff about this issue. While some critics conclude that citizen governance as a concept is to blame, others have suggested that it is the fault of the institutions in their failure to provide comprehensive training to their board members. For example, Bartlett and Grantham (1980) contend that the model of citizen governance has been implemented with only marginal success but that a board development program to raise the competence of board members in such key areas as policy planning, program evaluation, public relations, organizational management and fund raising is the crucial variable which is missing. The authors present a nine-component program, with the goals of increasing the efficiency, effectiveness and awareness of board members; of more clearly defining their functions and duties; of building local political and financial support; and of decreasing the variation in skill and background that they bring to the board.

Silverman (1981) reports a self-designed training program for mental health advisory and governing boards, which was planned for and by board members who represented 11 different boards and the major ethnic and economic groups in a metropolitan area. In assessing its effectiveness in terms of evaluation measures, he suggests that its success "attests to board members' capacity to exercise independent judgment about their needs and priorities and their ability to use resources to meet them" (Silverman, 1981). He also notes that the grass roots model of citizen participation in the curriculum development was highly cost-effective in its moderate use of consultants. Silverman

concludes that most board deficits are due to glaring inadequacies in preparing citizens for board membership.

After their review of the literature, Ragland and Zinn (1979) emphasize the contribution that training can make to board effectiveness:

> Analyses of governing boards consistently find that, with adequate initial training and continued support, boards can contribute significantly to the effectiveness of a center's operations, but unfortunately the commitment of the administration to board training and support is usually weak or totally absent. (Ragland & Zinn, 1979, p. 48)

The topic of training for CMHC staff and administrators about the role and functions of the board thus becomes a critical factor in initiating a fully operational support system for board members. Dreer and Langen Steketee (1978) outline professional staff roles and support models that can be used to facilitate the improved functioning of CMHC boards. As a case study of such an attempt, Ahmed and Harm (1979) discuss the relationship between the staff and the board as one center attempted to develop a partnership in which power, privileges and knowledge are shared. The Citizen Participation Program (1979) of NIMH developed an excellent orientation manual for citizen boards of community mental health centers, which could be supplemented by local materials. Ragland and Zinn (1979) suggest other resources for centers interested in developing training programs related to citizen governance issues.

The Model Board Concept

Windle and Cibulka (1981) present a conceptual framework for analyzing citizen participation in community mental health services, which emphasizes the importance of examining both organizational adaptation problems and issues around the distribution of power within the center and the community. They point out that both perspectives, that of organizational dysfunction and of the view of change as a threat to existing power distribution are mutually dependent and mutually reinforcing:

> ...barriers to improvement are in important respects qualitative rather than matters of degree and cannot be resolved solely by incremental strategies. (Windle & Cibulka, 1981, p. 15)

In discussing possible strategies for expansion of citizen participation in the governance of community mental health centers, they note the following: federal demonstration grants to CMHCs which wish to develop innovative models of governance; increased training for staff and board members; and federal assistance to local communities for the improvement of community organization on community mental health issues. In their view, the latter will probably be the most effective.

In their summary of theoretical models of citizen participation in community mental health centers, Ragland and Zinn (1979) outline a general model for CMHC Governing/Advisory Boards. The organizational principle is that there cannot be any one uniform or standardized citizen governance body that should be reproduced by every CMHC:

> ...that would be just the opposite of the main goal of citizen participation and decentralization of authority from the government to the people. A board's structure and function should be tailored to the unique social background, needs, politics, and personalities of its setting. (Ragland & Zinn, 1979, p. 61)

Thus, they delineate a theoretical model CMHC board, describing its 12 basic characteristics and providing 93 operational guidelines. The model is intended to serve as a rational, but highly flexible basis for CMHC board development. The authors point out, however, that not all the descriptive characteristics of the model will be relevant to all CMHC boards (see Appendix A for their description of the model).

Ragland and Zinn emphasize, however, that there are some supportive conditions which are essential to the viability and success of a CMHC board in its community. Based on conclusions of the articles summarized in their Annotated Bibliography, the conditions are viewed as "crucial for all boards, no matter what combination of characteristics of the model happens to be suited to the power structure, resources, and mental health needs of the catchment area" (Ragland & Zinn, 1979, p. 61).

SUPPORTIVE CONDITIONS FOR CMHC BOARDS[1]

a. A support staff and resources should be available such as the following: secretarial help for correspondence and typing, an assigned place to conduct meetings and collect materials and files, office supplies, and financial or other means for obtaining technical expertise and needed information on issues facing the board.

[1] Ragland & Zinn, 1979, pp. 61-64

b. The personal expenses (transportation, baby sitting, time off from work, materials, etc.) of members should be covered by the CMHC budget.

c. Access to budgetary and grant information and input into the development of the budget must be available for the board. The board should have the opportunity and authority to give approval to the budget.

d. The board should have an organized powerbase in the community to which it is accountable and with which it has open communication channels. [Figure 1] illustrates a minimum set of avenues for information flow which should be readily available to the board. These would facilitate community coordination and support for the CMHC.

e. The board must be able to make a legitimate claim that it is representative of the community. [Figure 2] illustrates one way in which a board could demonstrate that its members reflect the character of the catchment area.

f. Some form of orientation and continuing training should be provided to board members and to the staff of the CMHC in order to make relationships between them as supportive and effective as possible. This would educate all parties about the resources, options, rights, duties, and current policy issues of the board.

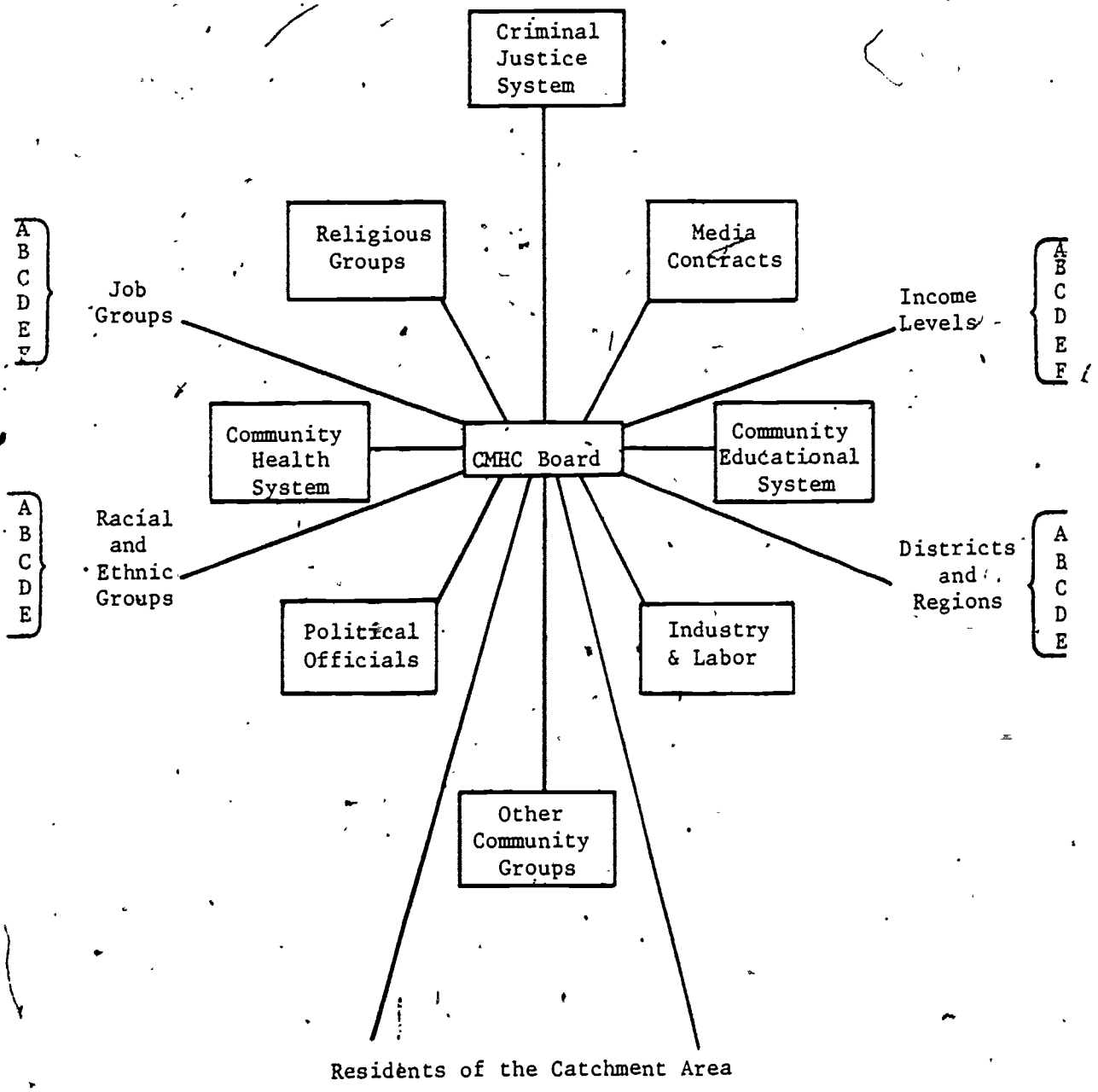
g. The board should have skills and resources available for determining the mental health needs and priorities of the community.

h. The board should perceive as a major goal the development of efficient mechanisms for enabling the CMHC to be responsive to the needs and conditions of the community.

FIGURE 1

COMPOSITION OF A REPRESENTATIVE GOVERNING/ADVISORY CMHC BOARD[a]

The success or failure of a board depends largely on the effectiveness of its two-way communication with the CMHC, community organizations, and residents. The following diagram represents a model board's communication channels.



[a]Ragland & Zinn, 1979, p. 63.

FIGURE 2

Composition of a Representative Governing/Advisory CMHC Board [a]

The following tables illustrate what might be considered to be a board that accurately represents its community. After having used census and other records or surveys to determine the makeup of the catchment area, the composition of this board was required to reflect those same statistics. In this example, a leeway of 5 percent has been accepted for each characteristic, but another board would be free to set its own standards as to what degree of representativeness it would want to attempt.

MAKEUP OF THE CATCHMENT AREA		COMPOSITION OF THE BOARD	
1 Percent of residents at various ages:		1. Percent of board members at various ages:	
Age range	Percent	Age range	Percent
12-18 yrs.	15	12-18 yrs.	15 (+ or - 5)
19-35 yrs.	20	19-35 yrs.	20 (+ or - 5)
36-50 yrs.	20	36-50 yrs.	20 (+ or - 5)
51-65 yrs.	20	51-65 yrs.	20 (+ or - 5)
65+ yrs.	15	65+ yrs.	15 (+ or - 5)
2. Percent of residents, male and female:		2. Percent of board members of each sex:	
Sex	Percent	Sex	Percent
Male	40	Male	40 (+ or - 5)
Female	60	Female	60 (+ or - 5)
3. Percent of residents in various occupations:		3. Percent of board members in various occupations:	
Occupation	Percent	Occupation	Percent
Services	20	Services	20 (+ or - 5)
Industrial	15	Industrial	15 (+ or - 5)
Education	12	Education	12 (+ or - 5)
Health	10	Health	10 (+ or - 5)
Construction	8	Construction	8 (+ or - 5)
Self-employed	15	Self-employed	15 (+ or - 5)
Unemployed	9	Unemployed	9 (+ or - 5)
Other	11	Other	11 (+ or - 5)

MAKEUP OF THE CATCHMENT AREA		COMPOSITION OF THE BOARD	
4 Percent of residents with each racial and ethnic background		4 Percent of board members with each racial and ethnic background	
Background	Percent	Background	Percent
White	55	White	55 (+ or - 5)
Black	10	Black	10 (+ or - 5)
American Indian	8	American Indian	8 (+ or - 5)
Oriental	7	Oriental	7 (+ or - 5)
Spanish speaking	15	Spanish speaking	15 (+ or - 5)
Other	5	Other	5 (+ or - 5)
5. Percent of population living in various neighborhoods or census districts of the catchment area:		5 Percent of board members who live in various neighborhoods or census districts of the catchment area:	
District number	Percent	District number	Percent
1	10	1	10 (+ or - 5)
2	20	2	20 (+ or - 5)
3	25	3	25 (+ or - 5)
4	15	4	15 (+ or - 5)
5	20	5	20 (+ or - 5)
6	10	6	10 (+ or - 5)

[a] Ragland & Zinn, 1979, p. 64.

i. The board should be concerned with optimizing the selection of the locations at which mental health services are provided and the types of facilities used.

j. The board should be concerned with the overall quality and continuity of care which residents receive from the CMHC.

Conclusion

As is clear from this brief review of studies on the issue of citizen participation in community mental health governance, there have been significant problems and ambiguously successful outcomes. A number of authors have concluded that the anticipated results have failed to materialize for a number of reasons, one being that centers have not been able to develop a leadership role for citizens or consumers in governance and advisory functions. Windle and Cibulka'a analysis (1981) offers important points for consideration, in terms of the cost of technical support to assist community mental health centers in fostering the necessary shifts in organizational behavior which would permit newly activist role for consumers on boards of trustees and advisory committees. Windle and Cibulka argue instead for increased federal support to help strengthen citizen interests and community organization so that demands for greater participation will emanate directly from non-elites. It may be that the new political current will encourage the emergence of such a trend at the state and local levels; it seems unlikely, however, that the fiscally conservative Reagan Administration will fund many such activities.

CHAPTER III

BACKGROUND INFORMATION ON THE ROLE OF BOARDS AND COUNCILS IN THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION*

Bernadette A. Brusco

FEDERAL INTENT AND PUBLIC LAW

Until the passage of the National Mental Health Act of 1946 (Public Law 79-487), the federal government's role in mental health was limited to serving narrowly defined special populations: the military, drug addicts, and residents of the District of Columbia. Generally, care and treatment of the mentally ill had historically been the responsibility of the states. The states, however, had been falling far short of providing adequate and humane mental health facilities and treatment (Freedman, 1967; Rosen, 1958). Beginning in 1937 with a Public Health Service report on the deplorable conditions in state mental facilities, the failure of the states was increasingly brought to the public's attention.

The first step toward a federal mental health policy was Congress' passage of the 1946 Mental Health Act. This act did not put the federal government in the position of providing direct services to the mentally ill. Rather, the federal government's role was to conduct research, experiments, investigations, and demonstrations in mental health areas. The relationship of the federal government to the states was to be: 1) a provider of information and data, 2) a trainer of personnel, and 3) a facilitator in developing and assisting states in effective and efficient methods in mental health care.

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*Revised version of Chapters One and Three in B.A. Brusco, Boards and councils of the Texas Department of Mental Health and Mental Retardation. San Antonio: Intercultural Development Research Association, 1979.

Out of this act, the National Institute of Mental Health (NIMH) was created to provide methodical and financial support to states for alternatives to institutionalization of the mentally ill. Each state was encouraged to designate an authority for mental health and to apply for demonstration grants for community-based mental health services. The authority for mental health could not be the state entity responsible for state hospitals. The concept of community-based mental health services had begun to emerge at the federal level, but as one part of a diverse program. It was not until 17 years later that it emerged as the main thrust of federal mental health policy.

What happened at the end of these intervening 17 years was a merging of the continued examination of the mental heath issue by the federal government, a heightened public awareness of the mental health issue, and the personal experiences of a United States President. The federal government had responded to public pressure for more information about mental health by passing the Mental Health Study Act of 1955. The Act was charged with examining the humane and economic aspects of mental health. The pressure for more data was generated in large part by the experiences of World War II. Over one million citizens were either denied acceptance into military service because of mental problems or, as a result of military service, needed treatment for mental illness.

The Joint Commission on Mental Illness and Health was formed in 1955 to conduct the inquiry mandated in the Mental Health Act. Their Report was presented to President John F. Kennedy on December 31, 1960. The President came to the issue of mental health services with a personal commitment, based on his experiences with a mentally retarded sister. The Joint Commission Report further stimulated the President's personal commitment, and coupled with his New Englander's trust and respect for community-level government, resulted in quick action. He formed a committee of cabinet members, economic advisors and NIMH staff to prepare recommendations based on the Joint

Commission's report and his own views. What emerged was the first presidential message devoted to mental health and illness (Brand, 1968).

Federal Intent

The Message from the President of the United States Relative to Mental Illness and Mental Retardation 1963 proposed a bold new approach to mental health care. The three major objectives were: 1) to seek the causes of mental illness and retardation, 2) to strengthen manpower in mental health, and 3) to strengthen and improve programs and facilities for the mentally ill. Specifically, the President asked that Congress: 1) authorize grants to states for the construction of comprehensive community mental health centers, 2) authorize grants to states for short-term project staffing grants, and 3) facilitate the preparation of community plans for the new facilities.

The message caused a great deal of excitment. It also created a good deal of confusion and controversy as to what was a community mental health center and what embodied community mental health care. After Congress legislatively responded to the message by passing The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, the controversy continued at the state level.

What did President Kennedy intend in his message? A review of his correspondence with the Secretary of Health, Education, and Welfare, Abraham Ribicoff, a member of the President's committee that helped draft his message, provides some clarification and definition of "community." The intent of the President's program was to phase out state mental hospitals and to provide an alternative form of care. Custodial isolation of the mentally ill was to be replaced by community care. His concepts of community care were rooted in the notion that mental health services must become part of the local society. Treatment and preventative measures would take place within the context of

the individual's surroundings and would draw support, both direct and indirect, from the individual's and the community's network of people, institutions and organizations. Geographical boundaries were to be determined in defining community.

Community involvement in the establishment and operation of mental health centers was envisioned. It was President Kennedy's intent that policy setting for the community mental health centers be grounded at the grass roots level. For two reasons the local boards and councils were at the heart of the new direction in mental health care. First, the intent was to create a new funding partnership, with state and locality on one side and the federal government on the other. The local boards were to be an important agent in forging this partnership. Second, all policy and treatment were to be reflective of and sensitive to the community. The community boards and councils were to be largely responsible for the successful implementation of the community mental health philosophy (Bloom, 1975; U. S. Senate, 1973).

That the intent was to mesh mental health care into the fabric of society is clear. How that notion of community was interpreted and expressed in statute, defined in regulations, implemented at the state and local levels and enforced, however, had serious implications for the delivery of community mental health services to individuals.

Public Law

How has the Congress interpreted the Presidential message in creating public law? In the 16 years since the message, there have been approximately 12 major pieces of legislation related to community mental health centers. Overall, the Presidential intent has been maintained. The legislative trend has been toward increasing the types of services required; enlarging the classes of special populations served; and strengthening, by more explicitly defining, the composition of local boards and councils. This body of legislation has been passed in the face of

some very determined opposition to the community mental health concept mounted by Presidents Nixon and Ford.

It is only in the area of funding that the Congress has moved in a direction not envisioned by President Kennedy. The President expected that the funding base for the centers would gradually shift from federal money to state, local and private monies. As a result of difficulties in securing state, local and private sources of financial support, however, community mental health centers now receive more, not less, federal funding. For the purposes of this review, it is necessary to examine in depth the first and the last major community mental health center legislation in order to establish the federal intent. The reader is referred to the Annotated Chronology (Appendix B) for a more comprehensive review of all major legislation.

Congress responded positively to the 1963 Presidential mental health message by enacting the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164). Federal funds were now available for construction and development of community mental health centers. The Act required:

1) the designation of a state advisory council composed of representatives from state agencies, non-governmental agencies and consumers;

2) a plan which divides a state into geographic areas and ranks the mental health needs by area; and

3) the provision of five basic services by centers: a) inpatient care, b) out-patient care, c) emergency services, d) partial hospitalization, and e) consultation and education.

In order to secure passage of the Act, Congress had to delete the section providing federal support for staffing. This was eventually passed in legislation introduced in the next session of Congress.

Over the years, legislation extended and enlarged this original act. The last major piece of legislation was the Special Health Revenue Sharing Act of 1975 (Public Law 94-63). This was an encompassing act dealing with a package of health programs. Title II of the Act, Community Mental Health Centers, more rigidly defined the community centers and the services they were to provide.

A community mental health center is defined as:

> a legal entity (1) through which comprehensive mental health services are provided.
>
> (A) principally to individuals residing in a defined geographic area (referred to in this title as a 'catchment area'),
>
> (B) within the limits of its capacity, to any individual residing or employed in such area regardless of his ability to pay for such services, his current or past health condition, or any other factor, and
>
> (C) in the manner prescribed by subsection (b), and (2) which is organized in the manner prescribed by subsections (c) and (d). (Title II, Part A, Sec. 201 (a))

Required services must include:

(A) inpatient services, outpatient services, day care and other partial hospitalization services, and emergency services;

(B) a program of specialized services for the mental health of children, including a full range of diagnostic, treatment, liaison, and follow-up services (as prescribed by the Secretary);

(C) a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison, and follow-up services (as prescribed by the Secretary);

(D) consultation and education services which -

(i) are for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities; and

(ii) include a wide range of activities (other than the provision of direct clinical services) designed to (I) develop effective mental health programs in the center's catchment area, (II) promote the coordination of the provision of mental health services among various entities serving the center's catchment area, (III) increase the awareness of the

residents of the center's catchment area of the nature of mental health problems and the types of mental health services available, and (IV) promote the prevention and control of rape and the proper treatment of the victims of rape;

(E) assistance to courts and other public agencies in screening residents of the center's catchment area who are being considered for referral to a State mental health facility for inpatient treatment to determine if they should be so referred and provision, where appropriate, of treatment for such persons through the center as an alternative to inpatient treatment at such a facility;

(F) provision of follow-up care for residents of its catchment area who have been discharged, from a mental health facility;

(G) a program of transitional half-way house services for mentally ill individuals who are residents of its catchment area and who have been discharged from a mental health facility or would without such services require inpatient care in such a facility; and

(H) provision of each of the following service programs (other than a service program for which there is not sufficient need (as determined by the Secretary) in the center's catchment area, or the need for which in the center's catchment area the Secretary determines is currently being met);

(i) A program for the prevention and treatment of alcoholism and alcohol abuse and for the rehabilitation of alcohol abusers and alcoholics.

(ii) A program for the prevention and treatment of drug addiction and abuse and for the rehabilitation of drug addicts, drug abusers, and other persons with drug dependency problems. [Title II, Part A, Sec. (a)]

The notion of community decision making was strengthened by clearly detailing who should represent the community, and by defining the representative's general responsibilites and areas of authority. The Act states that:

(c)(1)(A) The governing body of a community mental health center (other than a center described in subparagraph (B) shall (i) be composed, where practicable, of individuals who reside in the center's catchment area and who, as a group, represent the residents of that area taking into consideration their employment, age, sex, place of residence, and other demographic characteristics of the area, and (ii) meet at least once a month, establish general policies for the center (including a schedule of hours during which services will be provided), approve the center's annual budget and approve the selection of a director for the center. At least one-half of the members of such body shall be individuals who are not providers of health care. (Title II, Part A, Sec. 201)

Finally, Public Law 94-63 went far in providing direction to the board of trustees and/or advisory councils for establishing the general policies of the centers. The law sets forth some minimum required components for the plan which the board must submit with federal grant applications. The plan is required to provide for:

> (i) an overall plan and budget that meets the requirements of section 1861(z) of the Social Security Act, and (ii) an effective procedure for developing, compiling, evaluating, and reporting to the Secretary statistics and other information (which the Secretary shall publish and disseminate on a periodic basis and which the center shall disclose at least annually to the general public) relating to (I) the cost of the center's operation, (II) the patterns of use of its services, (III) the availability, accessibility, and acceptability of its services, (IV) the impact of its services upon the mental heath of the residents of its catchment area, and (V) such other matters as the Secretary may require;
>
> (B) such community mental health center will, in consultation with the residents of its catchment area, review its program of services and the statistics and other information referred to in subparagraph (A) to assure that its services are responsive to the needs of the residents of the catchment area;
>
> (C) to the extent practicable, such community mental health center will enter into cooperative arrangements with health maintenance organizations serving

residents of the center's catchment area for the provision through the center of mental health services for the members of such organizations under which arrangements the charges to the health maintenance organizations for such services shall be not less than the actual costs to the center to providing such services;

(D) in the case of a community mental health center serving a population including a substantial proportion of individuals of limited English-speaking ability the center has (i) developed a plan and made arrangements responsive to the needs of such individuals, and (ii) identified an individual on its staff who is fluent in both that language and English and whose responsibilites shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences;

(E) such community mental health center has (i) established a requirement that the health care of every patient must be under the supervision of a member of the professional staff, and (ii) provided for having a member of the professional staff available to furnish necessary mental health care in case of an emergency;

(F) such community mental health center has provided appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

> (G) in the case of an application for a grant under section 203 for a community mental health center which will provide services to persons in an area designated by the Secretary as an urban or rural poverty area, the applicant will use the additional grant funds it receives, because it will provide services to persons in such an area, to provide services to persons in such area who are unable to pay therefore... [Title II, Part A, Sec. 206(c)(1)(d)]

The last six provisions of Section 206 carefully lay out the fiscal aspects of the plan. If a center is receiving federal funds, it is under these federal provisions that the community mental health center operates. These centers are evaluated for compliance by a regional federal administrator at the time of grant submission.

Once the first federal legislation was passed, there existed a framework within which to administer the program to eligible states. The notion of "community" intended in President Kennedy's 1963 mental health message was maintained throughout the years of legislation. Did this series of public laws really begin about a new thrust in mental health care? The answer to this question can only be found in each state's response.

THE CONTENT OF MENTAL HEALTH IN TEXAS

From the 1850s through the 1960s, mental health activity in Texas was not unlike the other states. It consisted mainly of building and staffing state mental hospitals which were never innovative or adequate. Occasionally, the Legislative Budget Board would question a budget request (see Annotated Chronology, Item 15 in Appendix B), but the interest was sporadic. Mental

health has seldom been an issue for any high administrator of the state, so that there has been little legislative activity. During the flurry of activity in the 1960s, neither the Governor nor any high state administrator could be induced to participate in creating a state plan for mental health (McCleskey, 1968).

Texas has had limited private sector or professional leadership in this area. The statewide Citizens Committee for Mental Health Planning in the 1960s could not induce any influential businessmen to sit on the committee. Tentative findings from a 1979 survey indicate that when people engaged in community mental health work and related fields at the state and local levels are asked to identify past leaders, they could not (Brusco, 1979b). Citizens have been appointed to various planning committees; study groups, boards and councils have served long and conscientiously. However, few citizens of Texas have ever independently taken up the mental health cause and become widely and publicly identified as its champions. Several have tried, but have generally met with public and Legislative disinterest. It is only recently that a few citizen volunteers are beginning to emerge as potential mental health/community mental health leaders. Interest groups have recently formed around the community mental health centers (see, for example, DeMoll & Andrade, 1978), but it is too early to evaluate their effectiveness.

One effect of the lack of leadership is that Texas has lagged behind most other states and the federal government in almost every aspect of mental health care. Studies published in 1937 and 1964 ranked the states according to conditions at state mental hospitals and on fifteen indices of mental health. Texas ranked very low in these studies (see Annotated Bibliography, Items 5 and 26 in Appendix B). In the absence of a core of consistent and committed leadership, no cohesive statewide interest or Legislative group has emerged. It was within this historically leaderless void that the new federal community mental health programs were to be implemented.

Community Mental Health

Texas has always responded to federal legislation in mental health by passing state enabling legislation as is clearly shown in the Annotated Chronology (Appendix B). It did not, however, have a history of seeking federal mental health demonstration or study grants. Unlike some of the other states, Texas made no attempt from 1946 through 1963 to request any NIMH funds for comunity mental health services. The major impetuous to begin a state plan in anticipation of Congressional action after the 1963 Presidential message came from outside the state.

In October 1962, the American Medical Association (AMA) held a Mental Health Congress. At this meeting, some states were requested to create planning committees to develop a state mental health plan. The AMA asked the Texas Medical Association (TMA), the Texas Association for Mental Health and the Texas Neurological Association to bring together a fifteen-person planning committee.

The Commissioner of the Texas Division of Mental Health, who was a member of this AMA planning group, proposed submitting a planning grant request to NIMH. Several State departments were asked to join in the submission. Eventually, the Department of State Hospitals and Special Schools did join with the division in submitting this proposal. Attempts by the Commissioner to bring the AMA-initiated effort together with the division's planning grant request met with AMA opposition. The grant request was funded a short time later to the Division of Mental Health. The AMA planning group dissolved.

Once the planning grant was funded in 1963, the Mental Health Planning Committee (also known as the Statewide Citizen's Committee for Mental Health Planning) was established. This committee composed of 100 citizens worked over the next year and a half to create the Texas Plan for Mental Health (see Annotated

Chronology for full details of this committee, Item 25 in Appendix B).

The Planning Committee submitted its final report to the Legislature in January 1965. The twelve chief recommendations were:

1. The citizens of Texas, through community action, should endeavor to combat mental illness in every town, city and county in the State.

2. The 59th Texas Legislature should establish a new Texas Department of Mental Health organization chart for the proposed new department.

3. Greater emphasis should be placed on the prevention of mental illnesses and the promotion of mental health in local communities throughout Texas. Whenever possible, mental health facilities and personnel should work with city and county public health units, with private psychiatrists and physicians, psychiatric facilities in general hospitals, and with other agencies, facilities and persons having common goals and interests in providing better mental health services.

4. "Non-psychiatric" services performed by school teachers, ministers, physicians and others in a position to help troubled people to overcome emotional difficulties should be encouraged and strengthened throughout the state.

5. Community mental health centers should be located in the larger population centers of the State to serve people in or near the communities where they live. Also recommended as part of the total program of mental health services are intake centers, special diagnostic

centers, state mental hospitals and one maximum security unit. Community mental health centers throughout Texas are a long-range goal, but the first ones should be established and made operational as soon as possible. Impetus should come from the communities to be served.

6. Preventive, treatment and rehabilitative services for children and young people who are emotionally disturbed or mentally ill should be carried forward in pace with these services for adults.

7. Rehabilitation of mentally ill citizens should begin as closely as possible to the time and place that the illness begins. Rehabilitation services for these citizens in existing state facilities should be strengthened and expanded. These services should be further extended through community mental health centers.

8. The proposed Texas Department of Mental Health should be responsible for an accelerated program of recruiting and training personnel for various disciplines in mental health, for both public and private facilities.

9. The Houston State Psychiatric Institute should be strengthened and diversified. There should be established, as soon as possible: a general-purpose neuro-psychiatric and behavioral sciences research institute in conjunction with the University of Texas Southwestern Medical School, Dallas; a neurological sciences institute at the University of Texas Medical Branch, Galveston; an institute for research on mental retardation and human development in conjunction with the University of Texas, Austin; and a research institute dealing with sociocultural factors in mental illness, in San Antonio.

10. An Operations Research Section should be established within the proposed Texas Department of Mental Health.

11. The proposed Texas Department of Mental Health should foster a strong program of public information and education to combat mental illness.

12. The Texas Constitution (Art. 16, Sec. 54) should be revised to empower the Legislature to provide funds to assist in financing community mental health services. (The Statewide Citizens Committee for Mental Health Planning, 1964a, pp. 15-16)

The recommendations were not reached without some difficulty. Problems centered on the creation of a new mental health bureaucracy, particularly the disbanding of the existing bureaucracy, and jurisdictional assignment of existing state facilities and programs to the new department. The one hundred-member Planning Committee did not always function smoothly with the Steering Committee. Planning Committee members felt that all decision making was going to be made by the steering committee. Squabbles broke out among the members of the executive committee. Two members were top administrators from the Health Department and the Division of Mental Health. Each member represented different constituencies from different professional backgrounds and guarded different territories. Shortly before the plan was completed, Legislative pressure was exerted to replace the Planning Committee's psychiatrist-coordinator. He had run afoul of several influential legislators, the AMA and several members of the state's executive office. These difficulties were overcome, and a plan was produced.

A major political trade-off was effected in order to create the Texas Department of Mental Health (DMH). It came about when members of the Executive Committee agreed to shift jurisdiction of the state's tuberculosis hospitals to the Department of

Health. In turn, the Department of Health would cede all mental health jurisdiction of the Board of Hospitals and Special Schools to the new Department of Mental Health.

In drawing up the new DMH, the Planning Committee's strong feelings against a medically dominated department were evident. The nine members of the proposed Board of Trustees were not placed in categories. This was an attempt to open the door to a non-medical board. The pro-medical contingent, which was small, was satisfied with the recommendations for: 1) a strong medical advisory board, and 2) a psychiatrist-commissioner.

However, the Texas Medical Association intervened, and before the plan was submitted it was changed. The final plan reflected the TMA interests. Three of the nine members of the board were required to be physicians, with one being a psychiatrist. Also, the medical advisory committee was to be required by statute. In the law finally passed, these provisions were deleted (McCleskey, 1968).

The Mental Health and Mental Retardation Act of 1965, commonly known as House Bill 3, is Texas' response to the federal activity of the early 1960s. It is Texas' most important legislation in mental health and community mental health. Passed by the 59th Legislature, it has been routinely amended, but not significantly altered, by the 60th, 61st, 62nd, 63rd, and 64th Legislatures.

House Bill 3's passage was not assured and required much maneuvering. The Planning Committee presented its recommendations to the Legislature in January, 1965. Both the House and Senate responded by introducing mental health bills. The negotiations began in earnest shortly thereafter. The major areas of legislative disagreement involved the last minute inclusion of mental retardation; whether or not the commissioner had to be a pyschiatrist; and the number of mid-level administrators. Little attention was given to the content of the

bill, its philosophy, goals or programs. The Legislature generally favored reorganizing the mental health system and establishing community mental health centers.

For the first time in Texas' history, legislative interest was very high in mental health. Between January and April, 1965, many legislators became involved in the mental health bills, it seems, at the behest of interest groups representing medical societies, psychiatrists, and mental retardation associations. The Appropriations Committee became especially active, far beyond what had been anticipated. This committee revised the mid-level administrative structure so drastically that the backers of House Bill 3 attempted to persuade the Governor to veto the bill. No member of the executive branch took a role either for or against various forms of the proposed legislation. The final bill, the Mental Health and Mental Retardation Act, House Bill 3, was signed into law and became effective on September 1, 1965. Backers were very disappointed with the appropriation that followed, since the community centers' portion was so small (McCleskey, 1968).

House Bill 3 is terse and compact. The lack of broader description in the act has created some confusion in implementation. The purpose and policy section of House Bill 3 states that:

> ...the public policy of this state is to encourage local agencies and private organizations to assume responsibility for the effective administration of mental health and mental retardation services... [Article 1, Sec. 1.01(6)].

To carry out this policy, the Texas Department of Mental Health and Mental Retardation was created:

> Sec. 2.01. The Texas Department of Mental Health and Mental Retardation shall consist of a Texas Board of Mental Health and Mental Retardation, a Commissioner of Mental Health and Mental Retardation, a Deputy Commissioner for Mental Health Services, a Deputy Commissioner for Mental Retardation Services, a staff under the direction of the Commissioner and the Deputy Commissioners, and the following facilities and institutions together with such additional facilities and institutions as may hereafter by law be made a part of the Department... (Article 2). A list of state hospitals followed.

There are no requirements for board membership and no categories of membership. The law simply states that: "The Board consists of nine members appointed by the Governor with the advice and consent of the Senate" (Art. 2, Sec. 2.02).

It is the responsibility of the board to:

1. hold at least four regular meetings a year;
2. appoint a qualified person as commissioner (who will also be the authority for mental health;
3. appoint a medical advisory committee and any other necessary committees; and
4. formulate the basic and general policies to guide the department. (Art. 2, Sec. 2.05)

The Act provides that programs are to be made available in any of four ways, one of which may be through the Department's funding of community centers. Article 3, Community Centers for the Mental Health and Mental Retardation Services, states that community MHMR centers may be established by an organizational combination of a city, county, hospital district or school district. A contract between or among them describing the center and appointing a board of five to nine qualified voters of the region or members of the organizating entities governing board would be the center's organizing document. [Sec. 3.01 (a) (1) (2)].

If the CMHC is established by one organization, then:

> Sec. 3.02.(a) The board of trustees of community centers established by a single city, county, hospital district or school district may be the governing body of the single city, county, hospital district or school district, or that governing body may appoint from among the qualified voters of the region to be served a board of trustees consisting of not less than five (5) nor more than nine (9) persons. If the board of trustees is appointed from the qualified voters of the region to be served, the terms of the members thereof shall be staggered by appointing not less than one-third (1/3) nor more than one-half (1/2) of the members for one (1) year, or until their successors are appointed, and by appointing the remaining members for two (2) years, or until their successors are appointed. Thereafter, all appointments shall be for a two (2) year period, or until their successors are appointed. Appointments

made to fill unexpired terms shall be for the period of the unexpired term, or until a successor is appointed. (Article 3)

The local boards are responsible for:

1. administration of the community MHMR centers;

2. appointing advisory committees, medical committees or other committees;

3. appointing a director and delegate powers to the director following the policy guidelines of the board; and

4. employing and training center personnel or delegating this responsibility to the director. (Sec. 3.08)

The act provides policy direction for serving one special population, the indigent. It provides that: "A community center shall provide services free of charge to indigent persons" (Sec. 3.14.).

The act requires that a plan be submitted to TDMHMR. It must include:

> The projected financial, physical and personnel resources of the region to be served to develop and make available to the residents of the region an effective mental health or mental retardation services program, or both, through a community center or centers. [Article 4, Sec. 4.02 (2)]

No further definitions or requirements are provided for plan development, program policy or general center policy.

The act requires the department to prescribe rules, regulations and standards to insure adequate provision of services by the community MHMR center:

> Sec. 4.01. (a) The Department shall prescribe such rules, regulations and standards, not inconsistent with the Constitution and laws of this State, as it considers necessary and appropriate to insure adequate provision of mental health and mental retardation services by community centers.
>
> (b) Before any rule, regulation or standard is adopted the Department shall give notice and opportunity to interested persons to participate in the rule making.
>
> (c) The rules, regulations and standards adopted by the Department under this Section shall be filed with the Secretary of State and shall be published and available on request from the Secretary of State.
>
> (d) A copy of these rules shall be sent to each community center established in this State. (Article 9)

These rules have become formalized as the Rules of the Commissioner. Additional rules issued subsequently have further defined provisions of House Bill 3. They became effective in January 1976, and are not retroactive. One of the more important

Rules has expanded the provision requiring the board to submit a plan to the department. The plan is now mandated to include:

(A) The financial, physical, and personnel resources of the area to be served.

(B) The extent of involvement of service agencies in the area in the planning process and in the proposed delivery of services.

(C) The long range goals of the community center which shall include:

(i) types of services to be rendered;
(ii) needs for any projected services;
(iii) quantity of services to be rendered; and
(iv) impact of these services on other MHMR systems including state hospitals, state schools, and state centers for human development.

(D) The projected costs of the delivery of services.

The boards have also been given direction in setting program policy:

(a) Philosophy of Care.

1. Community centers shall develop services reflecting leading contemporary thought in the areas of community mental health and mental retardation.

2. Community centers shall utilize the principle of normalization and the principle of least restrictive alternative when planning and developing services.

3. In the development and operation of services delivered directly or by contract, community centers shall not abridge the human and legal rights of their clients.

4. Community centers shall take into account social, cultural, and economic factors of the population when planning, developing, and operating services.

5. Community centers shall demonstrate sustained concern for the mental health of the entire population of the area through services of education, consultation, and prevention.

6. Community centers shall strive for effective working relationships with state hospitals, state schools, and state centers for human development.

7. Community centers shall place high priority on the development of services which reduce the admission and recidivism to state hospitals and state schools.

8. Community centers shall administer effectively all resources available, including volunteers, to assure the highest quality of care possible.

9. Community centers shall make a continuing effort to ensure maximum accessibility of services to residents of the area.

10. Community centers shall make a continuing effort to ensure continuity of care to persons.

11. Community centers shall make a continuing effort to determine the need for mental health and mental retardation services and shall make such services available. (Texas Department of Mental Health and Mental Retardation, 1976, pp. 5-6)

The federal intent was to make the local community boards accountable to the state's mental health authority. In Texas, the Commissioner of TDMHMR is also the authority. The rules issued from the state's authority relative to the community centers comes out under the title of commissioner. In the twelve pages of Rules of the Commissioner, the State Mental Health Authority is referred to once, (Texas Department of Mental Health and Mental Retardation, 1976, p. 12). While this may appear to be a technicality, it creates confusion in setting up lines of communication and responsibility.

Although House Bill 3 went into effect in September 1965, it was not until the 60th State Legislature convened two years later that the first grant-in-aid was made to assist in opening community MHMR centers (see Table 1 for a list of appropriation dates for state grants-in-aid to create CMHCs).

The State's community mental health enabling legislation provided a framework which was to mesh with existing state and local legal and political realities. Public Law 94-63 and House Bill 3 mandated that the boards and councils would be the policy-making, and in some cases, the administrative organs of the community mental health centers. These boards and councils became part of a very important level of state and local government in Texas.

Boards and Councils in the Governmental Arena

In the United States, the executive branches of state governments are generally characterized by weak governors. Early colonial experience with royal governors and the misuse of

TABLE 1

START-UP DATES FOR THE 30 COMMUNITY MHMR CENTERS IN TEXAS

(1967-1981)

CENTER	CITY	DATE[a]
Tropical Texas MHMR Center	Edinburg	1967 (June)
Central Counties MHMR Services	Temple	1967 (Sept)
Austin-Travis County MHMR Center	Austin	1967 (Sept)
Southeast Texas Center	Beaumont	1967 (Sept)
El Paso MHMR Services	El Paso	1968 (Feb)
Authority of Harris County MHMR	Houston	1968 (Feb)
Amarillo Regional MHMR Center	Amarillo	1968 (May)
Bexar County MHMR Center	San Antonio	1968 (Sept)
Dallas County MHMR Center	Dallas	1968 (Sept)
Lubbock Regional MHMR Center	Lubbock	1968 (Sept)
Northeast Texas MHMR Center	Texarkana	1968 (Oct)
Trinity Valley MHMR Authority[b]	Fort Worth	1969 (Jan)
Heart of Texas Region MHMR Center	Waco	1969 (Jan)
MHMR Center for Greater West Texas[c]	San Angelo	1969 (Feb)
Nueces County MHMR Center	Corpus Christi	1969 (March)
Permian Basin Community Center for MHMR	Midland	1969 (June)
Central Plains MHMR Center	Plainview	1969 (Nov)
Gulf Coast Regional MHMR Center	Galveston	1969 (Oct)
Wichita Falls Community MHMR Center	Wichita Falls	1969 (Oct)
Gulf Bend MHMR Center	Victoria	1970 (Jan)
East Texas MHMR Regional Center	Tyler	1970 (Jan)
Central Texas MHMR Center	Brownwood	1970 (Jan)
Gregg-Harrison MHMR Center[d]	Marshall	1970 (Sept)
Abilene Regional MHMR Center	Abilene	1971 (June)
Brazos Valley MHMR Center	Bryan	1974 (March)
Deep East Texas Regional MHMR Services	Lufkin	1974 (Sept)
MHMR Services of Texoma	Denison	1974 (Sept)
Pecan Valley MHMR Center	Stephenville	1977 (Sept)
North Central Texas MHMR Center	McKinney	1977 (Sept)
Navarro County MHMR Center	Corsicana	1979 (Sept)

[a]The date when state grant-in-aid was first appropriated

[b]Now named Tarrant County MHMR Regional Center

[c]Now named Concho Valley for Human Development Center

[d]Now named Sabine Valley Regional MHMR Center

gubernatorial power during the Reconstruction Period created an atmosphere of distrust for a strong governor. Texas' weak executive is, however, one of the more extreme structural manifestations of this sentiments.

When the Texas Constitution of 1876 was drawn up, the state leaders made sure that the state's executive authority would be shared. Of the seven original offices which comprised the executive department, only one, the Secretary of State, was appointed by the Governor. This is the case today. The Constitution further provides for a legislature which only meets every two years and severely limits the powers of the Governor.

Boards

The diffusion of the power of the Governor continued with the creation over the years of numerous boards and commissions which regulate specific areas of government. Boards and commissions regulate public safety, health, public welfare, parks and wildlife, mental health and mental retardation, finance, government of the University of Texas System, and Comptroller (the State's purchasing agent), to name a few. As an example of the widespread use of the boards and commissions, in 1960, Governor Daniels appointed 275 citizens to various boards and commissions. This is one reason the system of boards and commissions is sometimes called Texas' fourth branch of government.

These boards can be very powerful because they set general policy for many state activities and select a full-time administrator. Even though the Governor appoints the board members, these boards are insulated from the Governor because he cannot legally remove them from office. Boards are arranged so that members serve overlapping six-year terms. Most of the time, given the length of their terms and of the Governor's term, the sitting boards and commissions have been appointed by a Governor who is no longer in office. While it may be argued that this places the boards and commissions outside of the ebb and flow of

electoral machinations, it also creates a new level of government that is very much removed from the average citizen (Benton, 1972; Citizens Conference on State Legislatures, 1971; Gantt, 1964; Gantt, 1971).

Advisory Councils

Advisory councils occupy a very ambiguous place in the State's policy-making structure. They were first formed in Texas in 1953 by Governor Shivers when he appointed citizens to study problems of public school teachers' pay. Over the last 20 years, their use has grown. One form of citizens councils are created for specific tasks and then disbanded when their recommendations are reported. Another is created by a board of trustees and the full-time administrator of an agency or department of the State to advise the administrator on a regular basis. This was the form used to create the TDMHMR Advisory Council.

Whether a council's advice is really part of the decision-making process in setting policy is determined department by department. An important set of variables is the specific relationship between the commissioner of the department, the council and the board. For this reason, general statements about the councils are difficult to make.

Advisory councils provide semi-formal channels for input into policy and decision-making structures. They have been used in Texas as a device to help assure that all groups have input into these structures. When board membership has eligibility stipulations, they usually related to geography or professional qualifications. Most councils, however, are required to represent some or all of the following characteristics of a population: 1) geography, 2) occupation or income, 3) sex, 4) education, 5) culture, 6) language, 7) age, and 8) other demographic characteristics.

Summary

The community mental health program was not created in a vacuum nor could it function in one. It had to "fit in" to a state governmental system and an in-place, or emerging, local political and community system. In addition, the public had evolved a set of values about mental illness and mental health and the appropriate care of patients. The task was one of implementing the complex concept of community mental health into a system of existing, evolving structures and processes.

CHAPTER IV

CITIZEN REPRESENTATION ON MENTAL HEALTH BOARDS AND COUNCILS IN TEXAS: WHO SERVES?

Sally J. Andrade

The Census reports that Texas had 14,228,383 inhabitants as of April 1, 1980. That figure represents a startling increase of more than 27% over the inhabitants enumerated in the 1970 count (Bureau of the Census, 1981). Almost three million Texas residents, or 21%, identified themselves as being of Spanish origin, with the great majority of them being Mexican American. There were slightly more than 1,700,000 Blacks, or 12% of the total. Thus, one-third of the state inhabitants, or one in every three, was a minority person. While the Census has noted that its counts of the Spanish origin population are provisional and concern has been expressed about undercounts of racially and linguistically distinct populations, it is assumed that the Census figures are the most accurate demographic indicators currently available.

The intent of this chapter is to explore to what extent Mexican Americans and Blacks are present on the boards and advisory councils of the Texas mental health service delivery system. Additional topics of relevance include the presence of women across the racial/ethnic groups and the diversity of occupations represented by board or council members.

The Board of Trustees, the Texas State Advisory Council for Construction of Community Mental Health Centers, the Texas State Mental Health Advisory Council, and the Community Mental Health Mental Retardation Center Advisory Committee all serve the Texas Department of Mental Health and Mental Retardation (TDMHMR). Analysis of their membership is based on the rosters developed by Brusco (1979a; 1980a) and by updated rosters obtained from the Department. The actual rosters of membership are presented in Appendix C.

To obtain more recent and more comprehensive membership data on the boards of trustees for the 30 community mental health mental retardation centers (CMHCs) in Texas, the IDRA Mental Health Research Project mailed each center's executive director a survey form requesting updated information. See Appendix D for a copy of the form and a discussion of some of the response problems. Appendix D also includes the 1981 rosters of each center's board, which are accompanied by the 1979 rosters compiled by Brusco (1979).

The author of this chapter has tabulated the membership data by simple frequency counts and percentages across the categories of ethnicity, sex, sex by ethnicity, occupation and counties of residence in order to assist the reader in discerning patterns of representation.

The TDMHMR Board of Trustees

The Texas Board of Mental Health and Mental Retardation consists of nine members appointed by the Governor with the advice and consent of the Senate. Each member serves for a term of six years, unless reappointed or until his or her successor is named. The Governor also designates the Chairperson. In order to guide TDMHMR in its administration of the service delivery system, the Board formulates basic and general policies consistent with the purposes, policies, principles and standards of the 1965 Texas Mental Health and Mental Retardation Act. The Board holds a minimum of four regular meetings per year in Austin on dates fixed by rules of the Board, and it also makes provisions for the holding of special meetings (Texas Department of Mental Health and Mental Retardation, 1981). Over the 16-year span of its existence, a total of 31 individuals have been selected to direct the state mental health system.

One prominent woman has served the entire period and was appointed as a Member Emeritus in 1981 in recognition of her leadership role and contributions to the state. Her honor,

however, does not reflect the general status of women, as less than 13% of the appointees have been female (4 of the 31), whereas 81% were men. Given an ethnic breakdown in which over 90% of the trustees were Whites, the governance pattern is one clearly dominated by White men (see Table 2). In terms of employment or occupation, it is not surprising (in light of both legal requirements and tradition), that the primary profession represented is that of physicians. The major constituency group, however, appears to be that of the business world, in that over 50% of the Board members were associated with corporations, banks, insurance companies, law firms or other businesses (see Table 3).

The issue of geographical representation on the TDMHMR Board is a complex one. Texas has 254 counties and hundreds of towns, plus numerous metropolitan areas. Given that there have been only thirty-one trustees in the history of the Board, it is unrealistic to expect anything resembling equity of geographical representation. Nonetheless, it is interesting to note that only seven counties have produced almost 52% of the TDMHMR Board members (see Table 3).

Four of the seven do not include large metropolitan areas. Valdez (1980) pointed out that CMHCs in Texas tend to be located in regions remote from counties with high percentages of Spanish Language/Spanish Surname individuals. With respect to the TDMHMR trustees, a similiar phenomenon appears to occur, in that only six of the 31 lived in the southwestern belt along the Texas/Mexico border which he discussed (see Figure 3).

Because the largest numerical concentration of Mexican Americans is actually in the urban areas of San Antonio, Houston, Dallas, Corpus Christi, El Paso and other SMSAs, (see Figure 4), it is equally relevant to question the degree to which urban Mexican American interests are represented on the Board. For example, the largest SMSA with a predominantly Mexican American

TABLE 2

ETHNICITY AND SEX OF MEMBERS OF
THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION, 1965-1981[a]

ETHNICITY

Total	White	Black	Mexican American
31	28	2	1
100%	90.3%	6.5%	3.2%

SEX

Total	Men	Women
31	27	4
100%	87.1%	12.9%

ETHNICITY BY SEX

	White		Black		Mexican American	
Total	Men	Women	Men	Women	Men	Women
31	25	3	1	1	1	0
100%	80.6%	9.7%	3.2%	3.2%	3.2%	-

SEX BY ETHNICITY

	Men		Women	
Total	White	Minority	White	Minority
31	25	2	3	1
100%	80.6%	6.5%	9.7%	3.2%

[a]Due to rounding, percentages may not sum to 100%.

TABLE 3

OCCUPATIONS AND COUNTIES OF RESIDENCE OF MEMBERS ON THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION BOARD OF TRUSTEES, 1965-1981[a]

OCCUPATION

Total	M.D.	Corporation Executive	Banking, Insurance, Business	Lawyer	Homemaker/ Volunteer	Elected Official	Academia or Clergy
31	8	6	6	4	3	2	2
100%	25.8%	19.4%	19.4%	12.9%	9.7%	6.5%	6.5%

COUNTY OF RESIDENCE

Harris - 4
Bell - 2
Travis - 2
Walker - 2
Webb - 2
Wichita - 2
Nueces - 2

7 counties

51.6% of members

Angelina - 1
Bailey - 1
Cameron - 1
Dallas - 1
Ector - 1
El Paso - 1
Guadalupe - 1
Hardemon - 1
Jefferson - 1
Lubbock - 1
Nacogdoches - 1
Tarrant - 1
Taylor - 1
Tom Green - 1
Victoria - 1

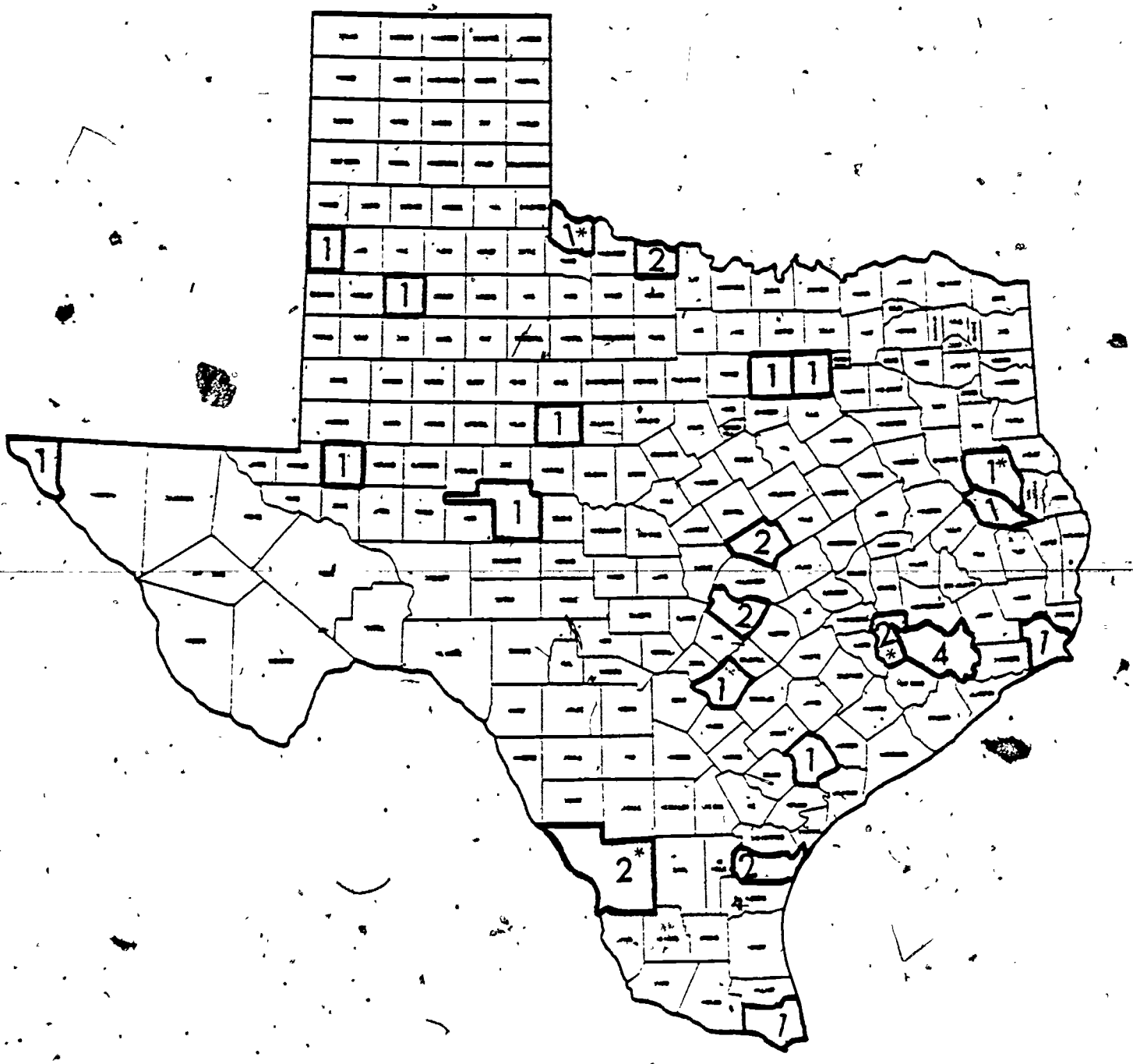
15 counties

48.4% of members

[a] Due to rounding, percentages may not sum to 100%.

FIGURE 3

GEOGRAPHICAL REPRESENTATION OF MEMBERS ON THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION BOARD OF TRUSTEES, 1965-1981 (By County)[a]

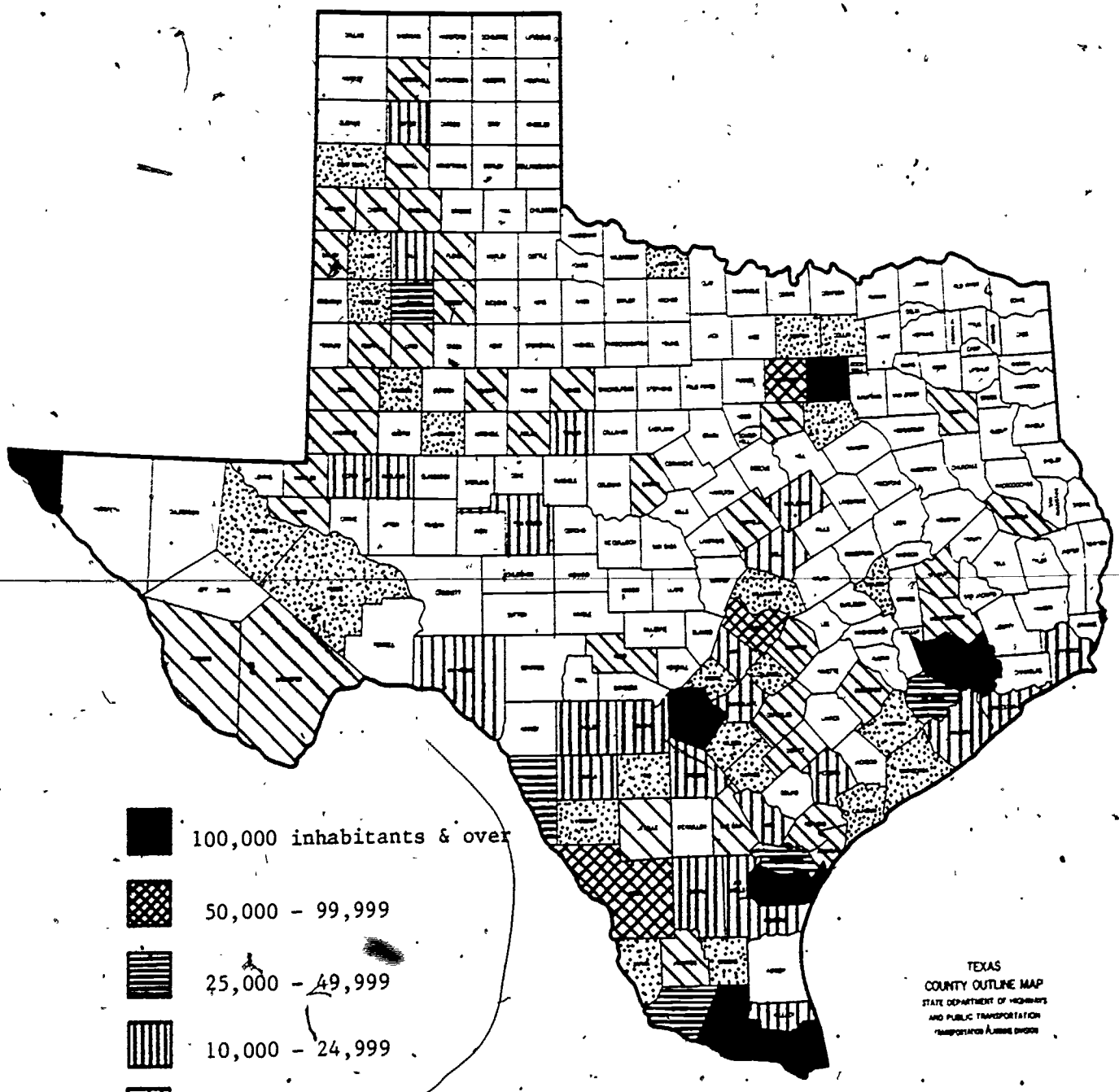


[a]The number inside each county's boundaries indicates the number of TDMHMR trustees who have resided there.

*Counties which are not in the catchment area of a community mental health center.

FIGURE 4

SPANISH ORIGIN POPULATION IN TEXAS, 1980



Mental Health Research Project, Intercultural Development Research Association (Bureau of the Census, 1980).

population, San Antonio, has never had a representative on the Board. And the only Mexican American trustee for TDMHMR came from the border city of Laredo, which does not have a community mental health center (but is served by a state-administered Center for Human Development).

In terms of racial/ethnic issues, the only two Blacks ever appointed to the TDMHMR Board both came from Wharton County and were associated with the small black university located there, Prairie View A & M University. This primarily rural county adjoins Harris County, which has the largest numerical concentration of Blacks in the State. The fact that a Black from Houston in Harris County has never been appointed appears to be a noteworthy omission.

The Texas State Advisory Council for Construction of Community Mental Health Centers (1966-1976)

The first TDMHMR advisory council was formed in 1966 to assist the Commissioner in establishing policies governing the preparation, conduct and arrangement of the Annual State Plan. After the plan was approved, the council would review applications for assistance or the Community Mental Health Construction Act. Often, the council would meet personally with the applicants, subsequently making its recommendations to the Commissioner. There were three categories of membership; 1) non-governmental, 2) state agency, or 3) consumer.

The 22 Council members who served from 1966 through 1976 largely mirror the pattern of the TDMHMR Board of Trustees, in that it has been composed primarily of White men (see Table 4). A notable exception is the significantly higher percentage of minority male representation based, however, on a relatively small number of individuals.

With respect to occupations (see Table 5), a very distinct pattern is evident, in that state administrators played a predominant role (36.4% of the members), with commercial

TABLE 4

ETHNICITY AND SEX OF MEMBERS ON
THE TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION
OF COMMUNITY MENTAL HEALTH CENTERS, 1966-1976[a]

ETHNICITY

Total	White	Black	Mexican American
22	17	2	3
100%	77.3%	9.1%	13.6%

SEX

Total	Men	Women
22	19	3
100%	86.4%	13.6%

ETHNICITY BY SEX

	White		Black		Mexican American	
Total	Men	Women	Men	Women	Men	Women
22	15	2	1	1	3	0
100%	68.2%	9.1%	4.5%	4.5%	13.6%	-

SEX BY ETHNICITY

	Men		Women	
Total	White	Minority	White	Minority
22	15	4	2	1
100%	68.2%	18.2%	9.1%	4.5%

[a]Due to rounding, percentages may not sum to 100%.

TABLE 5

OCCUPATIONS AND COUNTIES OF RESIDENCE OF MEMBERS ON THE TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS, 1966-1976[a]

OCCUPATION

Total	Bureaucrat[b]	Business	Lawyer	Elected Official	Academia	Homemaker/ Volunteer	Banker	M.D.
22	8	4	2	2	2	1	1	1
100%	36.4%	18.2%	9.1%	9.1%	9.1%	9.1%	4.5%	4.5%

COUNTY OF RESIDENCE

Travis - 8
Dallas - 2

2 counties

45.5% of members

Angelina - 1
Bell - 1
Bexar - 1
El Paso - 1
Hale - 1
Harris - 1
McLennan - 1
Tarrant - 1
Taylor - 1
Waller - 1
Webb - 1
Wichita - 1

12 counties

54.5% of members

[a]Due to rounding, percentages may not sum to 100%.

[b]Predominantly state administrators.

interests following a close second (businessmen, lawyers and bankers 31.8%). The limited geographic representation is even more pronounced in the case of this early Advisory Council, since almost half of its members over the decade came from only two counties, Travis and Dallas.

Texas State Mental Health Advisory Council

In 1975, the Construction Advisory Council was reconstituted into an 11-member Texas State Mental Health Advisory Council. Its membership included:

> ...representatives of non-government organizations or groups, and of state agencies concerned with planning, operation, or utilization of community mental health centers or other mental health facilities, including representatives of the consumers of the services provided by such centers and the facilities who are familiar with the need for such services, to consult with the state agency in carrying out such plan... (Texas Department of Mental Health and Mental Retardation, 1981, p. II-6)

A general reorganization of TDMHMR due to the influence of P.L. 94-63 resulted in the basic characteristics of the current Mental Health Advisory Council. Four classes of membership are represented:

a. Representatives of consumers;

b. Providers of mental health services and facilities who are familiar with the need of such services;

c. Representatives of non-government organization or groups; and

d. Representatives of state agencies which are concerned with the planning, operation, or use of community mental health centers or other mental health facilities.

Its responsibilities include consulting with the TDMHMR Commissioner on the development, modification and administration of the State Mental Health Plan, review of applications for federal construction funds and recommendations as to the amounts that projects should be funded.

A specified nominating procedure utilizes a standing committee of seven members (three appointed by the Chair, three appointed by the Commissioner and the Chair) to solicit nominations from a variety of organizations and agencies. After the Nominating Committee reviews all suggestions, it presents a list of nominees to the Council. The Council endorses a list of selectees and forwards their names to the Commissioner for approval. Members are appointed for three-year overlapping terms by the Commissioner of TDMHMR, serving until they are reappointed or a successor is named. Most of the members from the earlier Construction Advisory Council served on the first Mental Health Advisory Council.

Brusco (1979) reports that in 1977, a National Institute of Mental Health study identified Texas as having the smallest advisory council of the 50 states. At the December 1978 meeting of the Council, the suggestion was made that the Council be expanded to 15 members, in order to distribute the membership over all 12 Health Services Areas in the States.

During the four years of its existence, the Mental Health Advisory Council has developed a very different pattern of representation from that of the former Construction Advisory Council or of the TDMHMR Board of Trustees. While its members are primarily White, half of those individuals have been women, thus destroying the image of White males as the primary leaders. In addition, due to a rather sizeable increment in Mexican American

men and a smaller increase in Black women, the proportion of racial/ethnic representation appears to be more balanced, though still not in proportion to that of the state's minority populations. The exceptions are Black men and Mexican American women (see Table 6).

Nevertheless, the traditional occupational pattern continues. Physicians constitute the largest professional group and commercial interests a similar percentage (see Table 7). Even so, with respect to percentage changes, increments are evident in terms of representation by academia and clergy, homemakers/volunteers/citizens' advocates and educators.

Once again, geographical representation is limited, in that five counties produced 52% of the Council members, with Travis County being conspicuous (21% of the total and half of the physicians). For the first time, Bexar County is also notable in terms of the number of members appointed from there (see Table 7).

TDMHMR Advisory Committee on Community Mental Health Mental Retardation Centers[1]

At its July 8, 1978 meeting, the TDMHMR Board of Trustees received a recommendation that a Community Mental Health Mental Retardation Center (CMHC) Advisory Committee be created. The Texas Council of Community Mental Health Mental Retardation Centers, a voluntary association of CMHC boards of trustees, presented the recommendation. Two advisory committees to the TDMHMR Commissioner already existed, a medical committee and the Texas State Mental Health Advisory Committee previously discussed. After eight months of consideration, the TDMHMR Board voted to approve the establishment of the Advisory Committee on Community Mental Health Mental Retardation Centers at its February 1979 meeting.

[1]This section is an edited version of Brusco (1980a).

TABLE 6

ETHNICITY AND SEX OF MEMBERS ON
THE TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL, 1977-1981[a]

ETHNICITY

Total	White	Black	Mexican American
29	16	4	9
100%	55.2%	13.8%	31.0%

SEX

Total	Men	Women
29	18	11
100%	62.1%	37.9%

ETHNICITY BY SEX

	White		Black		Mexican American	
Total	Men	Women	Men	Women	Men	Women
29	8	8	1	3	9	0
100%	27.6%	27.6%	3.4%	10.3%	31.0%	-

SEX BY ETHNICITY

	Men		Women	
Total	White	Minority	White	Minority
29	8	10	8	3
100%	27.6%	34.5%	27.6%	10.3%

[a] Due to rounding, percentages may not sum to 100%.

TABLE 7

OCCUPATIONS AND COUNTIES OF RESIDENCE OF MEMBERS ON THE TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL, 1977-1981[a]

OCCUPATION

Total	M.D.	Business	Academia or Clergy	Bureaucrat	Education or Youth Work	Homemaker Volunteer	Clinical Psychologist	Lawyer	Banker
29	6	4	4	4	4	4	1	1	1
100%	20.7%	13.8%	13.8%	13.8%	13.8%	13.8%	3.4%	3.4%	3.4%

COUNTY OF RESIDENCE

Travis - 6
Bexar - 3
El Paso - 2
Harris - 2
Webb - 2

5 counties

51.7% of members

Angelina - 1
Brown - 1
Collin - 1
Dallas - 1
Ector - 1
Gregg - 1
Jefferson - 1
Lubbock - 1
McLennan - 1
Nueces - 1
Potter - 1
Tarrant - 1
Taylor - 1
Wichita - 1

14 counties

48.3% of members

[a] rounding, percentages may not sum to 100%.

The purpose of the CMHC Advisory Committee is to report directly to the TDMHMR Commissioner, advising him or her on the following issues:

1) administration of basic services provided by the community mental health mental retardation centers in the state;

2) uniform business procedures for CMHCs;

3) construction for CMHCs; and

4) proposed legislation on "Rules of the Commissioner" which pertain to screening and aftercare.

Members of the Advisory Committee are appointed by the Commissioner, who along with the Deputy Commissioner of Community Services, serves as an ex-officio member. Each chairperson of a CMHC may submit one name for nomination. Nominations may also be solicited from CMHC sponsoring agencies, health systems agencies, state advocacy organizations or other interested parties. Members of the Advisory Committee may be currently serving as trustees of community mental health mental retardation centers or be former trustees. The Committee "shall reflect social, economic and minority groups, as well as the State's geographical areas."

The Advisory Committee members serve at the pleasure of the Commissioner for one year, and members may be reappointed. Meeting times and tasks are determined by the Commissioner, within the stated purpose of the Committee. Members are not compensated for their services; however, travel costs are paid by the Department. A chairperson and vice-chairperson are elected by members.

When originally proposed, the CMHC Advisory Committee was to be composed of nine members. Before its final adoption, the membership was increased to eleven and the ex-officio members were added. In addition, the nominating procedures were expanded to permit nominations to be submitted by "other interested parties." The hope was that such an expansion and the opening up of the nominating process would ensure "broader consideration for geographic representation ...including urban and rural areas."

The first committee was appointed in September 1979, and its membership does not appear to fulfill its original mandate in terms of representation goals. Nine of the 11 members were white males, and there were no Black females nor any Mexican American representatives on the committee (see Table 8). Occupationally, the pattern was similar to the bodies described earlier (see Table 9). Geographically, although 10 different counties had members on the Committee, only eight of the 12 health service areas were represented.

On attempting to update the Advisory Committee's roster, the Mental Health Research Project was informed that the Committee was inactive. All members had been named for a terminal one-year appointment; apparently, no action had occurred since the expiration of that period, and its legal status was unclear. The 1981 list included only nine of the original appointees (see Appendix C for the two rosters).

Boards of Trustees of Community Mental Health Mental Retardation Centers in Texas

In the Spring of 1981, 263 individuals were volunteering their time and energy to serve as trustees for the 30 CMHCs in Texas (see Figure 5 for a map of the counties served). Twenty-five centers opted to have boards with nine trustees, the largest permitted by law, whereas four centers had eight trustees on their boards (although three had a vacancy, some with specific

TABLE 8

ETHNICITY AND SEX OF MEMBERS OF THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION ADVISORY COMMITTEE ON COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTERS, 1979[a]

ETHNICITY

Total	White	Black	Mexican American
11	9	2	0
100%	81.8%	18.2%	-

SEX

Total	Men	Women
11	7	4
100%	63.6%	36.4%

ETHNICITY BY SEX

	White		Black		Mexican American	
Total	Men	Women	Men	Women	Men	Women
11	5	4	2	0	0	0
100%	45.4%	36.4%	18.2%	-	-	-

SEX BY ETHNICITY

	Men		Women	
Total	White	Minority	White	Minority
11	5	2	4	0
100%	45.4%	18.2%	36.4%	-

[a]Due to rounding, the percentage may not sum to 100%.

TABLE 9

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION ADVISORY COMMITTEE ON COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS, 1979

OCCUPATION

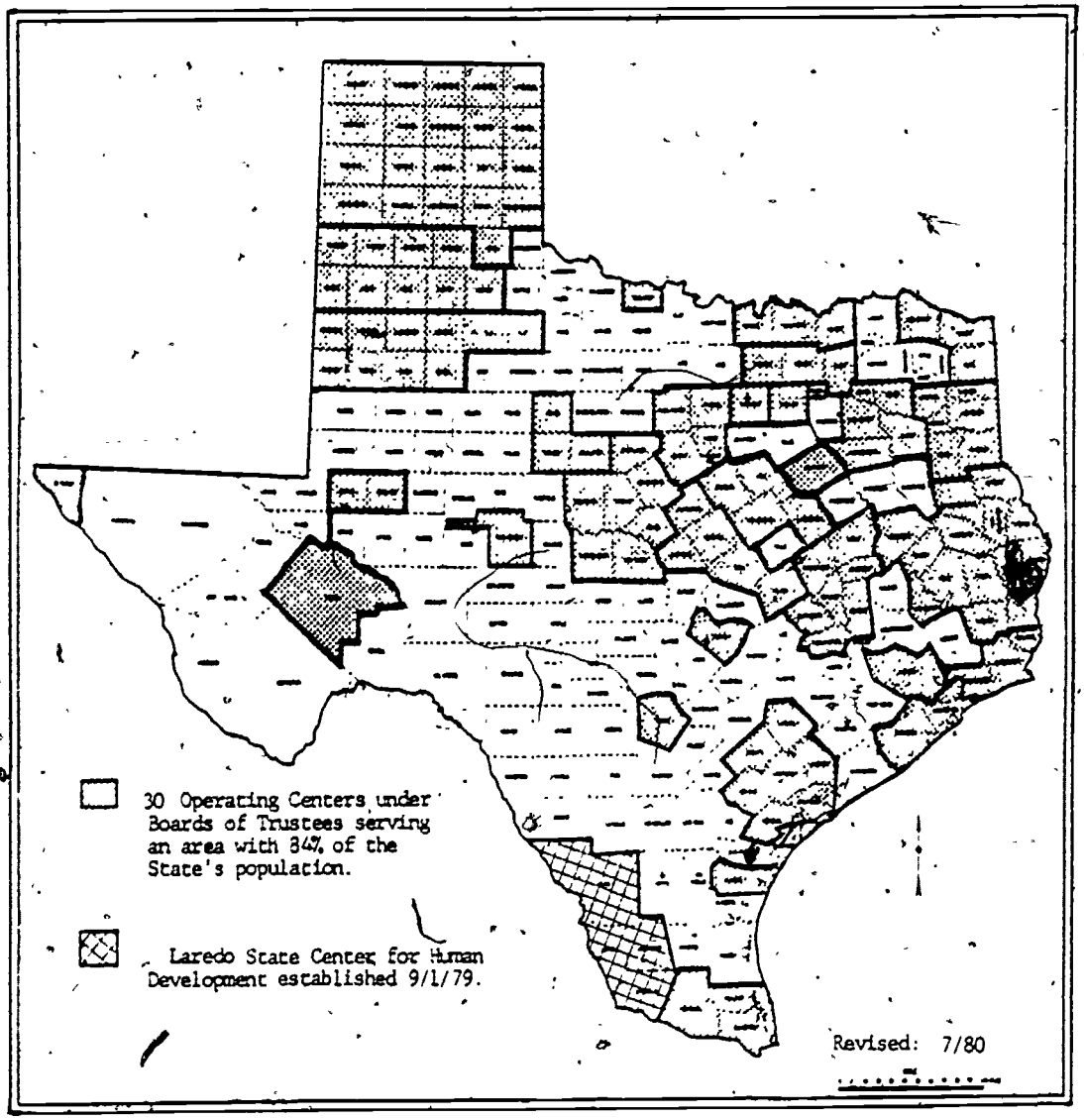
Total	M.D.	Business	Homemaker, Volunteer or Citizens Adv	Lawyer	Academia or Clergy	Computer Analyst	Rancher
11	2	2	2	2	1	1	1
100%	18.2%	18.2%	18.2%	18.2%	9.1%	9.1%	9.1%

COUNTY OF RESIDENCE

Amarillo - 1
Bexar - 1
Cameron - 1
El Paso - 1
Hamilton - 1
Harris - 1
Jefferson - 1
McLennan - 2
Nacogdoches - 1
Tarrant - 1

FIGURE 5

COMMUNITY MHMR CENTERS UNDER BOARDS OF TRUSTEES[a]



[a]Texas Department of Mental Health and Mental Retardation, 1980.

residential requirements). Interestingly, the center located in the state's largest metropolitan area chooses to operate with the smallest board, one of six members.

With respect to issues of representation, Whites also predominate at the CMHC level (81.6% of the trustees), with over half of the members being White men and 27% White women. Again, Mexican American men are the largest minority group represented, and Mexican American women constitute less than 2% of the total number of CMHC board members (see Table 10).

Occupationally, physicians play a much less visible role, but commercial interests continue in the majority, with business people, lawyers and financiers making up 34% of the board members. As is to be expected, however, there are more varied groups included in the local governance role of the CMHCs. Academics, clergy, and homemakers/volunteers/citizens' advocates all represent sizeable constituencies. Other health care professionals are represented for the first time, as is the farming and ranching business (see Table 11).

It is instructive to compare the 1981 rosters to those of 1979 (see Tables 12 and 13). Although evidence from a two-year period is hardly sufficient to document a trend, a slight shift from White male representatives is noticeable. Every other group, with one exception, indicates small gains. The importance of examining the sex-by-ethnicity factor in relation to geography, however, becomes apparent when one realizes that there was a decline in the number and percentage of Mexican American women serving as trustees. The obvious centers which might recruit Mexican American board members (e.g., San Antonio, El Paso, Harlingen, Houston) did not have a Mexican American woman serving in 1981. Similarly, it is somewhat amazing that Houston, with an almost 30% Black population in the largest urban area in the state, does not have a Black trustee, man or woman.

TABLE 10

ETHNICITY AND SEX OF THE BOARD MEMBERS OF THE 30 COMMUNITY MENTAL HEALTH CENTERS IN TEXAS, 1981[a]

ETHNICITY

Total	White	Black	Mexican American
261	213	23	25
100%	81.6%	8.8%	9.6%

SEX

Total	Men	Women
261	177	84
100%	67.8%	32.2%

ETHNICITY BY SEX

	White		Black		Mexican American	
Total	Men	Women	Men	Women	Men	Women
261	142	71	14	9	21	4
100%	54.4%	27.2%	5.4%	3.4%	8.0%	1.5%

SEX BY ETHNICITY

	Men		Women	
Total	White	Minority	White	Minority
261	142	35	71	13
100%	54.4%	13.4%	27.2%	5.0%

[a]Includes 2 other Hispanic, 1 of whom was female and the other male. Due to rounding, percentages may not sum to 100%.

TABLE 11

OCCUPATIONS OF THE
BOARD MEMBERS OF THE 30 COMMUNITY MENTAL HEALTH CENTERS
IN TEXAS, 1981

Total[a]	Business[b]	Academia or Clergy	Homemaker, Volunteer or Citizens Advocate	Education or Youth Work	Lawyer	M.D.	Other Health Professions	Banker or Financier	Bureaucrat or Military	Farmer or Rancher	Elected Official[c]	Support Services	Retired
263	54	37	30	30	22	18	15	14	12	11	9	7	6
100%	20.4%	14.1%	11.4%	11.4%	8.4%	6.1%	5.7%	5.3%	4.6%	4.2%	3.4%	2.7%	2.3%

[a] Due to rounding, percentages may not sum to 100%.

[b] Includes corporation officers, owners of businesses, "businessmen," CPAs, engineers, pharmacists, managers, insurance agents, realtors, consultants, supervisors and employees.

[c] Predominantly mayors or county judges.

TABLE 12

ETHNICITY AND SEX OF THE BOARD MEMBERS OF THE 29 COMMUNITY MENTAL HEALTH CENTERS IN TEXAS, 1979[a]

ETHNICITY

Total	White	Black	Spanish Surname
247	210	15	22
100%	85.0%	6.1%	8.9%

SEX

Total	Men	Women
247	170	77
100%	68.8%	31.2%

ETHNICITY BY SEX

	White		Black		Spanish Surname	
Total	Men	Women	Men	Women	Men	Women
247	146	64	11	4	13	9
100%	59.0%	25.9%	4.5%	1.6%	5.3%	3.6%

ETHNICITY BY SEX

	Men		Women	
Total	White	Minority	White	Minority
247	146	24	64	13
100%	59.0%	9.7%	25.9%	5.3%

[a]Due to rounding, percentages may not sum to 100%.

TABLE 13

OCCUPATIONS OF THE
BOARD MEMBERS OF THE 29 COMMUNITY MENTAL HEALTH CENTERS IN TEXAS, 1979[a]

Total	Business[b]	Academia or Clergy	Homemaker or Volunteer	Education or Child Care	Lawyer	M.D.	Elected[c] Official	Banker or Financier	Bureaucrat or Military	Other Health Personnel	Farmer or Rancher
247	60	37	31	27	23	17	15	13	9	8	7
100%	24.3%	15.0%	12.5%	11.0%	9.3%	6.9%	6.1%	5.3%	3.6%	3.2%	2.8%

[a]Due to rounding, percentages may not sum to 100%.

[b]Includes corporation officers, owners of businesses, "businessmen," CPAs, engineers, pharmacists, managers, insurance agents, realtors, consultants, supervisors and employees.

[c]Predominantly mayors or county judges.

Summary

Representation on the Board of Trustees, which constitutes the governance body of the Texas Department of Mental Health and Mental Retardation has been limited generally to White or Anglo male professionals or businessmen. This is probably due to the fact that Board Trustees are appointed by the Governor and that political considerations undoubtedly have a major impact on the selection process. Because women, Mexican Americans and Blacks have not had the opportunities nor the economic and social resources to assume major roles in politics in the state, they have often been at a disadvantage in terms of influencing gubernatorial appointments. This may change in the future, although the most recent appointments by Republican Governor William P. Clements have been three White male professionals and businessmen.

The advisors to the Department, in term of members on the three advisory groups, have had very similar characteristics, although the Texas State Mental Health Advisory Council in 1981 includes significantly more White women and Mexican American men. In contrast, the appointments by the Commissioner to the newer Community Mental Health and Mental Retardation Advisory Committee have included no Mexican Americans and no Black women. In general, Black male membership on the four bodies has been very limited, and Mexican American women are conspicuous by their total absence. Nevertheless, the mental health system appears to be somewhat more willing to accept female and racial/ethnic advice than in the past.

Geographically, the members of all four bodies have been appointed primarily from the large urban counties of Harris, Travis, Dallas, Bexar and El Paso. Nonetheless, representation of urban minority groups is particularly problematic. Although the border county of Webb, a predominantly Mexican American region, has been represented on all four, Bexar County, the largest SMSA with a Mexican American majority, has never had a

TDMHMR trustee selected. Similarly, Black trustees have come from a small rural county, while Houston, with the largest concentration of Blacks in the state, has never had a Black trustee or advisory group member.

With respect to the governing bodies of local community mental health mental retardation centers, the membership of CMHC boards of trustees, has been more diversified, primarily because of the higher proportion of White women serving. Racial/ethnic representation, while not so low as that on the TDMHMR Board, is still minimal, and minority women, particularly Mexican American women, are severely underrepresented. Occupationally, there is a wider range of constituencies represented across the 30 CMHCs as a group, although this factor varies by center, and business or commercial interests are always the predominant group. Geographic representation was not investigated, because many of the centers serve only one county, whereas others have much larger catchment areas and more lines of authority to consider. There was no attempt to analyze trustees' addresses in terms of geographic representation at the community level.

Because the 1979 data were categorized on the basis of Spanish surnames, rather than the specific ethnic origin of CMHC board members, the issue of actual Mexican American representation in 1979 is unclear. In collecting the 1981 data, the author was able to identify five specific instances of misclassification in the 1979 rosters at the state and local levels. In the 1981 survey of CMHCs, only two "Other Hispanics" (i.e., of Spanish but not Mexican origin) and two individuals of Mexican origin but with Anglo surnames were identified, in addition to the 23 Spanish-surnamed Mexican American board members. If center staff are correct in their categorization of board members by ethnicity, it may be that the issue of misidentifying other Hispanics or Spanish-surnamed Anglos as Mexican Americans is not a significant one. Nevertheless, for the sake of clarity, ethnic origin rather than Spanish surname is clearly a preferable index.

CHAPTER V

CITIZEN PARTICIPATION IN THE GOVERNANCE OF MENTAL HEALTH PROGRAMS IN TEXAS: CONCLUSIONS AND RECOMMENDATIONS

Sally J. Andrade

The primary responsibility of the IDRA Mental Health Research Project has been to collect and analyze empirical data to assist policy makers and administrators of human service delivery systems in Texas to serve Mexican American communities more effectively. Although ethnically targeted, the Project's findings generally have relevance for many other groups. This is certainly true in the case of the Project's study of mental health governance. As was seen in the preceding chapter, Texas continues to underutilize its human resources in the governance and advisory capacity of mental health service systems by failing to incorporate more leaders with diverse perspectives and life experiences.

Minorities and women continue to be underrepresented on the boards and councils of the Texas mental health system. There are also problems of occupational representation, in that the business interests of the state are well represented to the exclusion of other groups. Geographically, the major urban areas tend to be overrepresented, with the exception that in general urban minority groups are not at all visible at the state or the local level. Conspicuously underrepresented are Mexican American women, but there are very few other minority group members as well. The "representativeness" of a board or advisory council in terms of the degree to which its membership conforms to the population distribution of specific groups in a catchment area is not the fundamental issue of concern, however. Such "body counts" tend to engender a considerable amount of hostility and to deflect attention from the actual issue of representation of special groups on those bodies.

The intent of P.L. 94-63 was to structure the governance and advising functions in such a manner to ensure that the interests, needs and resources of special population groups would be made available to community mental health centers, thereby assisting them to provide effective and accessible services to their region. The responsibility of representing minority, women's or low-income interests was vested primarily in individuals from those special interest groups. What seems to have been lost from the concept is that each trustee on a board or member of an advisory council should seek to understand and thereby to represent all such groups in the community.

Regester (1974) outlined the practical impossibility of guaranteeing any equitable or statistical representation of "the community," in that no such entity exists. Every group -- whether racial/ethnic, occupational, geographic or special issue -- has its own definition of "the community," and generally, that definition is based on assumptions favorable to the particular group's goals and interests. Thus, how is a CMHC board or administration to encompass such diversity of conceptual and political perspectives?

Representation of business leaders on the boards and advisory councils of human service delivery agencies is generally a major goal of administrators, and, objectively, from a system perspective, this is sound judgment. Business people at the local and state levels are usually those individuals with the greatest political influence and the most fundraising success, both in the public arena and the private domain. As Windle and Cibulka (1981) note in their discussion of CMHC organizational problems, "Civic elite boards can help assure financial security." Yet the fact that other groups which are important in community life are underrepresented in the governance function often generates difficulties and stress that demand a great deal of attention from board members and administrators, as well as limiting the amount and quality of information available to agency decision makers.

The citizen governance model for community mental health centers may be one additional ideal which is the product of our society's commitment to the democratic process. As such, CMHC governance both benefits and suffers from the tensions inherent to such a democratic system of decision making. The CMHCs have been one other testing ground for the effectiveness of citizen governance. Yet, like so many program conceptualized in the federally activist decades from 1960 to 1980, there remain questions as to how thoroughly community representation was ever achieved and to what extent agency resources were directed at implementing citizen governance.

There is no way to guarantee more than the achievement of token representation or demographically accurate body counts in the membership of mental health boards and advisory groups. But, as Robins and Blackburn (1974) suggest:

> ...the effectiveness of boards is not ensured by provisions regarding composition and constitutional authority; rather, effectiveness is probably a function of the clarity of objectives assigned to a board, the competence of a board to achieve the explicit objectives, the formulation of objective criteria to measure achievement, and the tying of tenure of board members to achievement. The board and staff should apply the same management-by-objective approach to their respective efforts... This is not to say that efforts at representativeness be abandoned; however, it may be a disappointing instrument for attaining the desired responsiveness to community needs. It would be better to achieve consensus on the specific task of the board and to select people who have

> characteristics believed to be relevant to successful task performance. (Robins & Blackburn, 1974, p. 38)

The dilemma for Mexican Americans and for other underrepresented groups is that CMHC objectives and tasks seldom seem to address the need for appropriately designed and administered mental health services in their communities, as has been documented by the IDRA Mental Health Research Project's study of Texas centers (Brusco, 1980b; Moreno, 1981a; Moreno, 1981b; Ramirez, 1981; Sepulveda-Hassell, 1980; Valdez, 1980).

The extraordinary importance of the CMHC staff, and in particular of the CMHC executive director, cannot be overemphasized. As Enelow and Weston (1972) point out:

> The fundamental task of the administrator is to work toward the development of procedures that facilitate the negotiation for mutual surrender of some autonomy and for cooperation to avoid the type of chaos created when all principals attempt to strengthen their power to gain ascendency over other elements in the system. (Enelow & Weston, 1972, p. 609)

As Bartlett and Grantham (1980) conclude in their discussion of training programs for CMHC boards, professionals can control a board's effectiveness by encouraging its members in a passive role or by withholding information from them, yet:

> Increasing the competence and knowledge of boards is a crucial step in making citizen governance work and in ensuring community control of services. (Bartlett & Grantham, 1980, p. 111)

Thus, the issues of how to ensure adequate representation of special groups, such as Mexican Americans, in the governance and advising function and of maintaining comprehensive training programs for members of those bodies, along with agency staff, on effective citizen governance and leadership roles lie at the heart of an administrative dilemma. Many administrators in the past have been somewhat resistant to the concept of citizen governance and have perhaps not taken an active role in seeking out minority input. These same administrators are now faced with a federal situation requiring them to identify sources of community and state support for increased funding to community mental health centers.

Undoubtedly, there is no clearcut resolution to this question of citizen participation in the governance of mental health programs in Texas, or any other state. In terms of numbers and percentages, Mexican Americans and Blacks are underrepresented on the mental health boards and advisory councils of Texas, as are women of all ethnic groups. Continued attention will probably be focused on this aspect of representation, as well as that of occupational interests and consumers, by advocacy groups. In a time of federal withdrawal from the field of mental health, coalition building appears to be urgently required if community services are to continue. The Reagan Administration's emphasis on cutting federal spending in order to ensure that states and cities assume primary responsibility for social services implies that community solutions to local problems and needs will be forthcoming. Whether or not Mexican American community leaders and politicians will support any such coalitions for community mental health programs is probably linked to the development of responsive services for Mexican Americans. It remains to be seen how the latter can be achieved without a more visible and active role by Mexican American women and men in the governance function.

APPENDIX A

DESCRIPTIVE CHARACTERISTICS OF THE MODEL BOARD

Sherman L. Ragland & Harlan K. Zinn

Descriptive Characteristics of the Model Board [a]

a. Attitude Change

The board should assume a responsibility to improve and/or modify the attitudes of both the service providers and the clients of the CMHC. By using its resources of support staff; policy input, and community coordination, the board should focus on influencing the general attitudes of the CMHC director, staff, and community groups on broad policy issues and matters of local concern. The board should provide the kind of information and perspective to the director and consumers that is needed for policy decisions that are responsive to the needs and resources of the community.

b. Consumer Support

One of the major resources for citizen participation is based on the legitimacy or authority of citizens to participate in the decisionmaking process. Thus, the board should develop itself to be a prime community organization for providing residents with a mechanism for voicing their views.

c. Information Accessibility

Another major resource for citizen participation deals with the quantity and quality of information available on mental health issues. A model CMHC board should focus its activities on providing consumers and residents with high-quality information about the CMHC and the local mental health conditions. This will ensure that worthwhile services are utilized and that problems which develop are quickly brought to the attention of the director.

d. Negotiation

The board should have a structure and a function that place it in the role of provoking policy issues among the CMHC administration, interest groups, and constituencies in the community. It should then use its skills of mediation, management and use of information systems, and negotiation to bring about resolution of the conflicts provoked. The administration and staff of the CMHC could be brought into open and direct discussions with adversary groups, such as professional associations, committees of the board, formal and informal community organizations. By bringing about an open discussion and resolution of the issues, the board would satisfy its obligation to influence the process of policy decisionmaking.

e. Service Improvement

The major function of the board is to increase the availability, accessibility, and appropriateness of quality services. A primary responsibility of the board, therefore, is the identification of the most effective programs. Based upon this information, it must then influence policy decisions on schedules and operations in order to maximize impact, accessibility, and attractiveness of the services and programs to the residents and clients of the community.

f. Policy Development

A model board has clearly defined tasks relating to the process of policy development.

Task	Whose responsibility?		
(1) Policy *Formulation and Planning*	Board	Director	Staff
(2) Policy *Determination*	Board	Director	
(3) Policy *Execution*		Director	Staff
(4) Policy *Evaluation*	Board	Director	Staff

As the CMHC and its board develop in expertise and resources, previously jointly shared responsibilities could become more and more the sole responsibility of the board, especially in those areas where its success in cooperative and collaborative efforts had been demonstrated.

g. Systematic Development and Evaluation

The systematic development and evaluation of plans and policies for the CMHC should be a primary task for the board. According to this characteristic of a model board, the following should be standard operating procedure:

Stage 1: The board, the CMHC Director, and its staff participate in the identification of community mental health problems.

Stage 2: Because of their technical expertise, service providers develop feasible alternative solutions to these problems.

Stage 3: Mental health providers and the board jointly weigh and choose the best alternative.

Stage 4: The board exercises the final power of decision.

[a] Sherman L. Ragland & Harlan K. Zinn (Eds.), Citizen participation in community mental health centers: An annotated bibliography and theoretical models. Washington, D.C.: U.S. Government Printing Office (Stock No. 017-024-00935-1), 1979.

Stage 5: The service providers implement the board's decision while collecting careful and comprehensive feedback from consumers.

Stage 6: Evaluation is either (a) delegated to outside persons who make use of consumer, board, and staff inputs or (b) conducted utilizing internal resources of the board and center.

h. Behavior Change + Community Power

The model board features a combination of two strategies which are used in a two-stage process. The behavioral change approach is designed to influence the behavior of individuals through their membership on the CMHC board. The assumption is that people are more likely to support a decision and to assist in serving it out if they have participated in the decisionmaking process themselves. After these individuals (who represent the community) become identified with the attitudes and goals of the board, they are then taught community power strategies for (1) increasing the control exercised by the board, (2) determining the priorities of the CMHC, and (3) implementing the decisions of the board through their influence in the community.

i. Citizen Evaluation

(1) The board focuses its attention on providing relevant input into the evaluation research process for the CMHC. Board training emphasizes evaluation procedures and, as a knowledgeable partner, collaborates and cooperates with the director in utilizing budgeted evaluation funds.

(2) The board has a major influence over the development and application of policy recommendations which are based on evaluation research findings.

(3) Technical assistance should be provided to the board regarding methodology and background, but which does not decrease citizen initiative, autonomy, perspective, and authority to make policy considerations.

(4) Evaluation is an ongoing, well-supported feature of CMHC operations.

(5) There is a continual exchange of information between consumers, staff, administrators, and board members.

(6) The setting of evaluation criteria and the evaluation of programs by the board imply substantial input to policy formulation which must be taken into consideration during the policymaking process.

(7) The consumer input into evaluation should increase the coordination of CMHC policies with community norms, values, traditions, and groups.

(8) The members of the board must develop a comprehension of those aspects of evaluation research which are most relevant to the business of the board. This would certainly include an understanding of the implications of evaluation results and ways of utilizing these to improve the services of the CMHC through changes in policy.

j. CMHC Executive Leadership

The model board must be informed about its own status, skills, and potentials. At an early stage in its development the model board would impose a strict separation of the board from any administrative functions. The board would retain broad policy control and collaborate with the consultation and education component of the CMHC for public relations work, but it would limit its influence on operations to the giving and receiving of advice from the director.

k. Administrative Authority

At a later stage in the development of its resources and powers, the model board would increase its control over policymaking in order to better fulfill its mandate to improve the responsiveness of the CMHC to the community. The director would still be in charge of implementing policies, but the board would be responsible for the following tasks which might be considered administrative in nature:

(1) the board develops broad community objectives for the CMHC;

(2) the board determines the scope of programs and selects program activities from options developed in collaboration with the director;

(3) the board evaluates the results, both

quantitative and qualitative, of the levels at which services are offered;

(4) the board establishes long-range plans and time tables for programs;

(5) the board share jointly with the director the responsibility for exercising pressure and developing community awareness for securing and maintaining funding for the CMHC;

(6) the board evaluates and uses evaluation evidence in programing and making other policy decisions.

1. Complete Citizen Control

The well-developed model board, after having demonstrated its ability to coordinate community resources and determine policy for the CMHC, would firmly establish the local control of the CMHC by duly elected representatives. There would be a legally binding guarantee that the catchment area residents and their representatives govern the CMHC. The board would be in full charge of all policy and would be able to negotiate the conditions under which any of these powers could be changed. The major feature of this model board would be that there would be no intermediaries between the board and the sources of funding.

Joint collaboration and cooperation between the board and director would, of course, continue. The director and CMHC staff would function as expert technicians to present background, options, and advice to the board, but the board would make all policy decisions.

Operational Guidelines for the Model Board

Board Composition

1. The members of boards should reflect the community. The board, as a whole, is expected to represent the makeup of the community in terms of sex, employment, race, age, cultural background, education and other characteristics of the catchment area; it should be a cross-section of the community with members from all socioeconomic levels, many ethnic and religious groups, different political views, professional, trade, and other interest groups.
2. Careful consideration should be given to the total number of members on the board. Depending upon the individuals and the leadership skills of the officers, any number of members might be optimal for any particular board. Increase in size will usually increase the variety of beneficial inputs, but will also increase and complicate discussions and decisionmaking. After an initial board is composed of the required members to make it representative and functional, the board could gradually expand until its size starts to become detrimental to its impact and effectiveness.
3. It is important that individuals selected or elected to the board have sufficient interest, time, and energy to be active members.
4. A comprehensive profile of service agencies and organizations of the catchment area should be located or developed. With this as a guide, board members could be drawn from existing community groups, law enforcement agencies, schools, businesses, labor unions, churches and other religious groups, self-help groups, fraternal or recreational organizations, and related associations of residents. Each of these groups could be asked to select one of their members to represent them on the CMHC board. A process like this would give these board members a specific constituency to represent and to whom they would be accountable.
5. Board members could be selected who are officers or other representatives from local institutions such as school boards, city council, county administrators, boards of health, and civic groups.
6. Some members of informal, nontraditional groups, and people who have no special connection with any organizations should be selected as board members. This is because many low-income people and members of other disadvantaged groups do not join organizations at all. They would not be represented in any way on the board if only

delegates from official associations were selected to be members.

7. Some board members may be "self-selected" onto the board because they had been the original organizers of the CMHC or board.
8. Provisions should be made for retaining highly successful individuals as "ex officio" members after their terms have expired. This would continue to make their skills and resources available to the board.
9. Members may be elected from lists of enrolled or registered citizens interested in community mental health. Since it is usually impossible to include an entire catchment area in an election, a well-advertised public meeting might be held and members elected from a slate of candidates selected by the people who attended the meeting. Collaboration with the local Mental Health Association should be emphasized to acquire their support and expertise for the board's activities and elections.
10. Overlapping terms of office should be staggered to have input from new members and officers, while maintaining general stability on the board.
11. Controls on tenure, eligibility for reappointment and appointments to fill vacancies should consider the goal of democratic turnover of members.
12. Rules for assigning and terminating members should be stated in writing—based upon such problems as nonattendance, difficulty in working on committees, development of unconstructive public relations, and personal qualities that impair the board's effectiveness as a group.
13. Formal and informal leaders for the board could emerge. Formal leaders are granted the authority of an office, keep the board working on the agenda, and may act as spokesmen for the board. Informal leaders help maintain the social and emotional well-being of the group—this is important for ensuring that meetings do not become threatening or overwhelming to any of the members.
14. Office holders could rotate in order to provide more variety to the leadership and to allow alternative talents and abilities to surface.
15. A nominating committee could be established to recruit officers and other board members.

Personal Characteristics of Effective Leaders

16. Board officers should be familiar with the meaning and use of basic mental health terminology and be conversant both with general mental health issues as well as the local situation. They could either be selected on the basis of their prior knowledge, or special training could be provided to equip inexperienced members with the skills necessary to become officers.
17. To stimulate task achievement by the board, officers should ideally have a background in administrative and supervisory skills.
18. Officers should have planning and organizational abilities.
19. Officers should have good verbal communication skills. They will be required to interpret the concerns of consumers to the mental health professionals to explain issues and services to the consumers.
20. Officers should be confident individuals who can act well as spokesmen in dealing with the administration, community, and adversary groups.
21. Officers should have leadership abilities in addition to being responsible and civic-minded individuals.
22. Officers should have social and personal skills—to maintain a friendly and supportive climate. By being perceptive and resolving interpersonal problems before they get out of hand, elected and emerging leaders can develop group unity and mutual support.
23. The selection and retention of the CMHC director should involve consideration of the above leadership characteristics, in addition to professional expertise in mental health and the ability to work with the board, grantee, and community. The integrative aspects of the director's position are perhaps the most important.

Supportive Climates for Board Meetings

24. CMHC board officers should try to maintain a viable social climate during their meetings

and other activities. All of the members of a board are responsible for whatever type of social climate that materializes, but the officers play essential roles in directing the atmosphere toward one that is supportive, cooperative, and task oriented.

25. Model boards should avoid the kinds of attitudes which lead to the growth of a defensive climate by striving to develop a supportive climate. Supportive climates have been found to contribute to the effectiveness of small groups and the satisfaction members feel in associating and participating with them. The following chart describes some of the differences between groups in which members feel supported and ones where they feel defensive.

Supportive Climate		*Defensive Climate*
Description of issues and facts	vs.	Evaluation of ideas and people
Focus on the issues and problems	vs.	Focus on controlling others
Spontaneous comments encouraged	vs.	Great caution must be exercised
Members understand each other	vs.	Members are aloof and isolated
Members feel equal to each other	vs.	Some members dominate others
All viewpoints are tolerated	vs.	Some viewpoints are not tolerated

26. A problem orientation, in which the entire board is working on some common problem, will encourage mutual support and collaboration.
27. Members should feel free to state their ideas and make creative suggestions. Whenever members feel that they are being manipulated unfairly, they may become afraid to talk, develop alliances rather than work with the entire board, and generally lose a sense of identity with the board.
28. The board members should attempt to understand the circumstances and concerns of every member. Apathy exists on a board when members do not care to understand what other members are feeling or saying. This will quickly deaden the desire of members to be honest, open, and involved—thus decreasing the value the board has for the CMHC.
29. Democratic equality among members and between citizens, professionals, and the CMHC staff will improve the overall functioning of the board. To the extent that staff or others assume a condescending attitude, there will be resentment by the other members and groups with subsequent indifference and conflict.
30. A creative climate should be fostered in which nobody pretends to be absolutely certain what policies should be made or how CMHC services should be conducted. As long as the professionals, representatives of organizations, and citizens avoid being certain that only their particular suggestions will work, the board will continue to be an open forum for discussion in which all members feel involved. Absoluteness and rigidity will alienate and inhibit openness and exclude input from participating members. What should be sought is a climate that encourages spontaneous and creative discussion.

Orientation and Training

31. One primary section of Public Law 94-63, 201(c) deals with the hiring and releasing of the director of the CMHC by the governing board. Board members should develop skills and knowledge concerning the standards, norms, and abilities to expect from the director.
32. An initial orientation program should be conducted for new members. Training goals should be specific to the procedures, functions, tasks, and authorities of the board. The first sessions could introduce members to each other and teach them the tasks, procedures, and resources of the board.
33. Having a good handbook (loose-leaf format) for each member has been found to be an efficient way of introducing all the important material at once.
34. Orientation workshops or discussions should inform new members about the services, programs, how they relate to other services in the community, their effectiveness, organization of the CMHC and board, the board's authorities, resources, and operating procedures. Important contact persons in the CMHC and community should also be reviewed. All of this information should be put into written format and distributed to

all board members and to others associated with the board's operations.

35. One of the primary goals of any form of training should be to have members begin to trust and communicate with each other. By establishing these lines of communication and information flow, opinions and experiences that bear on current policy issues will be included in deliberations.
36. Training should depend upon the kind of strategies which will be used by the board. For example, for consumer review functions, members should be taught how to evaluate services, conduct surveys and needs assessments; for support activities, possible sources of funding should be explained to members and how to lobby for these; for a board which has assumed the role of community coordinator, members should be taught the variety of mental health related services in the community, the methods for coordinating these, and feasible projects they might undertake regarding outreach, volunteer, or collaborative programs.
37. Intensive continuing education programs for the board, as well as for the CMHC staff members should be organized. These would provide more indepth coverage of important issues and could set up mutual efforts by the board and staff. Inservice training sessions have been found useful for teaching the staff how to cooperate and integrate with the board's requests without causing disruption in their own work. An increase in mutual respect of their roles and relationships to one another is a likely byproduct of effective training programs.
38. Having continuing education programs on a quarterly or semi-annual basis has been found adequate. Region-wide meetings of boards from several States have been successful for large-group training. Professionals in mental health and in administration could be used for designing the content and focus of such conferences.
39. Experienced board members should train new members by informally explaining what they have found to be the most important issues, concepts, programs, people, and procedures. Formalized sessions and materials could also be used as ways for experienced members to teach new ones what they have learned.
40. Specific goals and training methods for the board and staff could be developed by the members themselves through their own needs assessment.
41. Local staff and State level personnel could be expected to implement training and support requested by the board.
42. Board member training has been found to work best with the following administrative characteristics: a whole weekday or 2 weekdays are devoted to training (rather than nights or weekends), timing of training is geared to the appointment of new members, and continuity or followup sessions are scheduled from the beginning.
43. In review of the budget by the board, provisions should be examined for reimbursement costs of training programs for the board members—their travel, per-diem, time-off-work, child care, and other expenses..

Functions

44. Permanent and temporary committees should be established to accumulate information and options about the policy issues facing the board.
45. Special advisors from the staff or community experts in related fields should be called upon to aid committees of the board when deemed appropriate and necessary.
46. The board could assume responsibility for distributing relevant and timely information regarding the wide range of community services offered. This function could well be integrated with the Consultation and Education Component (C&E) of the CMHC.
47. Shared leadership (rather than leadership by a single individual) will usually increase the motivation of group members and the development of the board's skills and powers. Different persons should assume leadership according to their own expertise, talents, and the needs of the group at particular points in time. This will increase the variety of input and diverse experiences brought into deliberations of policy issues.
48. Board members will naturally be motivated to different degrees for different reasons. Public recognition, social activity, [illegible]

mindedness, community status and the advocacy of special interest groups are all valid incentives for members to join the board beyond the traditional ones which focus on responsiveness and service to one's community. Public mention of the benefits of the board will also contribute to a sense of accomplishment.

49. Dependability, punctuality, mutual respect, trust, and confidence should be developed by the members. This sense of structure and continuity will lead to increased productivity and commitment to the work of the board.
50. Group cohesiveness or feelings of unity can be increased by pointing out shared values and goals of the members and by encouraging the members to see themselves as joined together for common, over-riding purposes. Whenever the board must cooperate with another group, such as the CMHC administration, it would usually be advisable to develop and reinforce a sense of common interests and goals.
51. The sense of freedom to participate and influence decisions should be encouraged in board members and residents of the community. This is an extremely strong motivation for conscientious participation in discussions, for maintaining viable communication channels with the community, and for effective cooperation with the CMHC director and community organizations.
52. Publicized meetings, workshops, and seminars should be conducted for the general public, as well as for individual community organizations involved with mental health services. This will increase the public's awareness of the board and make it known to more people as the channel through which to have an impact on local mental health problems.
53. The authorities, rights, and functions of the board should be made explicit. There should be no ambiguous language or overlapping authorities among the board, administration, staff, or grantee. A model board may have final authority over the budget and/or scheduling or any other aspect of CMHC operations. Legitimate rights and responsibilities of the board are exercised and encouraged by its officers, the administration, and the community.
54. A support staff for the board should be designated. This could be made up of part-time or full-time staff (hired solely by the board), reliable volunteers, or outside paid consultants. Ideally, this staff would be directly responsible and accountable to the board.
55. Organizational relationships and authorities of standing and temporary committees should be made explicit. This should increase their authorization to do serious work on issues, collect important information, and made policy recommendations. Clear-cut limits or boundaries of authority and responsibility must be set for each committee and for the board as a whole.
56. Committees and support staff should explain issues, collect and present relevant information, offer unbiased descriptions of alternative policies possible, and offer their own recommendations for policy.
57. The board should serve as advocates for appropriate funding and staffing; to do this, they must be provided with all the necessary information concerning budget and personnel needs.
58. Some of the functions, which model boards have performed by developing operational methods appropriate for the particular community, include:

    a. advising CMHC staff and administration;
    b. stimulating practical studies of problems;
    c. determining, approving, and revising the terms and guidelines related to mental health assessments and services;
    d. reviewing and commenting on findings and proposals by other organizations;
    e. making recommendations on contracts to be awarded by the CMHC;
    f. studying, planning, and monitoring the construction of facilities;
    g. working with the director in preparing grant proposals and participating in site visits;
    h. developing and sustaining communication linkages with minority organiza-

tions, caucuses, institutions, and communities;

i. obtaining views of minority groups and the general public on CMHC programs and services;
j. interpreting the needs and current mental health issues in the region to the administration;
k. proposing and recommending possible creative use of grants, contracts, and projects;
l. advising on manpower requirements and projects;
m. making recommendations for increased and improved training of board members and the staff;
n. collecting information on broad issues in mental health;
o. coordinating efforts of private, public, local, State, and Federal mental health agencies and offices;
p. evaluating adequacy of all CMHC activities and programs;
q. conducting periodic site visits to CMHC service delivery sites and programs;
r. coordinating mental health programs with the police, prisons, and the legal system of the area;
s. obtaining more knowledge and practical understanding of minority life styles, value systems, and the unique problems of each minority group;
t. coordinating and strengthening the variety of community-based prevention and treatment programs being carried out in the area.

Coordination

59. Full advantage should be taken by the board of any overlapping board memberships with other mental health agencies, organizations, or funding sources. The purposes of this would be to avoid duplication and to encourage the integration, coordination, and collaboration of all community resources.
60. Contacts should be established with Federal, State, and local officials for developing lobbying, program coordination, and grant and grievance procedures.
61. The goals and work of all local mental health experts, agencies, and groups should be listed and coordinated with the CMHC. This information center function could be achieved through forums, media campaigns, and collaboration with social service agencies of the community such as community action programs and should be jointly sponsored and supported by C&E and the board of the CMHC.
62. Community groups and agencies should be encouraged to work on *mutual* problems and goals. Collaboration could take such forms as community needs assessment, problem and resource delineation, and evaluation research.
63. Minutes of meetings should be distributed to board members, relevant CMHC staff, local and State organizations, and individuals in mental health programing.
64. Both formal and informal contacts can be used to gather and distribute information about programs and services. This could be done by having each member develop as many official and informal contacts as possible in his/her usual activities in the community. A formalized approach could also be developed with the board having a major responsibility for liaisons with a variety of institutions, service agencies, public offices, and corporations in collaboration with the CMHC Consultation and Education component.

Board Effectiveness

65. Board officers and other members must use their interpersonal, organizational, and administrative skills to decrease tensions among members and represented groups. By exercising tact along with effective assertiveness, petty hostilities can usually be overcome without damage to the board.
66. The board should attempt to develop and modify its functioning by analyzing its strengths and weaknesses. The following are some of the characteristics of effective small groups which would probably contribute to the impact and efficiency of a CMHC board. A well-developed board:

a. recognizes the values and limitations of the democratic procedures;
b. provides an atmosphere of psychological freedom for the expression of all

feelings and points of view;
c. achieves a high degree of effective intercommunication;
d. has a clear understanding of its purposes and goals;
e. is able to initiate and carry on effective, logical problemsolving that results in action;
f. recognizes that means must be consistent with ends;
g. faces reality and works on the basis of fact and personal experience;
h. provides for the sharing of the responsibilities of leadership;
i. makes intelligent use of the differing abilities of its membership and recognizes the need for and methods of utilizing outside resources;
j. strikes an appropriate balance between group productivity on business matters and the satisfaction of other needs of the members;
k. provides for satisfactory integration of individual values, needs, and goals with those of the group;
l. is objective about its own functioning, but can face its procedural-emotional problems and make whatever modifications are needed;
m. strikes a useful balance between using established methods and a willingness to change procedural patterns to meet new situations;
n. has a high degree of solidarity, but not to the extent of stifling individuality;
o. finds a healthy balance between cooperative and competitive behavior among its members.

67. Unnecessary blocks to communication and service, such as overly formal procedures and red-tape, should be examined, reviewed, and modified.
68. The board should evaluate its own performance, perhaps by addressing the following questions:
    a. What number of recommendations or policy decisions of the board were actually implemented?
    b. How many useful contacts have been established with the community by the board?
    c. Is there a permanent place assigned for conducting the affairs of the board?
    d. Has the board been successful at collecting input from the community regarding the services of the CMHC?
    e. Has the board recommended any cost-savings procedures for the CMHC?
    f. Have any new sources of funding for the CMHC been acquired by the board?
    g. Do the members know the kinds of support services and resources available to them in terms of material and staff?
    h. Has the board contributed any critical insights regarding improvement of services, community coordination, or improved utilization of CMHC programs?
    i. Have services been created or improved by the board?
    j. Has the influence of the board over budget and policies improved the value of the CMHC for the catchment area residents?
    k. Has the board been effective in advocating the rights and needs of the high-risk groups in the community?
    l. Has the board affiliated itself with any state-wide mental health associations?
    m. Does the board have a good working relationship with the local mental health association chapter?
    n. Does the board have sufficiently frequent and useful contacts with regional HEW mental health officials?

Needs Assessment

69. The board should study all available reports on local mental health facts and figures, such as those references listed in the Annotated Bibliography.
70. High-risk populations in the catchment area, such as the elderly, unemployed, youth, ethnic or racial groups, and the poor should be identified by the board and addressed in subsequent policy formulations.
71. Characteristics associated with the mental health, illness, and treatment of the high-risk groups should be identified, especially those over which the CMHC could have some influence.
72. Both short-term and long-term forecasts of mental health needs should be studied by

the board toward the goal of planning and coordination.

73. If possible, community household surveys could be conducted by the board and its staff in conjunction with the Consultation and Education component of the CMHC. The goal should *not* be an expensive study of precise statistics. Rather, the goal should be an economical study of the approximate numbers of people needing particular kinds of services. The results of this study would serve as a tool for setting priorities and designing services and their schedule of operations. Door-to-door canvases, telephone surveys, and storefront methods are listed in the Annotated Bibliography.
74. Surveys of consumer organizations, institutions (courts, schools, hospitals), fraternal and business organizations, religious and special interest groups should be conducted to determine how they see the mental health needs and services of the community.
75. The impact of current services should be estimated; that is, the percentages of people who need particular kinds of mental health services who actually receive such services from the CMHC.
76. Input from all relevant agencies and organizations and the CMHC staff should be collected regarding new services and improvements in current services.

Strategies

77. Brainstorming sessions have been found helpful for listing issues for the board to work on. During brainstorming, as many ideas as possible are suggested by all members. Any criticism, discussion, or evaluation of the suggestions is postponed until the initial list is compiled. From such an exhaustive list of possible issues and objectives, the most practical, realistic, and vital ones for the board to address would then be selected.
78. Three major strategies which CMHC boards have undertaken include coordination, support, and citizen review. Depending on the legal authorities, resources and philosophy of a board, its goals and objectives could be organized under one or more of these strategies: coordination, support, or review.
    a. Coordination aims at bringing the heads of agencies, facilities, and departments in order to coordinate their activities in relation to the delivery of a common mental health service. Methods for primary prevention of mental illness could be developed.
    b. Support functions include bringing together high-status members of the political, social, and financial community in order to provide support for the CMHC. Planning and carrying out public awareness campaigns has been a frequent activity of boards interested in a support strategy. Local advertising companies could be asked for help in organizing mass media, distributing public information, writing newspaper ads, and radio and TV spots. This function is usually jointly undertaken with the C&E Component of the CMHC.
    c. Review functions include citizens' expression of the specific mental health needs of the community and an objective review of the impact of services. The board could adopt a cost-effectiveness research program. This would emphasize determination of the costs of various services and program goals and their impacts on actual needs. Those programs would then be advocated which provided the best services for the most people. Using this strategy, a model board could assume clear-cut responsibilities for setting priorities and the kinds of special programs to be directed toward high-risk groups.

Logistics

79. Local policies and procedures for board meetings should be developed. Meetings should be held on a regular basis—typically on a fixed day each month. The schedule should contribute to a sense of continuity to the work of the board. Its committees and all meetings should begin and end on time.
80. Each member should be notified by mail at

least 1 week prior to meetings and be sent an agenda (list) of topics that will be discussed.

81. The first order of business is usually to approve the minutes of the last meeting. Minutes should include names of those attending, issues discussed, and the outcomes of votes taken. Topics to be considered during meetings could be grouped under "old" and "new" business.
82. Practical guidelines for running board meetings should be developed and used regularly. These may be based on standard guides such as Robert's Rules of Order for Parliamentary Procedure (majority rule), or should be tailored to fit the personalities and activities of the specific board. Requirements of the CMHC, local customs, and personal preferences of the members should be considered in formulating how a democratic airing of all responsible viewpoints would best take place.
83. An alternative to majority rule, which some boards use, is rule by consensus. Issues and decisions are discussed until almost everyone agrees to what should be done. Although this may be good for increasing a sense of unity, it may also paralyze the board through the delays required for extended discussions.
84. Strict procedures for voting should be developed. To pass motions, some boards require a majority vote, others a two-thirds vote. Different types of motions may require different percentages of votes to pass: Some issues may be decided by the entire board, some by an executive committee, some by individual officers. Specific voting procedures should seem reasonable to all board members.
85. The duties and rights of the board, its committees, and members should be formally stated in writing; this statement should be understood by all members.
86. A high drop-out rate of members can be avoided if there is clarity about the intended tasks of the board—for example, whether its emphasis is on consumer review, community development, and coordination, or CMHC support strategies.
87. The board could prepare periodic written reports concerning what are felt to be weaknesses in delivery of services and to make informed recommendations on how these weaknesses can be overcome.
88. The board should develop a schedule for reviewing the goals, priorities, and target dates of the programs of the CMHC. Progress should be noted, as well as identification of problem areas subject to modification.
89. The board should entertain the possibility of holding at least one yearly public meeting; it should be announced in newspapers, radio spots, and other media with special invitations to the general public. At that meeting, the program plan and the budget would be submitted for public scrutiny and comment.
90. The board should provide a clear opportunity and mechanisms for representatives of the community to be heard on all matters concerning the delivery of mental health services to its residents.

It is hoped that these guidelines provide a focus which advisory/governing boards can address in their continuing role—ensuring that CMHCs are effective and responsive in meeting the unique mental health needs of local communities.

APPENDIX B

ANNOTATED CHRONOLOGY OF FEDERAL AND STATE MENTAL HEALTH ACTIVITY

Bernadette A. Brusco

ANNOTATED CHRONOLOGY OF FEDERAL AND STATE MENTAL HEALTH ACTIVITY*

Bernadette A. Brusco

To gain a balanced picture of the arena in Texas in which the federal community mental health program was thrust, it is important to have an understanding of the State's previous activity in the mental health field. This activity did not take place in isolation, but is related in terms of initiative, response and compliance to local needs and federal activity. For these reasons, an Annotated Chronology of Federal Government and State of Texas Activity in Mental Health as Related to Community Mental Health 1859-1979 has been prepared to present this information. This format is intended to provide a concise uninterrupted presentation of this historical data.

Annotated Chronology of Activity of the Federal Government and the State of Texas in Mental Health as Related to Community Mental Health, 1856 - 1979.

Note: Texas activity appears in italics. Federal activity appears in regular type.

1. 1856. *First Texas state mental hospital approved for construction in the Austin area. It opened in 1861. Legislature named the institution the State Lunatic Asylum (now the Austin State Hospital). From 1856 - 1919, State asylums were under the jurisdiction of the Board of Managers, who were appointed by the governor.*

2. 1917 Federal Government entered the field of mental health with passage of the Selective Service Act, 1917. It created a division of Neurology and Psychiatry, under the Surgeon General, War Department. It was responsible for screening the mental fitness of recruits.

*Revised version of Chapter Two in B.A. Brusco, Boards and councils of the Texas Department of Mental Health and Mental Retardation. San Antonio: Intercultural Development Research Association, 1979.

3. 1919 *Texas state mental hospitals and charity-supported institutions came under administrative jurisdiction of the Board of Control, the State's purchasing agent. The board was appointed by the governor.*

4. 1930 Division of Mental Hygiene, Public Health Service was established. Responsible for the treatment of drug addicts, the psychiatric care of federal prisoners, and for providing psychiatric diagnostic services to the federal courts.

5. 1937 Public Health Service and the National Committee for Mental Hygiene formed. This committee provided the first nationwide documentation of abominable conditions in state mental hospitals. *(Texas was among the ten lowest states in type and quality of mental hospital).*

6. 1946 National Mental Health Act of 1946 established the National Institute of Mental Health (NIMH) and the National Advisory Mental Health Council. The act also authorized grants-in-aid to states for developing the community mental health concept. This act grew out of the World War II recruiting experience. Two million men were rejected on mental grounds. The services under this new act were still mainly limited to military veterans, residents of the District of Columbia and other special groups. The Public Health Division of Mental Hygiene, Public Health Service established in 1930 was disbanded.

7. 1946 National Institute of Mental Health became a bureau of the Public Health Service, Department of Health, Education and Welfare.

8. 1946 Hill-Burton Hospital Construction Program provided money for construction of hospitals which would include psychiatric facilities.

9. 1947 Texas created the Division of Mental Health Services within the State Department of Health. It was one of seven divisions within the Department of Health. The division was formed in response to the National Mental Health Act of 1946 which required the designation in each state of an Authority for Mental Health. The act prohibited designating agencies solely responsible for mental hospitals as the State's authority. Since the division was responsible for establishing guidelines for community-based services, the commissioner was designated the mental health authority. The State never appropriated any funds for the Division of Mental Health. It was supported on grants from NIMH. The division was reorganized in 1965.

10. 1949 In a report of the U.S. Public Health Service, Texas ranked below all states in meeting standards for psychiatric facilities. These standards were developed by the American Psychiatric Association. Only two other states spent less money than Texas in per capita appropriations for state hospitals.

11. 1949 First major administrative reform of mental health bureaucracy in Texas. State mental hospitals and charity-supported institutions were placed under the administrative jurisdiction of the Board of State Hospitals and Special Schools. They had previously been under the jurisdiction of the Board of Control, the State's purchasing agent. The Board of State Hospitals and Special Schools was reorganized in 1965.

12. 1954 New York became the first state to enact a community mental health law. It permitted specific governmental jurisdictions to operate mental health clinics.

13. 1955 Congress permitted NIMH to make grants-in-aid available to state mental hospitals to upgrade their therapeutic programs.

14. 1955 Mental Health Study Act (Public Law 84-182). This act's purpose was to study the humane and economic aspects of mental health. As a result of this, the Joint Commission on Mental Illness and Health was formed to undertake the research the act sought to encourage. The Joint Commission report was to be more than just an evaluation. It was to provide new solutions to mental health questions.

15. *1957* *Texas Legislative Budget Board balked at a request from the Board of Hospitals and Special Schools for funds to build a large state hospital in the Houston area. The board requested the Texas Medical Association (TMA) to sponsor a study of the State's mental health services. While the TMA agreed to sponsor the study, it would provide no funds or staff. After considerable difficulties in obtaining funding, H. E. Butt, a prominent South Texas businessman, funded the study. A physician was brought from out of state to head up the study. As a result of the study, the Budget Board appropriated the funds for the Houston State Psychiatric Institute (now called Texas Research Institute of Mental Sciences) with emphasis on staff and research.*

16. *1957* *Texas Mental Health Code (House Bill 6). Texas' first full mental health code. The major provisions of the code are the: 1) provisions for voluntary and involuntary hospitalization under several categories; and 2) the definition of mental illness as not including epilepsy, alcoholism, senility or mental deficiency. This code is still in force, having been amended several times.*

17. 1960 Action for Mental Health, the final report of the Joint Commission on Mental Illness and Health, was submitted to Congress, the Surgeon General and the governors of 50 states, December 31, 1960. The report recommended: 1) a shift of research funds from applied to basic long-term research; 2) liberalization and broadening of what constituted and who could perform mental health treatment within hospitals, clinics, etc.; 3) the establishment of one fully staffed full-time mental health clinic per 50,000 population; 4) that federal expenditures in this area should double within five years and triple within ten; 5) a new funding emphasis for mental health with the federal government on one side, and state and local governments on the other sharing costs; and 6) federal fiscal commitment should be graduated over a period of years and based on the amount of state funds expended previously. Congress allocated $4.2 million for planning grants for the development of community programs. *(Texas' share was $368,000.00; it was used to support the activity which culminated in the Texas Plan for Mental Health Services.)*

18. *1962* *Texas Mental Health Division, Health Department and Department of State Hospitals and Special Schools submitted a proposal to NIMH for a planning grant.*

19. 1963 Message from the President of the United States Relative to Mental Illness and Mental Retardation, by John F. Kennedy, Feb. 5, 1963. This grew out of the report of the Joint Commission on Mental Illness and Health of 1960. The major thrust of the speech was to shift emphasis in the treatment of the mentally ill from state hospitals to community-based mental health centers. Preventative mental health care was also emphasized.

20. 1963 The Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (Public Law 88-156). This amended the Social Security Act to provide funds to states to develop mental retardation plans. It was drafted and passed at the urging of the governors after receiving the Joint Commission report. *(Texas' share was $77,331 and was used to develop the Texas Plan to Combat Mental Retardation).*

21. 1963 Subcommittee Hearings on Health, March 5, 6, & 7, 1963, to consider the proposed legislation coming from the President's Mental Illness and Mental Retardation message. Thirty-nine states sent their governors or another top administrator to testify in favor of the legislation. Ten did not, including Texas. An overwhelming majority of the witnesses and the bulk of the testimony strongly favored the federal commitment to the community mental health concept.

22. 1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164), signed into law October 31, 1963. This provided federal funds for construction of community mental health centers (CMHCs) in aid in "the creation and development of new methods of treatment." It shifted the emphasis from institutionalization in state hospitals to community care, as a result of President Kennedy's message to Congress in 1963. In order to secure passage of the act, proponents had to delete the section providing federal support for staffing. The act also required: 1) designation of a state advisory council composed of representatives from state agencies, non-governmental agencies, and consumers; 2) a state plan which divides the state into geographic areas and ranks need by area; 3)

centers to provide the five essential services, (a) inpatient care, b) outpatient care, c) emergency service, d) partial hospitalization, and e) consultation and education.

23. 1963 *Texas State Advisory Council for Construction of Community Mental Health Centers was formed to determine the allocation of funds for community centers and to oversee the administration of the construction funds. This advisory council was required by the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164).*

24. 1963 *A planning grant requested by Texas Mental Health Division and Department of State Hospitals and Special Schools in 1962 was approved by NIMH. The grant called for a four-member executive, a seventeen-member steering committee, and approximately one hundred members to serve as a planning committee.*

25. 1963 *A Texas mental health planning committee, the Statewide Citizens Committee for Mental Health Planning, was formed out of a $182,800 federally funded planning grant awarded in July 1963. The executive committee was headed by the Commissioner of the Mental Health Division, who had been one of the initiators of the planning grant request. No members of the State's executive branch or the speaker of the house could be induced to serve. A general committee of 110 persons was formed through invitations of the Executive and Steering Committees. Members included approximately 45 state employees and 38 people having educational or research affiliations. There were 38 physicians on the committee. Thirty-four members came from Austin; the remainder heavily represented*

the other large cities. There were aproximately twenty-one women and four Spanish-surnamed members. Invitations to several influential businessmen were declined. The committee divided itself into thirteen task forces. Meetings were held in Austin for two days at a time. The committee's recommendations formed the Texas Plan for Mental Health, which helped form the basis for House Bill 3 (McCleskey, 1968; Statewide Citizens, 1964b).

26. 1964 *A study entitled Fifteen Indices: An Aid in Reviewing State and Local Mental Health and Hospital Programs, 1964, ranked Texas as follows:*

1. Number of Average Daily Resident Patients in Public Mental Hospitals per 100,000 General Population . . . . . TEXAS RANKS 44th

2. Number of Public Mental Hospital Physicians per 100 Resident Patients . . . . . TEXAS RANKS 16th

3. Number of Professional Patient-Care Personnel per 100 Resident Patients in Public Mental Hospitals . . . . . TEXAS RANKS 27th

4. Number of Full-Time Employees per 100 Patients in Public Mental Hospitals . . . . . TEXAS RANKS 40th

5. Average Daily Maintenance Expenditures per Resident Patient, Public Mental Hospitals . . . . . TEXAS RANKS 43rd

6. Number of American Psychiatric Assn. members per 100,000 population . . . . . TEXAS RANKS 33.5th

7. Scheduled Professional Man-hour in Outpatient Psychiatric Clinics per Week per 100,000 population . . . . . TEXAS RANKS 38th

8. Per Capita Personal Income . . . . TEXAS RANKS 36th

9. Per Capita General Expenditure of State and Local Governments . . TEXAS RANKS 41st

10. Per Capita Total General State Expenditures . . . . . TEXAS RANKS 46th

11. State Mental Hospital Operating Expenditures as a Per Cent of Total General State Expenditures . . . . . TEXAS RANKS 37th

12. Annual Per Capita Maintenance Expenditures for Public Mental Hospitals . . . . . TEXAS RANKS 50th

13. Per Capita Expenditures for Community Mental Health Programs . . . . . TEXAS RANKS 46.5th

14. Per Capita Expenditures for Public Mental Health Maintenance and Community Mental Health as a Per Cent of Per Capita General Expenditure for Health and Hospitals . . . . . TEXAS RANKS 46th

15. Per Capita Expenditures for Public Mental Hospital Maintenance and Community Mental Health as a Per Cent of Total Per Capita Expenditures for Health and Hospitals . . . . . TEXAS RANKS 42nd

AVERAGING THE 15 INDICES . . . . . TEXAS RANKS 39th

The indices were compiled by the American Psychiatric Association and the National Association for Mental Health. This report was used by the Mental Health Planning Committee to spur interest in the development of the Texas Plan for Mental Health (Statewide Citizens, Committee for Mental Health Planning, 1964a).

27. 1965 The Community Mental Health Centers Construction Act Amendment of 1965 (Public Law 89-105), August 4, 1965. This enlarged upon 1963 legislation by providing federal funds for initial staffing costs for professional and technical staff. These were the provisions deleted by the previous legislature in order to secure passage. They were passed at this time because opposition of the American Medical Association ceased, and with the death of President Kennedy, Congress wished to fulfill some of his legislative program.

28. 1965 *Texas Mental Health and Mental Retardation Act of 1965 (House Bill 3), September 1, 1956. The act brought about a reorganization of the mental health and retardation bureaucratic structure by: 1) dissolving the Board for Texas Hospitals and Special Schools; and 2) establishing the Texas Department of Mental Health and Mental Retardation (TDMHMR). The Commissioner of TDMHMR was also designated the mental health authority.*

29. 1967 The Mental Health Amendments of 1967 (Public Law 90-31), June 24, 1967. This extended initial staffing grants and construction grants for the period, 1968-70. Staffing grants were extended for two more years and construction grants for three more years.

30. 1967 The Partnership for Health Amendments of 1967 (Public Law 90-174), December 5, 1967. This was the first legislation which set out the percentage of federal assistance for service delivery (70%) and administrative support (30%).

31. *1967* *Sixtieth Texas Legislature voted first grants-in-aid to community mental health centers. Centers receiving funds were Edinburg County in June, 1967 and Austin, Beaumont, and Temple, in September, 1967.*

32. 1968 The Alcohol and Narcotic Addict Rehabilitation Amendments of 1968 (Public Law 90-574), October 15, 1968. These initiated the first major change in the community mental health concept by enlarging the scope of the CMHC program. Forty million dollars was authorized for fiscal year 1969-1970 for construction, training, staffing, and enrollment. The amendments identified special populations, alcoholics, and drug addicts, and appropriated funds for facilities to provide treatment and prevention services. Program evaluation and accountability were also required, which have grown to be significant aspects of the community centers' programs.

33. *1968* *Seven more community mental health centers received state grants-in-aid. The centers were in El Paso, Houston, Amarillo, San Antonio, Dallas, Lubbock and Texarkana.*

34. 1969 *Eight community mental health centers were located in Fort Worth, Waco, San Angelo, Corpus Christi, Midland/Odessa, Plainview, Galveston, and Wichita Falls.*

35. 1970 The Community Mental Health Centers Amendments of 1970 (Public Law 91-211), March 13, 1970. These extended the expiration date of all previous programs to June 30, 1970, and initiated the second major change in federal policy in community mental health legislation by identifying a third special population to be served -- children, and by acknowledging that more federal support would be needed in development of community mental health centers. The period of federal staffing support was increased from four to eight years. Also, poverty areas were recognized by this legislation. Designated poverty areas would receive 90% in federal funds for construction. Poverty areas could receive up to 100% federal money for one-year, non-renewable planning grants.

36. 1970 *Four community mental health centers were appropriated state grant-in-aids. The centers were located in Victoria, Tyler, Brownwood, and Marshall.*

37. 1970 The Comprehensive Drug Abuse and Control Act of 1970 (Public Law 91-153), October 27, 1970. Identified another special population, persons with drug abuse and drug dependence problems. Funds were allocated for: 1) drug abuse education, 2) special detoxification units, 3) inpatient services, and 4) community-based aftercare.

38. 1970 Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment, and Rehabilitation Act of 1970 (Public Law 91-616), December 31, 1970. It required that the alcohol abuse and prevention programs funded in this law be community-based.

39. 1971 *Texas appropriated funds to establish a community mental health center in Abilene.*

40. 1973 President Nixon's Budget Message of 1973 proposed the termination of the community mental health center's program on the grounds that it was a demonstration program. The Nixon Administration impounded funds authorized by Congress, which led to a legal suit. The U.S. District Court for the District of Columbia on August, 1973, Judge Gessel, presiding, held that Congress did not intend for the Community Mental Health Centers Act to be a demonstration program. National Council of Community Mental Health Centers vs. Weinberger, 1973.

41. 1973 Health Programs Extension Act of 1973 (Public Law 93-45). This authorized funds for one year for health related programs, including community mental health centers while the controversy with the Nixon administration was resolved.

42. 1974 National Health Planning and Resources Development Act of 1974. This act provided for planning and coordinating legislation. Some aspects of the act are that it: 1) created Health Systems Agencies which are responsible for health planning in Health Service Areas (12 in Texas); 2) designated a State Planning and Development Agency; and 3) required the Governor to appoint a Statewide Coordinating Council.

43. 1974 Community Mental Health Centers Extension Act of 1974, December 1974 (Vetoed December 21, 1974). All legislation funding community mental health centers was being provided by a month-to-month Congressional resolution. This act, the product of a conference committee, provided for a two-year extension of the Community Mental Health Center Act through June 30,

1976. Important extensions and modifications to the original community mental health center act were: 1) the requirement of services to the elderly, children, courts and other community agencies, follow-up care and half-way houses; 2) the integration of community mental health center services and records with existing health and social welfare agencies; 3) the installation of a quality assurance program for the assessment of utilization of the center's services; and 4) the extension of many health programs not related to the original community mental health centers act. President Ford vetoed the act because he viewed it as too expensive, and, in his opinion, it included programs already provided for under Medicare.

44. *1974* *Three community mental health centers were established with the appropriation of state grants-in-aid. They were located in Bryan, Lufkin, and Denison/Sherman.*

45. 1975 Special Health Revenue Sharing Act of 1975 (Public Law 94-63), July, 1975. The act was passed over the veto of President Ford. It revised and extended for over two years the original Community Mental Health Center's Act and greatly expanded the content of the act. The funding aspects were extended and remained unchanged in content. Of the services to be provided, the original five were still required: 1) inpatient care, 2) outpatient care, 3) partial hospitalization, 4) emergency service, and 5) consultation and education.

In the program and planning area, the Act required that each center provide a program plan for culturally deprived populations, economically deprived populations, and linguistic minorities.

Finally, the Act required: 1) implementation of a continuous quality assurance program; 2) collaboration among all agencies providing mental health services; 3) an integrated confidential record keeping system; and 4) community citizen participation in the policy making and program planning of the centers.

46. 1975 *Texas Health Planning and Development Act of 1975 (House Bill 2164). This act was created to implement Public Law 93-641, the National Health Planning and Resource Development Act of 1974. The major section of the Act: 1) provided for the administration of a state Certificate-of-Need program by fixing statewide planning responsibility; 2) replaced the Texas Department of Health with the Texas Department of Health Resources (currently it is once again the Texas Department of Health); 3) expanded the new State Board of Health from a nine to an 18-member board; 4) charged the new Texas Department of Health with preparation of a preliminary State Health Plan; 5) provided for the development of a Health Service Plan; 6) established a three-member Texas Health Facilities Commission to develop and administer the Certificate-of-Need Program; and 7) established the Statewide Health Coordinating Council (SHCC) to review annually and coordinate the Health Sytems Plan of each Health Systems Agency.*

47. 1977 *General reorganization at the state level to meet the requirements of P.L. 94-63. The Texas State Advisory Council for Construction of Community Mental Health Centers was disbanded and reorganized as the State Mental Health Advisory Council. This council was to consult with the Commissioner of TDMHMR in the Commissioner's capacity as the state's designated mental health authority. The four classes of*

membership are: 1) consumers, 2) providers, 3) representatives of non-governmental entities, and 4) representatives of state agencies.

48. 1977 President Jimmy Carter appointed the President's Commission on Mental Health, with Rosalyn Carter as Honorary Chairperson, on February 17, 1977, to review the mental health needs of the United States and to make recommendations to the President as to how the Nation might best meet those needs.

49. 1978 The President's Commission on Mental Health submitted its Report to the President and three volumes of Task Panel Reports to President Carter.

50. 1978 The Hogg Foundation on Mental Health in Austin sponsored the first Robert L. Sutherland Seminar in Mental Health as the initial public presentation and debate on the Report of the President's Commission on Mental Health as it related to mental health services in Texas (DeMoll & Andrade, 1978).

51. 1978 The Community Mental Health Centers Extension Act of 1978 (Public Law 95-622), November 9, 1978. This act authorized financial distress grants and increased from three to five the number of such grants available to any center, and also permited "phasing of required services".

52. 1978 A National Institute of Mental Health Report noted in 1977 that Texas had the smallest Advisory Council in the United States (Hagedorn, 1978). In December 1978, the Council moved to enlarge its membership to fifteen in order that each Health Service Area would have a representative.

53. 1979 The Bodrd of Trustees of TDMHMR established a new Advisory Council for Community Mental Health Mental Retardation Centers to advise the Commissioner of TDMHMR.

APPENDIX C

ROSTERS OF THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION BOARD OF TRUSTEES AND ADVISORY GROUPS

TABLE C-1

TDMHMR FIRST BOARD OF TRUSTEES (1965)

NAME	OFFICE ON BOARD	SEX	LENGTH OF SERVICE	ETHNICITY			OCCUPATION	CITY (COUNTY)
				W	B	MA		
Ward R. Burke		M	9/1/65-3/23/71	1			Corporation Lawyer	Lufkin (Angelina)
Horace E. Cromer	chair from 9/1/65-7/70	M	9/1/65-7/70	1			M.D. Internal	Austin (Travis)
Robert S. Tate		M	9/1/65-3/23/71	1			D.D. Methodist Minister	Austin (Travis)
Mrs. H. E. Butt		F	9/1/65-1/31/81	1			Homemaker	Corpus Christi (Nueces)
George A. Constant		M	9/1/65-6/3/69	1			M.D. Neurology-Psychiatry	Victoria (Victoria)
Raleigh R. White		M	9/1/65-6/14/69	1			M.D. Surgeon Scott White	Temple (Bell)
Elbert E. Hall		M	9/1/65-3/70	1			Life Insurance Broker	Abilene (Taylor)
Peter de Wetler		M	9/1/65-1/31/67	1			Mayor El Paso Industrialist/Bus.	El Paso (El Paso)
Jess M. Osborn		M	9/1/65-5/25/73	1			Banker	Muleshoe (Bailey)
TOTALS WHERE APPLICABLE		M 8 / F 1		9	0	0		

TABLE C-2

~~TAMUMR~~ BOARD OF TRUSTEES 1ST BOARD SERT 1965 THROUGH PRESENT BOARD JULY 1981

NAME	OFFICE ON BOARD	SEX	LENGTH OF SERVICE	ETHNICITY			OCCUPATION	CITY (COUNTY)
				MEX AM	BLACK	WHITE		
Ward R. Burke	2nd Chair	M	9/1/65-3/23/71				Corporation Lawyer	Lufkin (Angelina)
Horace E. Cromer	1st Chair	M	9/1/65-7/70			1	M. D. Internal Med.	Austin (Travis)
Robert S. Tate		M	9/1/65-1/31/71			1	D.D. Methodist Minister	Austin (Travis)
Mrs. H. E. Butt[a]		F	9/1/65-5/28/81			1	Homemaker	Corpus Christi (Nueces)
George A. Constant		M	3/1/65-6/3/69			1	M.D. Neurology-Psychiatry	Victoria (Victoria)
Raleigh R. White		M	9/1/65-6/14/69			1	M.D. Surgeon Scott White	Temple (Bell)
Elbert E. Hall		M	9/1/65-3/70			1	Insurance	Abilene (Taylor)
Peter de Wetler		M	9/1/65-1/31/67			1	Mayor Businessman-Industrialist	El Paso (El Paso)
Jess H. Osborn		M	9/1/65-5/25/73[a]			1	Banker, ex. State Rep. 3 terms	Muleshoe (Bailey)
Issac Arnold		M	7/24/67-?/70			1	Engineer/V.P. and Exec.Dir.Oil Corp	Houston (Harris)
Charles H. Brown		M	6/3/69-?/71			1	M.D. Psychiatry	Wichita Falls (Wichita)[3]
Edwin R. Van Zandt	4th Chair	M	6/14/69-11/31/81			1	Newspaper Exec. Bank VP	Beaumont[4] (Jefferson)
Barnie E. Rushing		M	3/20/70-5/10/73			1	Businessman/ Dept.Store Exec.	Lubbock (Lubbock)
Joe K. Butler	3rd Chair	M	8/26/70-3/15/73			1	Oil & Real Estate Pres.St.Bd.of Ed.	Houston (Harris)
Leonides G. Cigarroa		M	3/24/71-6/19/73	1			M.D.	Laredo (Webb)
Olin B. Gober		M	3/24/71-10/30/78			1	M.D. Cardio Chief of Staff	Temple (Bell)
Walter A. Brooks		M	3/24/71-1/31/83			1	M.D. Surgeon	Quanah (Hardeman)
O. J. Baker		M	3/24/71-3/1/77		1		Prairie View U. Librarian	Prairie View (Waller)
Lynn Darden		M	5/10/73-3/8/79			1	Lawyer	Wichita Falls (Wichita)[3]
O. P. Leonard, Jr.		M	5/10/73-1/27/75			1	Dept Store Exec	Fort Worth (Tarrant)
Robert H. Parsley		M	5/25/73-1/31/79			1	Lawyer	Houston (Harris)
Margaret Cigarroa		F	6/73-1/31/81			1	M.D.	Laredo (Webb)
Menton J. Murray		M	5/22/79-3/8/79			1	Lawyer/past Elected Official	Harlingen (Cameron)
Mrs. Iris B. Thomas		F	5/24/77-1/31/83		1		Housewife/ Volunteer	Prairie View (Waller)
A. L. Mangham		M	1/17/79-/85			1	Mayor	Nacogdoches (Nacogdoches)
L. Gray Beck	Chair, 1981	M	2/8/79-/85			1	Ret. President Gen. Telephone	San Angelo (Tom Green)
Mrs. Marvin Selig		F	2/8/79-/85			1	Housewife/ Volunteer	Seguin (Guadalupe)
William B. Schnapp		M	2/15/79-/85			1	Self-employed Investments	Houston (Harris)
Sam F. Rhodes		M	4/21/81-87			1	CPA, Partner Accounting Firm	Dallas (Dallas)
David M. Shannon		M	4/21/81-/87			1	President, Insur. Agency	Odessa (Ector)
Roger Bateman		M	5/23/81-/87			1	Investment Holding Company	Corpus Christi (Nueces)
TOTALS WHERE APPLICABLE		F - 26		1	2	28		

[a] Member Emeritus

TABLE C-3

TDMHMR BOARD OF TRUSTEES: CHRONOLOGY OF CHAIRMEN 1965-1981

NAME	OFFICE ON BOARD	SEX	ETHNICITY MA	ETHNICITY B	ETHNICITY W	LENGTH OF SERVICE	OCCUPATION	CITY and (COUNTY)
Horace E. Cromer	appointed 9/1/65-11/5/69	M			1	9/1/65-7/70	M.D.	Austin (Travis)
Ward R. Burke	appointed 11/5/69-3/23/72	M			1	9/1/65-3/23/71	Corporation Lawyer	Lufkin (Angelina)
Joe K. Butler	appointed 3/25/71-1/8/73	M			1	8/26/70-3/15/73	Oil and Real Estate	Houston (Harris)
Edwin R. Van Zandt	appointed 1/8/73-3/79	M			1	6/14/69-1/31/75 2/3/75-1/31/81	Newspaper Exec. Presently Bl VP	Rusk (Cherokee)
L. Gray Beck	appointed 2/79	M			1	3/79	Retired Pres Cen. Teleph.	San Angelo (Tom Green)
TOTALS WHERE APPLICABLE		M 5 F 0	0	0	5			

TABLE C-4

TDMHMR BOARD OF TRUSTEES: CHRONOLOGY OF MEXICAN AMERICAN APPOINTMENTS TO BOARD 1965-1981

NAME	OFFICE ON BOARD	SEX	LENGTH OF SERVICE	OCCUPATION	CITY and (COUNTY)
Leonides G. Cigarroa		M	3/24/71 Died 6/19/73	M.D.	Laredo (Webb)
TOTALS WHERE APPLICABLE		M 1			

TABLE C-5

TDMHMR BOARD OF TRUSTEES: CHRONOLOGY OF BLACKS APPOINTED 1965-1981

NAME	OFFICE ON BOARD	SEX	LENGTH OF SERVICE	OCCUPATION	CITY and (COUNTY)
O. J. Baker		M	3/24/71-1/31/77	University Librarian	Prairie View (Waller)
Mrs. Iris B. Thomas	Vice Chair, 1981	F	5/29/77-1/31/83	Homemaker/ Volunteer	Prairie View (Waller)
TOTALS WHERE APPLICABLE		M 1 F 1			

TABLE C-6

TDMHMR BOARD OF TRUSTEES: CHRONOLOGY OF WOMEN APPOINTED 1965-1981

NAME	OFFICE ON BOARD	LENGTH OF SERVICE	ETHNICITY			OCCUPATION	CITY and (COUNTY)
			MEX AM	BLACK	WHITE		
Mrs. H. W. Butt[a]		9/1/65-1/31/81			1	Homemaker	Corpus Christi (Nueces)
Margaret G. Cigarroa		6/73-1/31/81 Replaced L. Cigarroa			1	M.D.	Laredo (Webb)
Mrs. Iris B. Thomas	Vice Chair, 1981	5/29/77-1/31/83		1		Homemaker/Volunteer	Prairie View (Waller)
Mrs. Marvin Selig		3/79			1	Homemaker/Volunteer	Seguin (Guadalupe)
TOTALS WHERE APPLICABLE			0	1	3		

[a]Member Emeritus

TABLE C-7

TDMHMR CURRENT BOARD OF TRUSTEES AS OF JULY 1981

NAME	OFFICE ON BOARD	SEX	ETHNICITY			LENGTH OF SERVICE	OCCUPATION	CITY and (COUNTY)
			W	B	HA			
L. Gray Beck	Chair	M	1			3/8/79 replaced Darden	retired Pres Gen. Tele-phone	San Angelo (Tom Green)
Walter A. Brooks		M	1			3/24/71-1/31/77 5/25/77-1/31/83	M.D. Surgeon	Quanah (Hardeman)
A. L. Mangham, Jr.		M	1			10/78 replaced Gober	Mayor Nacogdoches	Nacogdoches (Nacogdoches)
William B. Schapp		M	1			3/79-3/84 replaced Parsley	self-employ-ed invest-ments	Houston (Harris)
Mrs. Marvin Selig		F	1			3/79-3/84 replaced Murray	Homemaker/ Volunteer	Seguin (Guadalupe)
Mrs. Iris B. Thomas	Vice-Chair	F		1		5/24/77-1/31/83 replaced Baker	Homemaker/ Volunteer	Prairie View (Waller)
Sam F. Rhodes		M	1			4/2/81-1/31/87 replaced Cigarroa	CPA, Partner Accounting Firm	Dallas (Dallas)
David M. Shannon		M	1			4/2/81-1/31/87 replacedVantandt	President Ins. Agency	Odessa (Ector)
Roger Bateman		M	1			5/28/81 - 1/31/87 replaced Butt	Invest. Holding Co.	Corpus Christi (Nueces)
Mrs. Howard E. Butt [a]		F	1			9/1/65 - 5/28/81	Homemaker/ Volunteer	Corpus Christi (Nueces)
TOTALS WHERE APPLICABLE APPLICABLE		M 5 F 4	9	1	0			

[a]Member Emeritus

TABLE C-8

TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS: 1966

NAME	OFFICE ON BOARD	SEX	ETHNICITY			OCCUPATION	CITY and (COUNTY)
			MEX AM	BLACK	WHITE		
Mrs. E. E. Searcy		F			1	Homemaker/ Volunteer	Fort Worth, (Tarrant--Johnson)
*Don Wooten		M			1	Railroad Employee	Abilene (Taylor)
J. E. Bridges		M			1	Founder--Res. Homes Mentally Retarded	Austin (Travis
C. G. Fairchild		M			1	Assist. Com. TDMHMR	Austin (Travis)
Charles Barnett		M			1	Ph.D. Deputy Comm. TDMHMR	Austin (Travis)
C. L. Abernathy		M			1	County Judge	Plainview (Hale)
John D. Simpson	Chair	M			1	President Superior Dairies	Austin (Travis)
TOTALS WHERE APPLICABLE		M 6 / F 1	0	0	7		

TABLE C-9

TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS: 1967-1968

NAME	OFFICE ON BOARD	SEX	ETHNICITY			OCCUPATION	CITY and (COUNTY)
			MEX AM	BLACK	WHITE		
Mrs. E. E. Searcy		F			1	Homemaker/ Volunteer	Fort Worth (Tarrant-Johnson)
Don Wooten		M			1	Railroad Employee	Abilene (Taylor)
Frank A. Borreca		M			1	Exec. Dir. Harris Co. Cntr for the Retarded	Houston (Harris)
J. E. Bridges		M			1	Founder Res. Program Mentally Retarded	Austin (Travis)
C. G. Fairchild		M			1	Assis. Comm. TDMHMR	Austin (Travis)
Robert L. Leon		M			1	M.D. Psych.	San Antonio (Bexar)
Kenneth N. Nuhn		M			1	Dir. Hospital Services Tx. St. Dept Health	Austin (Travis)
John D. Simpson		M			1	Pres. Superior Dairies	Austin (Travis)
C. L. Abernethy	Chair	M			1	County Judge	Plainview (Hale)
TOTALS WHERE APPLICABLE		M 8 / F 1	0	0	9		

TABLE C-10

TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS: 1969

NAME	OFFICE ON BOARD	SEX	ETHNICITY			OCCUPATION	CITY and (COUNTY)
			MEX AM	BLACK	WHITE		
Mrs. E. E. Searcy		F			1	Homemaker/ Volunteer	Austin (Travis)
Don Wooten		M			1	Railroad Employee	Snyder (Scurry)
J. E. Bridges	Chair	M			1	Founder Res. Program Mental Retarded	Austin (Travis)
Frank A. Borreca		M			1	Exec. Dir. Harris Co. Center for the Retarded	Houston (Harris)
C. G. Fairchild		M			1	Asst. Com. TDMHMR	Austin (Travis)
William M. Collier, Jr.		M			1	Chief Const. Div. Tx. State Dept. Health	Austin (Travis)
Robert L. Leon		M			1	Psychiatry M.D.	San Antonio (Bexar)
C. L. Abernethy		M			1	County Judge	Plainview (Hale)
John D. Simpson		M			1	President Superior Dairies	Austin (Travis)
TOTALS WHERE APPLICABLE		M 8 / F 1	0	0	9		

TABLE C-11

TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS: 1970

NAME	OFFICE ON BOARD	SEX	ETHNICITY			OCCUPATION	CITY and (COUNTY)
			MEX AM	BLACK	WHITE		
Mrs. E. E. Searcy		F			1	Homemaker/ Volunteer	Fort Worth (Tarrant--Johnson)
Don Wooten		M			1	Railroad Employee	Snyder (Scurry)
J. E. Bridges		M			1	Founder Res. Prog. Mentally Retarded	Austin (Travis)
Hon. William C. Black		M			1	County Judge	Belton, (Bell)
Frank A. Borreca		M			1	Exec. Dir. Harris Co. Center for the Retarded	Houston (Harris)
William Collier, Jr.	Chair	M			1	Chief Construction Div., Tx. Dept. Health	Austin (Travis)
Robert L. Leon		M			1	Psychiatry M.D.	San Antonio (Bexar)
John D. Simpson		M			1	Pres. Superior Dairies	Austin (Travis)
C. L. Abernathy		M			1	County Judge	Plainview (Hale)
Jose Lozano Gonzalez		M	1			Eng./Admin. Laredo-Webb Co. Health Dept.	Laredo (Webb)
George R. Ragland		M		1		Ph.D. Professor Prairie View College	Prairie View (Waller)
TOTALS WHERE APPLICABLE		M 10 / F 1	1	1	9		

TABLE C-12

TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS: 1971 - 1972

NAME	OFFICE ON BOARD	SEX	ETHNICITY MA	B	W	OCCUPATION	CITY and (COUNTY)
Mrs. E. E. Searcy		F			1	Homemaker/ Volunteer	Fort Worth (Tarrant--Johnson)
Don Wooten		M			1	Railroad Employee	Abilene (Taylor)
J. E. Bridges		M			1	Founder Res Program Mentally Retarded	Austin (Travis)
Frank A. Borreca		M			1	Ex. Dir. Harris Co. Center for the Retarded	Houston (Harris)
William M. Collier, Jr.		M			1	Founder Res. Program Mentally Retarded	Austin (Travis)
Robert L. Leon		M			1	Psychiatry M.D.	San Antonio (Bexar)
John D. Simpson		M			1	President Superior Dairies	Austin (Bexar)
C. L. Abernathy		M			1	County Judge	Plainview (Hale)
Jose Lozano Gonzales		M	1			Eng./Admin. Laredo-Webb Co. Health Dept	Laredo (Webb)
George R. Ragland		M		1		Ph.D. Prof. Prairie View College	Prairie View (Waller)
TOTALS WHERE APPLICABLE		M 9 F 1	1	1	8		

TABLE C-13

TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS: 1973-1974

NAME	OFFICE ON BOARD	SEX	ETHNICITY MA	B	W	OCCUPATION	CITY and (COUNTY)
Frank A. Borreca		M			1	Exec. Dir. Harris Co. Cntr for Retarded	Houston (Harris)
Helen Farabee		F			1	Housewife-Volunteer	Wichita Falls (Wichita)
Jerry C. Gilmore		M			1	Lawyer	Dallas (Dallas)
J. E. Bridges		M			1	President Marbridge Foundation	Austin (Travis)
William M. Collier, Jr.		M			1	Chief Construction Div. Tx. Dept. Health	Austin (Travis)
Robert L. Leon		M			1	Psychiatry M.D.	San Antonio (Bexar)
Jess M. Irvin, Jr.		M			1	Commissioner Tx. Rehab. Commission	Austin (Travis)
John D. Simpson		M			1	President Superior Dairies	Austin (Travis)
C. L. Abernathy		M			1	County Judge	Plainview (Hale)
Jose Lozano Gonzales		M	1			Eng.-Admin. Laredo-Webb Co. Health Dept	Laredo (Webb)
George R. Ragland		M		1		Ph.D. Prof. Prairie View College	Prairie View (Waller)
TOTALS WHERE APPLICABLE		M 10 F 1	1	1	9		

TABLE C-14

TEXAS STATE ADVISORY COUNCIL FOR CONSTRUCTION [illegible] MENTAL HEALTH CENTERS: 1975-1976

NAME	OFFICE ON BOARD	SEX	ETHNICITY			OCCUPATION	CITY and (COUNTY)
			MEX AM	BLACK	WHITE		
Frank A. Borreca		M			1	Exec. Dir. Harris Co. Cntr. for Retarded	Houston (Harris)
Helen Farabee		F			1	Homemaker	Wichita Falls (Wichita)
Jerry C. Gilmore		M			1	Lawyer	Dallas (Dallas)
Arthur L. Gonzalez	Chair	M	1			Banker	El Paso (El Paso)
Robert L. Leon		M			1	Psychiatry M.D.	San Antonio (Bexar)
Jess M. Irwin, Jr.		M			1	Commissioner Tx. Rehab. Commission	
Stan Pinder		M			1	Ph.D. Dir. of Comm. Services	Austin (Travis)
John D. Simpson		M			1	Chairman Superior Dairies	Austin (Travis)
Vivienne Mayes		F		1		Ph.D. Math Prof Baylor.	Waco (McLennan)
Ward R. Burke		M			1	Lawyer	Diboll (Angelina)
Sam Moreno		M	1			Partner Camacho Box Co..	Dallas (Dallas)
TOTALS WHERE APPLICABLE		M 9 F 2	2	1	8		

TABLE C-15

TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL: 1977

NAME	CLASS	OFFICE ON BOARD	SEX	ETHNICITY			OCCUPATION	PROVIDER CONSUMER	CITY and (COUNTY)
				MA	B	W			
Helen Farabee	a	Chair	F			1	Homemaker	C	Wichita Falls(Wichita)
John D. Simpson	a		M			1	Pres. Superior Dairies	C	Austin (Travis)
Ward R. Burke	a		M			1	Lawyer	C	Diboll (Angelina)
Sam Moreno	a		M	1			Businessman	C	Dallas (Dallas)
Vivienne Mayes	a		F		1		Ph.D. Math Professor	C	Waco (McLennan)
Arthur Gonzales	a		M	1			Banker	C	El Paso (El Paso)
Robert L. Leon	d		M			1	M.D., Psychiatrist UTHSC	P	San Antonio (Bexar)
Stan Pinder	d		M			1	Dir. of Community Service Ph.D.	P	Austin (Travis)
Vernon Max Arral	d		M			1	Deputy Commissioner Special Programs TRC Government Employee	P	Austin (Travis)
Frank A. Borreca	c		M			1	Exec. Dir. Harris Co. Cntr for Retarded	P	Houston (Harris)
TOTALS WHERE APPLICABLE			M8 F2	2	1	7			

TABLE C-16

TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL: 1978

NAME	HEALTH SERV. AREA	OFFICE ON BOARD	SEX	ETHNICITY MA	B	W	OCCUPATION	PROVIDER CONSUMER	CITY and (COUNTY)
Vernon Max Arrell	6		M			1	Deputy Commissioner Special Programs TRC	P	Austin (Travis)
Frank A. Borreca	11		M			1	Exec. Dir. Harris Co. Cntr for Retarded	P	Houston (Harris)
David F. Briones	3		M	1			Asst. Prof. Psychiatry Texas Tech M.D.	P	El Paso (El Paso)
Ward R. Burke	10		M			1	Lawyer	C	Diboll (Angelina)
Charlotte Douglas	5		F			1	Teacher/Homemaker	C	Plano (Collin)
Helen Farabee	4	Chair	F			1	Housewife	C	Wichita Falls(Wichita)
Leonard E. Lawrence	9		M		1		Child M.D. Psychiatrist	P	San Antonio (Bexar)
Robert L. Leon	9		M			1	M.D., Prof of Psychiatry, UTHSC	P	San Antonio (Bexar)
Vivienne Mayes	6		F		1		Ph.D. Math Professor	C	Waco (McLennan)
Stan Pinder	6		M			1	Director of Comm. Services, Ph.D.	P	Austin (Travis)
Arturo Volpe	8		M	1			Tex. Youth Council Public Sch. Admin.Ph.D.	C	Laredo (Webb)
TOTALS WHERE APPLICABLE			M8 F3	2	2	7			

TABLE C-17

TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL: 1979

NAME	HEALTH SER AREA	OFFICE ON BOARD	SEX	ETHNICITY M	B	W	OCCUPATION	PROVIDER CONSUMER	CITY and (COUNTY)
Ester Quine	1		F			1	Exec. Dir. YMCA	C	Amarillo (Potter)
Jan Reeves Rigsby	2		F			1	Homemaker	C	Lubbock (Lubbock)
David F. Briones	3		M	1			Asst. Prof. Psychiatry Tex. Tech M.D.	P	El Paso (El Paso)
Amber Cree	4		F			1	Volunteer/Homemaker	C	Abilene (Taylor)
Janie Clements	4		F			1	Homemaker	C	Brownwood (Brown)
Charlotte Douglas	5		F			1	Homemaker/Teacher	C	Plano (Collin)
Robert L. Zapalac	6		M			1	M.D.	P	Austin (Travis)
Vivienne Mayer	6		F		1		Ph.D. Math Professor	C	Waco (McLennon)
Vernon Max Arrell	6	Chair	M			1	Deputy Commissioner Special Programs Gov't Employee TRC	P	Austin (Travis)
Dan F. Goodwin, Jr.	7		M			1	Clergy	C	Kilgore (Gregg)
Rodolfo A. Santos	8		M	1			Owner Dry Goods Store	C	Laredo (Webb)
Leonard Lawrence	9		M		1		Child Psychiatrist M.D.	P	San Antonio (Bexar)
Ward R. Burke	10		M			1	Lawyer	C	Diboll (Angelina)
Frank A. Borreca	11		M			1	Dir. Harris Co. Cntr for Retarded	P	Houston (Harris)
David M. Shannon	11		M			1	Ins. Agent	P	Odessa (Ector)
TOTALS WHERE APPLICABLE			M 9 F 6	2	1	11			

TABLE C-18

TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL: 1981

NAME	HSA	OFFICE	SEX	ETHNICITY W	B	MA	OCCUPATION	PROVIDER/ CONSUMER	CITY (COUNTY)
Janie Clements	4	Chair	F	1			Homemaker	C	Brownwood (Brown)
David F. Briones	3	Vice Chair	M			1	M.D., Ast. Prof., Psych. Texas Tech Med School	P	El Paso (El Paso)
Robert L. Navarro	11	Secy	M			1	M.S.W., President Hispanic Internatl Uni.	C	Houston (Harris)
Ester Quine	1		F	1			Executive Director YMCA	C	Amarillo (Potter)
Jan Reeves Rigsby	2		F	1			Homemaker	C	Lubbock (Lubbock)
Amber Cree	4		F	1			Volunteer/Homemaker	C	Abilene (Taylor)
Robert L. Zapaloc	6		M	1			M.D., Psychiatrist	P	Austin (Travis)
Dan F. Goodwin, Jr.	7		M	1			Minister	C	Kilgore (Gregg)
Vernice M. Mohroe			F		1		M.S.W., Asst. Prof. Lamar University	C	Beaumont (Jefferson)
Lyman G. Phillips	6		M			1	M.D., Psychiatrist	P	Austin (Travis)
Jane H. Preston	6		F	1			M.D., Physician	P	Austin (Travis)
Weselene L. Wiley			F		1		M.S.S.W., Asst. Reg. Dir. for Staff, TDHR	P	Arlington (Tarrant)
Beth Woolsey	12		F	1			Realtor	C	Corpus Christi (Nueces)
Josue R. Gonzales			M			1	Ph.D., Clinical Psy. Private Practice	P	San Antonio (Bexar)
Vacancy	12								
TOTALS WHERE APPLICABLE			M 6 F 8						

TABLE C-19

TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL: CHRONOLOGY OF CHAIRMEN APPOINTED 1966-1981

NAME	OFFICE ON BOARD	SEX	ETHNICITY MA	B	W	OCCUPATION	PROVIDER CONSUMER	CITY and (COUNTY)
John D. Simpson	1966	M			1	Pres. Superior Dairies	C	Austin (Travis)
C. L. Abernethy	1967-1968	M			1	County Judge	C	Plainview (Hale)
J. E. Bridges	1969	M			1	President Marbridge Foundation	C	Austin (Travis)
William Collier, Jr.	1970	M			1	Chief Construction Div. Tx. St. Dept. Health	P	Austin (Travis)
Robert L. Leon	1973-1975	M			1	M.D., Psychiatrist	P	San Antonio (Bexar)
Helen Farabee	1976-1979	F			1	Housewife	C	Wichita Falls (Wichita)
Max Arrell	1979	M			1	Deputy Commissioner Social Program TRC	P	Austin (Travis)
Janie Clements	1981	F			1	Homemaker	C	Brownwood (Brown)
TOTALS WHERE APPLICABLE		M6 F 1	0	0	7			

TABLE C-20

TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL: MEXICAN AMERICANS APPOINTED 1966-1981

NAME	OFFICE ON BOARD	SEX	OCCUPATION	PROVIDER CONSUMER	CITY and (COUNTY)
Jose Lozano Gonzalez		M	Eng.-Ad. Laredo Webb Co. Health Dept.	P	Laredo (Webb)
Sam Moreno		M	Partner Camacho Box Co.	C	Dallas (Dallas)
Arthur Gonzales		M	Banker	C	El Paso (El Paso)
Arturo Velpe		M	Public Sch. Adm.	C	Laredo (Webb)
David F. Briones		M	Psychiatrist M.D.	P	El Paso (El Paso)
Rudolfo A. Santos		M		C	Laredo (Webb)
Robert L. Navarro		M		C	Houston (Harris)
Lyman G. Phillips		M	M.D.	P	Austin (Travis)
Josue R. Gonzalez		M	Ph.D. Psychologist Private Practice	P	San Antonio (Bexar)
TOTALS WHERE APPLICABLE		M9 F0			

TABLE C-21

TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL: BLACKS APPOINTED 1966-1981

NAME	OFFICE ON BOARD	SEX	OCCUPATION	PROVIDER CONSUMER	CITY and (COUNTY)
George R. Ragland		M	Head Dept of Soc. Prairie View College	C	Prairie View (Waller)
Vivienne Mayes		F	Ph.D. Prof Math Baylor Univ.	C	Waco (McLennan)
Leonard Lawrence		M	M.D. Child Psychiatrist	P	San Antonio (Bexar)
Vernice M. Monroe		F	M.S.W., Asst. Prof. Lamar Univ.	C	Beaumont (Jefferson)
Weselene L. Wiley		F	M.S.S.W., Asst. Reg. Dir. for Staff, TDHR	P	Arlington (Tarrant)
TOTALS WHERE APPLICABLE		M2 F3			

TABLE C-22

TEXAS STATE MENTAL HEALTH ADVISORY COUNCIL: WOMEN APPOINTED 1966-1981

NAME	OFFICE ON BOARD	ETHNICITY			OCCUPATION	PROVIDER CONSUMER	CITY and (COUNTY)
		MA	B	W			
Mrs. E. E. Searcy				1	Homemaker/Volunteer	NA	Ft. Worth (Tarrant-Johnson)
Helen Farabee	Chair 1975-79			1	Homemaker	C	Wichita Falls (Wichita)
Vivienne Hayes			1		Ph.D. Math Prof. Baylor Univ.	C	Waco (McLennan)
Charlotte Douglas				1	Teacher/Homemaker	C	Plano (Collin)
Ester Quine				1	Exec. Dir. YMCA Amarillo	C	Amarillo (Potter)
Jan Reeves Rigsby				1	Homemaker	C	Lubbock (Lubbock)
Amber Cree				1	Homemaker/Volunteer	C	Abilene (Taylor)
Janie Clements	Vice Chair, 1979 Chair, 1981			1	Homemaker	C	Brownwood (Brown)
Vernice M. Monroe			1		M.S.W., Asst. Prof. Lamar Univ.	C	Beaumont (Jefferson)
Jane Preston				1	M.D.	P	Austin (Travis)
Weselene L. Wiley			1		M.S.S.W., Asst. Reg. Dir. for Staff, TDMHMR	P	Arlington (Tarrant)
Beth Woolsey				1	Realtor	C	Corpus Christi (Nueces)
TOTALS WHERE APPLICABLE		0	3	9			

TABLE C-23

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION ADVISORY COMMITTEE ON COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTER MEMBERS, 1979

NAME	HSA	OFFICE	SEX	ETHNICITY			OCCUPATION JOB TITLE FIRM/ORGANIZATION	RESIDENCE CITY (COUNTY)
				W	B	MA		
Frank M. Adams	10		M	1			President, Tx.Council of CMHCs, Inc. Attorney	Beaumont (Jefferson)
E. Warren Alexander	6		M	1			Rancher	Hamilton (Hamilton)
Joseph L. Bart, Jr.	11		M	1			Public Relations (Railroad)	Houston (Harris)
Shirley K. Camfield	5		F	1			Citizens Advocate Past Pres., Mental Health Assc. of Texas	Fort Worth (Tarrant)
Frances Davis	1		F	1			M.D., Psychiatrist	Amarillo (Amarillo)
Mrs. Frank Karoffa	6		F	1			Past Pres., Texas Assc. for Retarded Cit.	Waco (McLennan)
Menton Murray, Sr.	8	Chair	M	1			Attorney	Harlingen (Cameron)
Ire Smith, Jr.	9		M		1		Computer Analyst	San Antonio (Bexar)
Nancy C. Speck	10		F	1			Ph.D., Special Education	Nacogdoches (Nacogdoches)
Curtis J. Spier	3		M	1			M.D., Physician	El Paso (El Paso)
Theodore Telbot	6		M		1		Administration	Waco (McLennan)
TOTALS WHERE APPLICABLE			M 7 F 4	9	2	0		

TABLE C-24

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION ADVISORY COMMITTEE ON COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTER MEMBERS, 1981

NAME	HSA	OFFICE	SEX	ETHNICITY W	ETHNICITY B	ETHNICITY HA	OCCUPATION JOB TITLE FIRM/ORGANIZATION	RESIDENCE CITY (COUNTY)
Frank M. Adams	10		M	1			Pfesident, Tx. Council of CMHCs, Inc. Attorney	Beaumont (Jefferson)
E. Warren Alexander	6		M	1			Rancher	Hamilton (Hamilton)
Joseph L. Bart, Jr.	11		M	1			Public Relations (Railroad)	Houston (Harris)
Shirley K. Camfield	5		F	1			Citizens Advocate Past Pres., Mental Health Assn. of Texas	Fort Worth (Tarrant)
Frances Davis	1		F	1			M.D., Psychiatrist	Amarillo (Amarillo)
Menton Murray, Sr.	8	Chair	M	1			Attorney	Harlingen (Cameron)
Ira Smith, Jr.	9		M		1		Computer Analyst	San Antonio (Bexar)
Nancy C. Speck	10		F	1			Ph.D., Special Education	Nacogdoches (Nacogdoches)
Theodore Talbot	6		M				Administration	Waco (McLennan)
TOTALS WHERE APPLICABLE			M 6 / F 3	7	2	0		

APPENDIX D

ROSTERS OF THE BOARDS OF TRUSTEES OF COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

The survey form sent to community mental health mental retardation centers in Texas in order to update the rosters of their board of trustees, along with the letter of explanation and the guide to completing the form, are on the next three pages. These were mailed February 4, 1981, and all CMHCs had responded by May 1, 1981. There were a few minor changes made during the summer due to communication with centers regarding the rosters.

Although the data in general are very complete, one of the major difficulties in the survey findings was the failure of several centers to clarify the status of each board member as consumer or provider. The federal guidelines on this issue require that an individual who is not a provider but who is a member of the immediate family of any of the five categories of providers be labeled as a provider. The IDRA Mental Health Research Project, however, was unable to correct the rosters on the basis of the occupational information provided. In some instances, it was clear that an error was made (e.g., in identifying a physician as a consumer). Furthermore, it was determined that in numerous instances, CMHC staff simply did not have sufficient information about some board members to answer that question. There may be other reasons as well that this item was left blank or not completed for all members in other instances. Therefore, it was decided to print the rosters exactly as they were completed by the CMHCs. The MHRP staff have made no judgment as to the consumer or provider status of individuals, and if the item is blank, it is because the center failed to provide the information requested.

INTERCULTURAL DEVELOPMENT RESEARCH ASSOCIATION

DR. JOSE A. CARDENAS, Director

February 4, 1981

Dear (CMHC Executive Director):

The IDRA Mental Health Research Project is updating its roster of the boards of Texas' community mental health centers. In order to assure that we have the most accurate information on your center, we are enclosing a copy of the roster currently available. Please verify if these individuals are still serving and add any new members not listed. In addition, the following information on members of your governing board is requested:

- office held, if any
- sex and ethnicity
- occupation (job title & organization)
- city and county of residence
- consumer/provider status

For your convenience, we have provided on the back of the form a brief explanation of the information needed.

As has been our practice in the past, we will add new members to our mailing list to receive the Mental Health Research Project Newsletter. We will also provide to you as a resource document the updated Texas CMHC Boards and Councils monograph of the IDRA Mental Health Research Project.

Thank you for your assistance. If you should have any questions, please call me at (512) 684-8180, extension 209.

Sincerely,

Rosa M. Moreno, M.Ed.
Research Associate
Mental Health Research Project

Enclosure

RMM:rht

CALLAGHAN, SUITE 350/111 SAN ANTONIO, TEXAS 78228 PHONE (512) 684-8180

TEXAS COMMUNITY MENTAL HEALTH CENTERS
BOARD OF TRUSTEES

DATE: February, 1981 CENTER:

NAME	Office on Board	Sex	ETHNICITY					Consumer Provider	OCCUPATION	RESIDENCE
			White/ Anglo	Mex. Amer.	Other Hispanic	Black	Other		Job Title Firm/Organization	City and County

IDRA MENTAL HEALTH RESEARCH PROJECT

GUIDE TO COMPLETING FORM

COLUMN 1
(Name)

Please correct any errors that may appear in the names listed. Add the names of any new members and cross off names of members no longer serving.

COLUMN 2
(Office on Board)

Indicate if member currently is serving as an officer, e.g. Chairperson, Secretary, etc.

COLUMN 3
(Sex)

M = Male; F = Female

COLUMN 4
(Ethnicity)

Indicate for each member the appropriate ethnic designation:

White/Anglo - Not of Hispanic origin.
Mexican American - of Mexican origin.
Other Hispanic - of Cuban, Puerto Rican, Spanish, Central or South American origin (not of Mexican origin).
Black - Not of Hispanic origin.
Other - Racial or ethnic origin other than the above (e.g. Native American, Oriental, etc.)

COLUMN 5
(Consumer/Provider)

Based on the federal definition of a provider outlined in P.L. 96-79, designate each board member as a provider or a consumer. Briefly summarized, a provider is anyone who:

1) is a direct provider of mental health care or health care services or is a member of the governing board of a health care provider, (excluding CMHC);

2) receives income from or is employed by a mental health or other health care facility;

3) is a researcher or instructor in the mental health or medical care field;

4) is engaged in issuing group health insurance;

5) is a producer or supplier of pharmaceutical drugs;

6) is a member of the immediate family of any of the above.

COLUMN 6
(Occupation)

List the job title or position held by the board member and the organization or firm with which he/she is connected.

COLUMN 7
(Residence)

City and County in which member resides.

TABLE D-1

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: ABILENE REGIONAL MHMR CENTER — LOCATION: ABILENE

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Malcolm C. Schulz		M	X				Attorney-at-Law (self)	C	Abilene (Taylor)
B. J. Estes, M.D.		M	X				Physician (self)	P	Abilene (Taylor)
Ray B. King	Vice-Chmn.	M	X				Insurance (self)	P	Abilene (Taylor)
Mrs. Joy Carter	Chair-person	F	X				Business (self)	C	Abilene (Taylor)
G. H. King	Secretary	M	X				Vice-President; West Tex. Utilities Co.	C	Abilene (Taylor)
John McGaughey		M	X				Director, Tri-County Co-op	C	Stamford (Jones)
Calvin Featherston		M	X				Sr. Vice President Citizens Natl. Bank	C	Abilene (Taylor)
Don Neill		M	X				Sr. Vice President First State Bank	C	Abilene (Taylor)
George Dawson, M.D.		M	X				Physician (self)	P	Abilene (Taylor)
TOTALS WHERE APPLICABLE		M 8 / F 1	9					C 6 / P 3	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-2

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: ABILENE REGIONAL MHMR CENTER — LOCATION: ABILENE

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Mrs. Wm. (Amber) Crae	Chairperson	F			1	Housewife	Abilene (Taylor)
Malcolm C. Schulz	Vice Chairperson	M			1	Lawyer	Abilene (Taylor)
John Allen Chalk		M			1	Lawyer	Abilene (Taylor)
B. J. Estes, M.D.	Secretary	M			1	M.D.	Abilene (Taylor)
Dwight L. Kinard		M			1	CPA	Abilene (Taylor)
Roy B. King		M			1	Ins. Agent	Abilene (Taylor)
Mrs. C. D. Carter		F			1	Housewife	Abilene (Taylor)
Father Stephen White		M			1	Clergy	Stamford (Jones)
John Bliznok, M. D.		M			1	M. D.	Abilene (Taylor)
TOTALS WHERE APPLICABLE		M 7 / F 2	0	0	9		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

TABLE D-3

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: AMARILLO MHMR REGIONAL CENTER — LOCATION: AMARILLO

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Bruce Coleman		M	X				Farmer & Rancher Self-employed		Hereford (Deaf Smith)
Robert L. Patterson	Chairman	M	X				Engineer Argonaut Energy Co.		Amarillo (Potter)
Burr Morris	Vice Chairman	M	X				Minister 1st Presbyterian Chur.		Dalhart (Dallam)
Mrs. Stan Friend		F	X				Spec. Educ. Teacher Pampa ISD		Pampa (Gray)
Mrs. Rachel Snyder	Secretary	F	X				Homemaker		Canadian (Hemphill)
Leonard Gerhardt		M	X				Accountant - CPA Gerhardt & Puckett CPA		Amarillo (Potter)
Frank Sanchez		M			X		Liaison Office Super. Amarillo ISD		Amarillo (Randall)
Clark Wooldridge		M	X				Assoc. Soc. Work Prof. WTSU		Amarillo (Randall)
Jim Shelton		M	X				Investments-Publisher Self-employed		Amarillo (Randall)
TOTALS WHERE APPLICABLE		M 7 / F 2	8	0	1			C / P	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-4

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: AMARILLO MHMR REGIONAL CENTER — LOCATION: AMARILLO

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Bruce Coleman	Chairperson	M				Farmer	Friona (Parmer)
Robert L. Patterson	Vice Chairperson	M			1	Vice President, Argoret Energy Corp.	Hughes Spring (Cass)
Burr Morris	Secretary/ Treasurer	M			1	Clergy	Dalhart (Hartley)
Mrs. Stan Friend		F			1	Teacher	Pampa (Gray)
Mrs. Rachel Snyder		F			1	Director of Day Care Center	Canadian (Hemphill)
Leonard Gerhardt		M			1	CPA	Amarillo (Potter)
Pattilou Dawkins		F			1	Housewife	Bonham (Fannin)
Frank Sanchez		M	1			Amarillo ISD	Amarillo (Potter)
Dick Brooks		M			1	Banker	Amarillo (Potter & Randall)
TOTALS WHERE APPLICABLE		M 6 / F 3	1	0	8		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: AUSTIN-TRAVIS COUNTY MHMR CENTER — LOCATION: AUSTIN

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Judy Yudof	Chairperson	F	X				Housewife/Volunteer		Austin (Travis)
Travis E. Benford		M		X			Asst. to Regional Dir of Med. Svcs TDHR	P	Austin (Travis)
John R. Moore, II		M			X		Administrator, TDHR		Austin (Travis)
Gen. Garwood Marshall EdD		M		X			Assoc.Prof.Math. Huston-Tillotson Coll	C	Austin (Travis)
Jose M. Saenz	Vice-Chan.	M			X		Senior Translator TDHR		Austin (Travis)
E. Janice Sumner	Sec./Treas.	F	X				Attorney	C	Austin (Travis)
Steve M. Ferguson, Sr.		M		X			Personnel Director Travis State School	P	Austin (Travis)
Jerry Henderson, Ph.D.		M	X				VP of Res.&Engr. Tex.Nuclear Engy Co.	C	Austin (Travis)
Beatrice Fincher		F			X		Owner Spanish Publications (Ad agency)		Austin (Travis)
TOTALS WHERE APPLICABLE		M 6 / F 3	3	3	3			C 3 / P 2	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-6

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: AUSTIN-TRAVIS COUNTY MHMR CENTER — LOCATION: AUSTIN

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Judy Yudof	Chairperson	F			1	Housewife	Austin (Travis)
Travis Benford	Treasurer	M		1		DHR employee	Austin (Travis)
Ronald T. Luke, Ph.D.		M			1	Research & Planning Consultants	Austin (Travis)
John R. Moore, II	Vice Chairperson	M			1	DHR employee	Austin (Travis)
Nancy Boyd		F			1	CPA	Austin (Travis)
Lenard Mapp		M		1		Management/ Production IBM	Austin (Travis)
Martin Manosevitz, Ph.D.		M			1	Dept. of Psychology UT Austin	Austin (Travis)
Gen. Garwood Marshall		M		1		College Admin. Huston-Tillotson	Austin (Travis)
Vacant							
TOTALS WHERE APPLICABLE		M 6 / F 2	0	3	5		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

TABLE D-7

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: BEXAR COUNTY MHMR CENTER — LOCATION: SAN ANTONIO

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Sue M. Hall, J.D.		F	X				Attorney-at-Law	C	San Antonio (Bexar)
John R. Heard		M	X				Attorney-at-Law	C	San Antonio (Bexar)
Cervando Martinez, Jr.MD	Chairman	M			X		Asst. Professor UTHSC	P	San Antonio (Bexar)
Ira Smith, Jr.		M		X			Superintendent C.P.S.	C	San Antonio (Bexar)
Stephen Tucker, Ph.D.		M	X				Professor Trinity University	P	San Antonio (Bexar)
Pablo Escamilla, Jr.		M			X		Private Investigator for Law firm	C	San Antonio (Bexar)
Bernardo Eureste, Jr.		M			X		Instructor Worden's Sch/Soc.Work	P	San Antonio (Bexar)
Oscar E. Cisneros	Vice-Chmn.	M			X		Attorney-at-Law	C	San Antonio (Bexar)
Albert G. Bustamante		M			X		County Judge	C	San Antonio (Bexar)
TOTALS WHERE APPLICABLE		M 8 / F 1	3	1	5			C 6 / P 3	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-8

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: BEXAR COUNTY MHMR CENTER — LOCATION: SAN ANTONIO

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Sue Hall, J.D.		F			1	St. Mary's Univ.	San Antonio (Bexar)
John Heard		M			1	Lawyer	San Antonio (Bexar)
Cervando Martinez, M.D.		M	1			Asst. Prof. Psychiatry UTHSC	San Antonio (Bexar)
Ira Smith, Jr.	Vice Chairperson	M		1		Supv. Data Input, Adm City Public Service	San Antonio (Bexar)
Stephen Tucker, Ph.D.		M			1	Asst. Prof. & Chair Health Care, Trinity Univ.	San Antonio (Bexar)
Mary Alice Viesca		F	1			Associate Professor Counseling, SAC	San Antonio (Bexar)
Bernardo Eureste		M	1			City Councilman College Prof. MSW	San Antonio (Bexar)
Oscar Cisneros		M	1			Lawyer	San Antonio (Bexar)
Albert Bustamante	Chairperson	M	1			County Judge	San Antonio (Bexar)
TOTALS WHERE APPLICABLE		M 7 / F 2	5	1	3		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: BRAZOS VALLEY MHMR CENTER — LOCATION: BRYAN

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
James Florence	Vice Chairman	M	X				Bank President	C	Hearne(Robertson)
Gordon Richardson		M	X				Insurance Agent	P	Caldwell(Burleson)
James O. Hill		M	X				County Judge	C	Centerville (Leon)
Thomas Swygert		M	X				Minister	C	Brenham (Washington)
Elizabeth Faulk	Secretary-Treasurer	F	X				Homemaker	C	Madisonville (Madison)
Benjamin Swank		M	X				County Judge	C	Navasota (Grimes)
R. J. Holmgreen	Chairman	M	X				County Judge	C	Bryan (Brazos)
Mrs. Neville Clarke		F	X				Homemaker	C	Bryan (Brazos)
Mr. W. R. Vance		M	X				Attorney	C	Bryan (Brazos)
TOTALS WHERE APPLICABLE		M 7 / F 2	9	0	0			C 8 / P 1	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-10

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: BRAZOS VALLEY MHMR CENTER — LOCATION: BRYAN

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
James Florence		M			1	Bank President	Hearne (Robertson)
Gordon Richardson		M			1	Insurance Agent	Caldwell (Burleson)
William Vance		M			1	Lawyer	Bryan (Brazos)
James O. Hill	Vice Chairperson	M			1	County Judge	Centerville (Leon)
Thomas Swygert	Chairperson	M			1	Clergy	Brenham (Washington)
Thelma Van Overbeck		F			1	Lawyer	Bryan (Brazos)
S. S. Cox, Ph.D.		M			1	Retired Professor, English	College Station (Brazos)
Elizabeth Faulk		F			1	Homemaker	Madisonville (Madison)
Benjamin Swank	Secretary Treasurer	M			1	County Judge	Anderson (Grimes)
TOTALS WHERE APPLICABLE		M 7 / F 2	0	0	9		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

TABLE D-11

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: CENTRAL COUNTIES CENTER FOR MHMR SERVICES LOCATION: TEMPLE

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a]				OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
			W	B	MA	OH			
E. Warren Alexander		M	X				Retired Rancher		Hamilton (Hamilton)
George English	Treasurer	M		X			Principle Middle School		Temple (Bell)
Robin Smith, Ph.D.	Chairman	M	X				Business & Mgt. Dept. American Tech. Univ.		Temple (Bell)
Mrs. Jackie Goodnight	Vice Chairman	F	X				Rancher-Housewife		Salado (Bell)
Mrs. Lea Ledger	Secretary	F	X				Manager Dress Shop		Copperas Cove (Coryell)
Mrs. Gloria J. Walker		F	X				Insurance-Housewife		Killeen (Bell)
Robert Palmer, M.D.		M	X				Hematology Dept. Scott & White Hospital		Temple (Bell)
Fred Brewton		M	X				Retired Miniater-Rancher		Lometa (Lampasas)
Robert Scott		M	X				Attorney		Gatesville (Coryell)
TOTALS WHERE APPLICABLE		M 6 / F 3	8	1				C / P	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-12

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: CENTRAL COUNTIES CENTER FOR MHMR SERVICES LOCATION: TEMPLE

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a]			OCCUPATION	CITY (COUNTY)
			SS	B	O		
E. Warren Alexander	President	M			1	Farmer	Hamilton (Hamilton)
George English	Vice Pres.	M		1		Assistant Principal Middle School	Temple (Bell)
Robin Smith, Ph.D.		M			1	University Professor American Tech. Institute	Temple (Bell
Mrs. Jackie Goodnight	Secretary	F			1	Housewife	Belton (Bell)
Mr. G. Weldon Kirby		M			1	Rancher	Lometa (Lampasas)
Mrs. Lea Ledger		F			1	Dress Shop Owner	Copperas Cove (Coryell)
Mrs. Gloria J. Walker		F			1	Housewife	Killeen (Bell)
Robert Palmer, M.D.		M			1	M.D., Scott White Clinic	Temple (Bell
TOTALS WHERE APPLICABLE		M 5 / F 3	0	1	7		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: CENTRAL PLAINS MHMR CENTER — LOCATION: PLAINVIEW

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
W. W. Allen	Chairman	M	X				Sr. Vice President Hale County State Bank	C	Plainview (Hale)
Baker Duggins	Vice Chmn.	M	X				Teacher-Counselor Friona Schools	C	Friona (Parmer)
T. A. Hayburst		M	X				Owner - Print Shop A & H Printing	C	Tulia (Swisher)
Mrs. John (Carol) Lantz	Secretary	F	X				School Nurse Dimmitt Schools	C	Dimmitt (Castro
Raymond Lewis		M	X				Farmer, Self-employed Olton, Texas	C	Olton (Lamb)
Glen Williams		M	X				County Judge Muleshoe, Texas 79347	C	Muleshoe (Bailey)
Robert Alldredge		M	X				Director, Caprock Ed.Coop., Floydada ISD	C	Floydada (Floyd)
Emilio Aguilar		M			X		ASCS Office, Matador	C	Matador (Motley)
TOTALS WHERE APPLICABLE		M 7 / F 1	7	0	1			C 8 / P 0	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: CENTRAL PLAINS MHMR CENTER — LOCATION: PLAINVIEW

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
W. W. Allen	Chairperson	M			1	Vice President, Bank	Plainview (Hale)
Baker Duggins	Vice Chairperson	M			1	School Counselor	Friona (Parmer)
T. A. Hayburst		M			1	Owner, Print Shop	Tulia (Swisher)
Mrs. John (Carol) Lantz	Secretary	F			1	School nurse	Dimmitt (Castro)
Raymond Lewis		M			1	Farmer	Olton (Lamb)
Glen Williams		M			1	County Judge Bailey County	Muleshoe (Bailey)
Mr. Jerry Cannon		M			1	Superintendent Floydada Schools	Floydada (Floyd)
Forrest Campbell		M			1	Retired County Judge	Matador (Motley)
Vacant							
TOTALS WHERE APPLICABLE		M 7 / F 1	0	0	8		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

TABLE D-15

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: CENTRAL TEXAS MHMR CENTER — LOCATION: BROWNWOOD

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Janie Clements	Chairman	F	X				Homemaker		Brownwood (Brown)
Jamee H. Dudley	Treasurer	M	X				Attorney-at-law Sudderth,Woodley,Dudley		Comanche (Comanche)
W. T. Harlow		M	X				Mayor City of Brownwood		Brownwood (Brown)
Mrs. Lois McCartey	Secretary	F	X				Bookeeper/Secretary Oil & Gas Production		Coleman (Coleman)
Doug Hayes	Vice Chmn.	M	X				Banker City National Bank		San Saba (San Saba)
Gloria Willen		F	X				Director, Social Work Tarleton State Univ.		Brownwood (Brown)
John Davenport		M	X				Co-Owner Davenport Sportg.Goods		Brady (McCulloch)
Bill Easley		M	X				Minister		Rising Star(Eastld)
Lee Ruth Campbell		F	X				Retired Elementary School Teacher		Goldthwaite(Mills)
TOTALS WHERE APPLICABLE		M 5 / F 4	9	0	0			C / P	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: CENTRAL TEXAS MHMR CENTER — LOCATION: BROWNWOOD

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
James Bunnell		M			1	County Judge	Brownwood (Brown)
Janie Clements	Chairperson	F			1	Housewife	Brownwood (Brown)
James H. Dudley	Vice Chair/ Treesurer	M			1	Lawyer	Comanche (Comanche)
Arlene Fry	Secretary	F			1	Housewife	Cisco (Eastland)
W. T. Harlow		M			1	Mayor-Brownwood	Brownwood (Brown)
Owen Yarborough		M			1	Owner, Retail Stores	Goldthwaite (Mills)
David Youngblood		M			1	Businessman Ins./Real Estate	Brady (McCulloch)
Mrs. Lois McCartey		F			1	Housewife	Coleman (Coleman)
Doug Hayes		M			1	Bank President	San Saba (San Saba)
TOTALS WHERE APPLICABLE		M 6 / F 3	0	0	9		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: CONCHO VALLEY CENTER FOR HUMAN ADVANCEMENT LOCATION: SAN ANGELO

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a]				OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
			W	B	MA	OH			
Harold Broome		M	X				Owner/Manager Southwestern Stockman	C	San Angelo (Tom Green)
Jack Grafa		M	X				Life Ins. Salesman	C	San Angelo (Tom Green)
Mack McCoulskey	Vice Chairperson	M	X				Professor at ASU	C	San Angelo (Tom Green)
Stanley Vayden, M.D.	Chairperson	M	X				Medical Doctor	C	San Angelo (Tom Green)
Richard Fuentes, Jr.		M			X		Owner Ricardo's Restaurant	C	San Angelo (Tom Green)
Mary Anna Massey	Secretary	F	X				Housewife	C	San Angelo (Tom Green)
Jack Ray	Treasurer	M	X				Investment Counselor Schneider, Bernet	C	San Angelo (Tom Green)
Charles Bittera		M	X				Retired	C	San Angelo (Tom Green)
Pat Harrison		F	X				Housewife	C	San Angelo (Tom Green)
TOTALS WHERE APPLICABLE		M 7 / F 2	8		1			C 9 / P 0	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-18

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: CONCHO VALLEY CENTER FOR HUMAN ADVANCEMENT LOCATION: SAN ANGELO

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a]			OCCUPATION	CITY (COUNTY)
			SS	B	O		
Harold Broome		M			1	Owner, Southwestern Stock Supply	San Angelo (Tom Green)
Colonel Joe Finn		M			1	Col., USAF	San Angelo (Tom Green)
Jack Grafa		M			1	Business Mgr., Insurance	San Angelo (Tom Green)
C. D. Henry	Treasurer	M			1	San Angelo ISD	San Angelo (Tom Green)
Mack McCoulskey		M			1	University Professor Angelo State	San Angelo (Tom Green)
Alma Perez	Secretary	F	1			Homemaker	San Angelo (Tom Green)
Liz Shotts	Vice Chairperson	F			1	Homemaker	San Angelo (Tom Green)
Stanley Vayden, M.D.	Chairperson	M			1	M. D.	San Angelo (Tom Green)
Gerald B. Wadzeck		M			1	Retired School Educator	San Angelo (Tom Green)
TOTALS WHERE APPLICABLE		M 7 / F 2	1	0	8		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

TABLE D-19

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: DALLAS COUNTY MHMR CENTER — LOCATION: DALLAS

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Harvey Phillips		M	X				Retired	C	Dallas (Dallas)
Delbert Schuler		M	X				Systems Analyst EDS Corp.	C	Richardson (Dallas)
Charles Mitchell, M.D.		M		X			Orthopedic Surgeon Physician	P	Dallas (Dallas)
Barbara Douglas	Secretary	F	X				Proprietor The Cedar Chest	P	Ceder Hill (Dallas)
Carolyn Foxworth	Acting Chairperson	F	X				Intrm.Devopment Dir. Dallas Museum Fn.Arts	C	Dallas (Dallas)
Jane Wetzel		F	X				Volunteer	C	Dallas (Dallas)
Sam Rhodes		M	X				Accountant, Touche-Ross & Co.	C	Dallas (Dallas)
J. Sanders Thompson III		M	X				V.P. Corporate Svcs. Southland Fin. Corp.	C	Dallas (Dallas)
James Clark, Jr.	Treasurer	M	X				Self-employed Investor	C	Dallas (Dallas)
TOTALS WHERE APPLICABLE		M 6 / F 3	8	1				C 7 / P 2	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: DALLAS COUNTY MHMR CENTER — LOCATION: DALLAS

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Doug Barnes	Chairperson	M			1	Lawyer	Dallas (Dallas)
Mrs. Emilie Scheppa	Vice Chairperson	F			1	Homemaker	Dallas (Dallas)
Harvey Phillips	Secretary	M			1	Owner, Tool & Die Company	Dallas (Dallas)
Mrs. Lee Vaenker	Treasurer	F			1	Retired Nurse	Irving (Dallas)
Thomas Baker		M			1	Oil Developer	Dallas (Dallas)
Clark Breeding		M			1	Retired CPA	Dallas (Dallas)
Delbert Schuler		M			1	Lawyer	Richardson (Dallas)
Mrs. Jack O'Callaghan		F			1	Homemaker	Dallas (Dallas)
Charles Mitchell, M.D.		M		1		Orthopedic M. D. Surgeon	Dallas (Dallas)
TOTALS WHERE APPLICABLE		M 6 / F 3		1	8		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surnamed; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: DEEP EAST TEXAS REGIONAL MHMR SERVICES — LOCATION: LUFKIN

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Ward Burke		M	X				Attorney-at-Law Temple Eastex, Inc.	P	Diboll (Angelina)
George E. Gee		M	X				Pharmacist George Gee Pharmacy	P	Jasper (Jasper)
Agnes Rhoder		F		X			Full-time Doctoral Student, U. of Texas	P	Crockett (Houston)
Mr. R. B. Hille	Secretary	M	X				Insurance Agent R. B. Hille Insurance	P	Livingston (Polk)
Nancy Speck, Ph.D.	Treasurer	F	X				University Professor Stephen F. Austin	P	Nacogdoches (Nacogdoches)
Allen Sturrock	Vice Chairman	M	X				County Judge Tyler County	P	Woodville (Tyler)
Mr. V. B. Woods	Chairman	M	X				Retired Bank President Lovelady State Bank	P	Woodlake (Trinity)
Rev. Robert Carter		M	X				Minister Pinecrest Baptist Ch.	P	Silsbee (Hardin)
Perry Sampson		M		X			Coordinator, Federal Grants, Center ISD	P	Center (Shelby)
TOTALS WHERE APPLICABLE		M 7 / F 2	7	2				C 0 / P 9	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: DEEP EAST TEXAS REGIONAL MHMR SERVICES — LOCATION: LUFKIN

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Ward Burke	Chairperson	M			1	Lawyer	Diboll (Angelina)
George E. Gee		M			1	Pharmacist Owner, Gee's Pharmacy	Jasper (Jasper)
Agnes Rhoder		F			1	Teacher	Crockett (Houston)
Mr. R. B. Hille	Secretary	M			1	Insurance	Livingston (Polk)
Nancy Speck, Ph.D.		F			1	University Instructor	Nacogdoches (Nacogdoches)
Allen Sturrock	Vice Chairperson	M			1	Tyler Co. Judge	Woodville (Tyler)
Mr. V. B. Woods	Treasurer	M			1	Bank President	Woodlake (Trinity)
Ray Martin		M			1	County Judge	Kountz (Hardin)
Perry Sampson		M		1		Center ISD	Center (Limestone)
TOTALS WHERE APPLICABLE		M 7 / F 2	0	1	8		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

TABLE D-23

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: MHMR REGIONAL CENTER OF EAST TEXAS — LOCATION: TYLER

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Earl C. Andrews	Chairman	M	X				Retired Businessman	P	Tyler (Smith)
Isadore Roosth	Secretary Treasurer	M	X				Businessman-Financier	P	Tyler (Smith
Mildred Speights	Vice Chairman	F	X				Retired Teacher	C	Mineola (Wood)
Bobby Sanders		M	X				Attorney	C	Canton (Van Zandt)
Linda Underhill		F	X				Retired Legal Secty.	P	Athens (Henderson)
George B. Pearson		M	X				Hospital Administrator	P	Tyler (Smith)
Mrs. I. T. Hunter		F		X			Retired	C	Tyler (Smith)
George T. Hall		M	X				Bank President	P	Tyler (Smith)
A. C. McMillan		M		X			School Principal	C	Emory (Rains)
TOTALS WHERE APPLICABLE		M 6 / F 3	7	2				C 4 / P 5	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: MHMR REGIONAL CENTER OF EAST TEXAS — LOCATION: TYLER

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Earl C. Andrews	Chairperson	M			1	Retired Business Executive	Tyler (Smith)
Masters H. Moore, M.D.		M			1	Pediatrician M.D.	Tyler (Smith)
Isadore Roosth	Secretary Treasurer	M			1	Financier	Tyler (Smith)
Mildred Speights	Vice Chairperson	F			1	Teacher	Mineola (Wood)
Bobby Sanders		M			1	Lawyer	Canton (Van Zandt)
Linda Underhill		F			1	Homemaker	Athens (Henderson)
Rebecca Laughlin		F			1	Tyler Jr. College Teacher Soc.& Psychology	Tyler (Smith)
Mrs. E. B. Long		F		1		Counselor, Tyler Jr. College	Tyler (Smith)
TOTALS WHERE APPLICABLE		M 4 / F 4	0	1	7		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surnamed; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: EL PASO CENTER FOR MHMR SERVICES — LOCATION: EL PASO

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Margo Smith	Secretary	F	X				Dir. Indep. Youth Activities, Ft. Bliss	C	El Paso (El Paso)
Adalberto Franco		M			X		Teacher Coronado High School	P	" " "
Irving Gray		M				X	Director Project BRAVO	P	" " "
Rev. G. Taft Lyon, Jr.	Chairperson	M	X				Reverend Manhattan Presbyterian Church	P	" " "
Kenneth C. Mearns	Vice Chairman	M	X				Director of Training Lincoln Natl.Life Ins.	P	" " "
Alex Marquez		M			X		Bailiff County District Court	C	" " "
Sandy Kahn		F	X				Banker	C	" " "
Cornelia Gladden, R.N.		F		X			School Nurse Ysleta ISD		" " "
TOTALS WHERE APPLICABLE		M 5 / F 3	4	1	2	1		C 4 / P 3	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-26

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: EL PASO CENTER FOR MHMR SERVICES — LOCATION: EL PASO

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Linda Perez	Chairperson	F	1			Principal El Paso Elementary School	El Paso (El Paso)
Helen Villegas		F	1			Nurse	El Paso (El Paso)
Lydia Rios Aguirre		F			1	Program Supervisor/Status Offender Program	El Paso (El Paso)
Margo Smith		F			1	Recreation Supervisor/Army	El Paso (El Paso)
Adalberto Franco		M	1			Executive Director Newark Methodist Hospital	El Paso (El Paso)
Irving Gray		M			1	Executive Director Alcoholic Program St. Joseph Hospital	El Paso (El Paso)
Della Haddad		F			1	Teacher, Special Education	El Paso (El Paso)
Rev. G. Taft Lyon Jr.		M			1	Clergy	El Paso (El Paso)
TOTALS WHERE APPLICABLE		M 3 / F 5	3	0	5		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: GULF BEND MHMR CENTER — LOCATION: VICTORIA

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Al Shields, M.D.		M	X				General Practice of Medicine	P	Victoria (Victoria)
H. Carlos Baker	2nd V.P.	M	X				Retired	C	Edna (Jackson)
Bill Koons	1st V.P.	M	X				Episcopal Priest	C	Port Lavaca (Calhoun)
Dorothy Ramsey		F	X				Homemaker	C	Goliad (Goliad)
Carolyn Ferguson		F	X				Homemaker	C	Cuero (DeWitt)
Bud Meyer	Chairman	M	X				President Mayer Manufacturing	C	Hallettsville (Lavaca)
Dodie Griffin	Secretary	F	X				Homemaker	C	Port Lavaca (Calhoun)
Jay Lack		M	X				Vice President Lack Stores	C	Victoria (Victoria)
Edward Kircher		M	X				Catholic Priest	-	Woodsboro (Refugio)
TOTALS WHERE APPLICABLE		M 6 / F 3	9					C 8 / P 1	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-28

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: GULF BEND MHMR CENTER — LOCATION: VICTORIA

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Harris Mar	Chair	M			1	Manager-South Western Bell	Victoria (Limestone)
Al Shields, M.D.	Vice-chair	M			1	General Practice	Victoria (Victoria)
H. Carlos Baker	2nd Vice-chair	M			1	Administrator Edna ISD	Edna (Jackson)
Bob Harvey		M			1	Employee, Nat'l Starch Plant	Long Mott (Calhoun)
Bill Koons		M			1	Clergy	Rufugio (Refugio)
Dorothy Ramsey	Secretary	F			1	Housewife	Goliad (Goliad)
Carolyn Ferguson		F			1	Homemaker	Cuero (DeWitt)
Bud Meyer		M			1	Owner-Furniture Mftg. Company	Hallettsville(Lavaca)
Dodie Griffin		F			1	Employed-Occupation Unknown	Lavaca (Calhoun)
TOTALS WHERE APPLICABLE		M 6 / F 3	0	0	9		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: GULF COAST REGIONAL MHMR CENTER — LOCATION: GALVESTON

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Thomas Mackey, Ph.D.		M	X				Technical Consultant Key Metals & Minerals		Texas City (Galveston)
Mr. C. A. Christian		M	X				Volunteer Brazoria Work Act. Ctr	C	Freeport (Brazoria)
Dan R. Keller		M	X				Dir. of Business Dev. Gulf Consumer Svc. Co.		Pearland (Brazoria)
Janice Stanton	Vice Chairman	F		X			College Coordinator Operation SER	P	Galveston (Galveston)
Forrest Hawkins, Th.D.	Chairman	M	X				Marital and Family Therapy	P	Freeport (Brazoria)
Grace K. Jameson, M.D.		F	X				Associate Professor UTMB	P	Galveston (Galveston)
Gerald Harryman	Treasurer	M	X				Santa Fe Insurance		Alta Loma (Galveston)
Peggy Buchorn		F	X				Rancher, devotes time to Comm. activities		Brazoria (Brazoria)
Gloria Marek		F	X				Consultant The Consultant Group		Dickinson (Galveston)
TOTALS WHERE APPLICABLE		M 5 / F 4	8	1				C 1 / P 4	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-30

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: GULF COAST REGIONAL MHMR CENTER — LOCATION: GALVESTON

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Mrs. Kenneth Buchorn	Chair	F			1	Ranch Owner	Brazoria (Brazoria)
Thomas Mackey, M.D.	Vice-chair	M			1	Lawyer'Eng.	Texas City (Galveston)
Mr. C.A. Christian	Treas.	M			1	Retired Businessman with Dow CHemical	Freeport (Brazoria)
Don R. Keller		M			1	Supervisor at Gulf Oil Co.	Houston (Harris)
Janice Stanton		F			1	Works for Operation E.E.R.	Galveston (Galveston)
George H. Freeborn		M			1	Owns local Business	LaMarque (Galveston)
Forest Hawkins, TH.D.		M			1	Family Counselor, Clergy	Freeport (Brazoria)
Grace K. Jameson, M.D.		F			1	M. D.	Galveston(Galveston)
Jerry Harryman		M			1	Local Businessman	
TOTALS WHERE APPLICABLE		M 5 / F 3	0	0	9		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

TABLE D-31

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: THE AUTHORITY FOR MH AND MR IN HARRIS COUNTY — LOCATION: HOUSTON

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Robert Navarro, M.S.W.	Chairman	M			X		President, Hispanic International Univ.	C	Houston (Harris)
Eric G. Andell	Vice Chairman	M	X				Attorney-at-Law	C	" "
Joseph L. Bart, Jr.		M	X				Public Relations Southern Pacific	C	Houston (Harris)
M. McDermouth, M.S.W.	Secretary	F	X				Social Worker None	P	" "
Mark Mendelowitz		M	X				C.P.A. Self-employed	C	Baytown (Harris)
T. S. Hancock		M	X				Retired	C	Houston (Harris)
TOTALS WHERE APPLICABLE		M 5 / F 1	5		1			C 5 / P 1	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-32

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: THE AUTHORITY FOR MH AND MR IN HARRIS COUNTY — LOCATION: HOUSTON

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Myrtle Fonteno	Chair	F		1		Co-owner tourist bureau	Houston (Harris)
Robert Navarro, M.S.W.	Vice-chair	M	1			Teacher-Univ. Without Walls	Houston (Harris)
Eric G. Andell	Secretary	M			1	Lawyer	Houston (Harris)
Joseph L. Bart, Jr.		M			1	Employee, Southern Pacific	Houston (Harris)
Margaret McDermoth, M.S.W.		F			1	M.S.W.	Houston (Harris)
Mark Mendelowitz		M			1	CPA	Baytown (Harris)
T. S. Hancock		M			1	Retired Educator	Houston (Harris)
TOTALS WHERE APPLICABLE		M 5 / F 2	1	1	5		

[a] SS = Spanish Surnamed; B = Black; O = Other

IDRA Mental Health Research Project, 1981

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: HEART OF TEXAS REGION MHMR CENTER — LOCATION: WACO

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Jacque Browder		F	X				Homemaker	C	Clifton (Bosque)
Judge Calvin Hardison		M	X				County Judge	C	Groesbeck (Limestone)
Beverly Cox		F	X				Homemaker	C	Waco (McLennan)
David C. Murdoch	Chairman	M	X				President, Murdoch Chrysler-Plymouth Inc.	C	Waco (McLennan)
Kerry Irons, M.D.	Vice Chairman	M	X				Chief Phys., Emergency Hillcrest Hospital	P	Waco (McLennan)
Arlene Fred	Secretary	F	X				Homemaker	C	Waco (McLennan)
Cynthia Lewis		F	X				President Pioneer Ins. Agency	C	Mart
Theodore Talbot		M		X			Vice President Texas St.Tech.Inst.	P	Waco(McLennan)
Vacant									(Hill)
TOTALS WHERE APPLICABLE		M 4 / F 4	7	1				C 6 / P 2	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: HEART OF TEXAS REGION MHMR CENTER — LOCATION: WACO

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Jesse Derrick	Chair	M			1	Owner-Bankers & Farmers Ins.	Waco (McLennan)
Beverly Cox	Vice-chair	F			1	Homemaker	Waco (McLennan)
Theodore Talbot	Secretary	M		1		University Prof, TSTI-Waco	Waco (McLennan)
Alan L. Lee		M			1	Administrator Nursing Home	Itasca (Hill)
Mrs. James Browder		F			1	Housewife	Clifton (Bosque)
Ernest Garcia		M	1			Personnel & Counseling, TSTI Waco	Waco (McLennan)
Mrs. Jim Lewis		F			1	Owns Ad Agency	Mart (McLennan)
David C. Murdoch		M			1	Pres. Waco Chrysler/Plymouth	Waco (McLennan)
Calvin Hardison		M			1	County Judge	Groesbeck (Limestone)
TOTALS WHERE APPLICABLE		M 6 / F 3	1	1	7		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: LUBBOCK REGIONAL MHMR CENTER — LOCATION: LUBBOCK

NAME	OFFICE OR BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Jim Kimmel	Chairman	M	X				Attorney	C	Lubbock (Lubbock)
Susan Moore	Secretary	F	X				Banker	C	" "
S. M. Kennedy		M	X				University Professor	C	" "
Jim Clopton	Treasurer	M	X				University Professor Private Practice	P	" "
Tom McGovern		M	X				Counselor Psychiatric	P	" "
Norma Porres, M.D.		F				X	Medical Doctor	P	" "
Ramon Chapa		M			X		Public Administrator	C	" "
J. C. Smith	Vice Chairman	M	X				Farmer	C	" "
Mrs. Jan Rigsby		F	X				Housewife	C	" "
TOTALS WHERE APPLICABLE		M 6 / F 3	7		1	1		C 6 / P 3	

IDRA Mental Health Research Project, 1981

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COMMUNITY MENTAL-HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: LUBBOCK REGIONAL MHMR CENTER — LOCATION: LUBBOCK

TRUSTEE NAME	OFFICE OR BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Jim Kimmel	Chair	M			1	Lawyer	Lubbock (Lubbock)
Susan Moore	Vice-Chair	F			1	Banker	Lubbock (Lubbock)
S. M. Kennedy		M			1	Univ. Prof. (Pol. Sci.) Texas Tech	Lubbock (Lubbock)
Arnold Maeker		M			1	Architect	Lubbock (Lubbock)
Jim Clopton		M			1	Univ. Prof. (Psych.) Texas Tech	Lubbock (Lubbock)
Tom McGovern		M			1	Counselor In-Patient Unit Texas Tech Sch. Med.	Lubbock (Lubbock)
Norma Porres, M.D.		F	1			Family Practice M.D.	Lubbock (Lubbock)
Claude Dollins		M			1	Marriage & Family Counselor	Lubbock (Lubbock)
Vacant							
TOTALS WHERE APPLICABLE		M 6 / F 2	1		7		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

TABLE D-37

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: NAVARRO COUNTY MHMR CENTER — LOCATION: CORSICANA

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR, PROVIDER	RESIDENCE CITY (COUNTY)
Lynn Sanders	Chairmen	M	X				Banker	C	Corsicana (Navarro)
Erwin Golden	Vice Chairman	M	X				Real Estate Broker	C	"
Jane Biltz	Treasurer	F	X				Homemaker	P	"
Ceanne Harper	Secretary	F	X				Homemaker	C	"
Kent Rogers, M.D.		M	X				Physician	P	"
Gioia Keeney		F	X				Homemaker	C	"
Robert Evans		M	X				Hospital Administr.	P	"
Robert Edwards		M		X			Administrator Corsicana ISD	C	"
Lonnie Teague, Ed.D.		M	X				Dean, Navarro College	C	"
TOTALS WHERE APPLICABLE		M 6 / 3 P	8	1				C 6 / 3 P	

IDRA Mental Health Research Project, 1981

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: NORTH CENTRAL TEXAS MHMR SERVICES — LOCATION: McKINNEY

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Ray Johnson, Ph.D.		M	X				Prof. of Psychology N.Texas St. University		Denton (Denton)
William Tooley, M.D.	Vice Chairman	M	X				Self-employed Psychiatrist		McKinney (Collin)
Nita Adkisson		F	X				Owner, Flower & Gift Shop		Greenville (Hunt)
Albert Barstis		M	X				Prof. of Sociology Tex. Women's Univ.		Denton (Denton)
George Bryant, Ed.D.	Chairman	M	X				Assoc.Prof.,Psychology E. Texas St. Univ.		Commerce (Hunt)
Kay Goodman	Parlia-mentarian	F	X				Teacher, Plano Indep. Schools		Plano (Collin)
Connie Kelleher	Secretary Treasurer	F	X				Mgt. Consultant Robt. Sage & Assoc.		Denton (Denton)
Col. John Davis		M	X				Retired Military Housing Rental		Princeton (Collin)
Roselyn Davis		F		X			Managing Broker Century 21 Real Estate		Greenville (Hunt)
TOTALS WHERE APPLICABLE		M 5 / F 4	8	1				C / P	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: NORTH CENTRAL TEXAS MHMR SERVICES — LOCATION: McKINNEY

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Roy Johnson, PH.D.	Chair	M			1	Univ. Prof. Dept Psy NTSU	Denton (Denton)
William Tooley, M. D.	Vice-Chair	M			1	Psychiatrist	McKinney (Collin)
Nita Adkisson	Sec/Treas.	F			1	Own Florist Shop	Greenville (Hunt)
Albert Barstis		M			1	Univ. Prof. Tex. Womens U (Psych)	Denton (Denton
George Bryant, Ed.D.		M			1	Univ. Prof. East Tex. State U	Commerce (Hunt)
Kay Goodman		F			1	Graduate Student - Homemaker	Plano (Collin)
Robert Johnson, D.P.H.		M			1	Univ. Prof-East Tex. State, Public Health	Commerce (Hunt)
Connie Kelleher		F			1	Works for Management & Marketing	Denton (Denton)
Col. John Davis		M			1	Retired Military	Princeton (Collin)
TOTALS WHERE APPLICABLE		M 6 / F 3	0	0	9		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: NORTHEAST TEXAS MHMR CENTER — LOCATION: TEXARKANA

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
G. W. Thompson, M.D.	Chairperson	M		X			General Practitioner Self-employed	P	Texarkana (Bowie)
Mary Clinton	Secretary	F	X				High School Counselor DeKalb High School	C	DeKalb (Bowie)
J. E. Rorie, M.D.	Treasurer	M	X				Pediatrician Collum Carney Clinic	P	Texarkana (Bowie)
Norman Rachel	Vice Chairperson	M	X				Draftsman Red River Army Depot	C	Texarkana (Bowie)
Mary Scoggins		F	X				Retired Teacher	C	Bogata (Red River)
Hubert Simpson		M	X				New Boston I.S.D. Supt. of Schools	C	New Boston (Bowie)
James Stingley		M	X				Spec. Ed. Director Cass County Co-Op	C	Atlanta (Cass)
Mamie Collins		F		X			Homemaker	C	Clarksville (Red River)
Nancy Sandefur		F	X				Texarkana Chamber of Commerce	C	Texarkana (Bowie)
TOTALS WHERE APPLICABLE		M 5 / F 4	7	2				C 7 / P 2	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: NORTHEAST TEXAS MHMR CENTER — LOCATION: TEXARKANA

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
G.W. Thompson, M.D.	Chair	M		1		M.D. General Practice	Texarkana (Bowie)
Mary Clinton	Secretary	F			1	DeKalb ISD School Council	DeKalb (Bowie)
J.E. Rorie, M. D.	Treasurer	M			1	M. D. Pediatrician	Texarkana (Bowie)
Susan Chadick		F			1	Lawyer	Texarkana (Bowie)
Letha Hall		F			1	Business Manager, Motor Co.	Clarksville (Red River)
Norman Rachel	Vice-chair	M			1	Draftsman	Texarkana (Bowie)
Mary Scoggins		F			1	Homemaker	Bogata (Red River)
Hubert Simpson		M			1	Superintendent New Boston ISD	New Boston (Bowie)
James Stingley		M			1	Director/Special Education Co-op Atlanta ISD	Atlanta (Cass)
TOTALS WHERE APPLICABLE		M / F 4	0	1	8		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

COMMUNITY MENTAL HEALTH MENTAL-RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: NUECES COUNTY MH AND MR COMMUNITY CENTER — LOCATION: CORPUS CHRISTI

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
F. Starr Pope, Jr.		M	X				Attorney, Kleberg, Redford & Weil		Corpus Christi (Nueces)
Fela Leal	Chairman	F			X		A & M Extension Service		Corpus Christi (Nueces)
Mrs. Beth Woolsey		F	X				Housewife/Student		" "
Ms. Lena Coleman		F		X			Dir., Hialco-OIC Skills Tng. Prog.		" "
Fred J. Nemec	Treasurer	M	X				CPA, Fields & Nemec		Robstown (Nueces)
Frank M. Garza	Vice Chairman	M			X		Attorney		Corpus Christi (Nueces)
John C. Tijerina		M			X		V.Pres, Bank of Robstown		Robstown (Nueces)
Ms. Anadelia Gonzales	Secretary	F			X		Personnel Director, Nueces Co. Cthouse		Corpus Christi (Nueces)
Ms. Lucy McCracken		F	X				Housewife		Corpus Christi (Nueces)
TOTALS WHERE APPLICABLE		M 4 / F 5	4	1	4			C / P	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: NUECES COUNTY MHMR COMMUNITY CENTER — LOCATION: CORPUS CHRISTI

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Starr Pope, Jr.	Chair	M			1	Lawyer	Corpus Christi (Nueces)
Fela Leal	Vice-Chair	F	1			Admin., A&M Extension Service	Corpus Christi (Nueces)
Waldon A. Rippy	Treas.	M			1	CPA	Corpus Christi (Nueces)
Rev. Rudy Sanchez		M	1			Clergy	Corpus Christi (Nueces)
Robert N. Barnes		M			1	County Judge	Corpus Christi (Nueces)
Ms. Lena Coleman		F		1		Trainer, Hialko DIC Skills Training	Corpus Christi (Nueces)
TOTALS WHERE APPLICABLE		M 4 / F 3	2	1	4		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: PECAN VALLEY MHMR REGION CENTER — LOCATION: STEPHENVILLE

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE, FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Randall C. Perkins, D.O.	Treasurer	M	X				Doctor of Osteopathy Granbury Med. Clinic	P	Granbury (Hood)
Mrs. Lanelle Padgett	Chairman	F	X				Co-owner Granbury Care Center	P	"
Gordon Gafford, M.D.	Vice Chairman	M	X				Medical General Surgery	P	Mineral Wells (Palo Pinto)
Metta Collier		F	X				Diamond C Ranch	C	Stephenville (Erath)
Neal Guthrie		M	X				Owner Gibson Discount Ctr.	C	"
J. T. Jones		M	X				Owner Rambling Oaks Ranch	C	Weatherford (Parker)
Roger E. Marks, M.D.		M	X				Medical - General Marks English Hospital	P	Glen Rose (Somervell)
Jamie Vick		F	X				Dist. Representative Phil Gramm's Office	C	Weatherford (Parker)
Ellis White		M	X				Mayor City of Mineral Wells	C	Mineral Wells (Palo Pinto)
TOTALS WHERE APPLICABLE		M 6 / F 3	9					C 5 / P 4	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-45

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: PECAN VALLEY MHMR REGION CENTER — LOCATION: STEPHENVILLE

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Kave Martino	Vice-Chair	F	1			Dir. Student Personnel Weatherford H.S.	Weatherford (Parker)
Richard M. Blythe		M			1	Dir., Foster Home for Children	Stephenville (Erath)
Randall C. Perkins M.D.		M			1	M.D. Granbury Medical Clinic	Granbury (Hood)
Mrs. Lanell Padgett		F			1	Owner/Dir./Manager Nursing Home	Granbury (Hood)
James R. Crane		M			1	President, 1st National Bank	Glen Rose (Somervell)
Gordon Gafford, M. D.		M			1	M.D.	Mineral Wells(Parker)
Robert J. Glasgov	Chair	M			1	District Attorney, Lawyer	Stephenville (Erath
Gary Willi[illegible]	Treas	M			1	County Auditor	Weatherford(Parker)
TOTALS WHERE APPLICABLE		M 6 / F 2	1	0	7		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

TABLE D-46

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: PERMIAN BASIN COMMUNITY CENTERS FOR MH AND MR — LOCATION: MIDLAND

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
David M. Shannon		M	X				Businessman	C	Odessa (Ector)
Watson LaForce, Jr.	Chairperson	M	X				Businessman	C	Midland (Midland)
Harry W. Clark	Treasurer	M	X				Banker	C	Midland (Midland)
Don Hungerford	Vice Chairperson	M	X				Minister	C	Odessa (Ector)
Mrs. Emory Parrott		F	X				Housewife	C	Midland (Midland)
Bruce Bangert	Secretary	M	X				Attorney	C	Odessa (Ector)
William C. Morrow		M	X				Attorney	C	Midland (Midland)
Billy Bassett		M	X				Businessman	C	Odessa (Ector)
Dottie Huelster		F	X				Housewife	C	Ft.Stockton (Pecos)
TOTALS WHERE APPLICABLE		M 7 / F 2	9					C 9 / P	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-47

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: PERMIAN BASIN COMMUNITY CENTERS FOR MH AND MR — LOCATION: MIDLAND

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
David M. Shannon	Chair	M			1	Owner-Ins. Agency	Odessa (Ector)
Watson LaForce Jr.	Vice-Chair	M			1	Independent Oil Operator	Midland(Midland)
Mrs. Wray Storey	Secretary	F			1	Homemaker	Odessa (Ector)
Harry W. Clark	Treas.	M			1	Banker	Midland (Midland)
Don Hungerford		M			1	Clergy	Odessa (Ector)
Mrs. Cecil Aycock		F			1	Homemaker	Midland (Midland)
Gene Garrison		M			1	Self-Employed/Consulting	Odessa (Ector
Mrs. Emory Parrott		F			1	Homemaker	Midland (Midland)
TOTALS WHERE APPLICABLE		M 5 / F 3	0	0	8		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: SABINE VALLEY REGIONAL MHMR CENTER — LOCATION: LONGVIEW

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Ben Bane	Chairman	M	X				Mgr., SWEPCO	C	Marshall (Harrison)
Oscar Berglund		M	X				Officer (retired), Savings & Loan Co.	C	Marshall (Harrison)
Mr. Willie D. Finch		M		X			Nurse, Hospital	P	Gilmer (Upshur)
Mrs. Claire Foster		F	X				Housewife	C	Longview (Gregg)
Mrs. L. C. Hammons	Secretary-Treasurer	F		X			Teacher (retired)	C	Overton (Rusk)
Frank R. Jackson, M.D.	Vice Chairman	M	X				Physician	P	Longview (Gregg)
J. Ray Kirkpatrick		M	X				Attorney, Law Firm	C	Marshall (Harrison)
Sidney Burns		M	X				County Auditor Panola County	C	Carthage (Panola)
Rev. O. D. Oliver		M	X				Minister Baptist Church	C	Kilgore (Gregg)
TOTALS WHERE APPLICABLE		M 7 / F 2	7	2				C 7 / P 2	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

TABLE D-49

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: SABINE VALLEY REGIONAL MHMR CENTER — LOCATION: LONGVIEW

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Ben Bane		M			1	Manager-SWEPCO Elec. Power Co.	Marshall (Harrison)
Oscar Berglund		M			1	Ret. Bank Officer	Marshall (Harrison)
Mr. Willie D. Finch		M		1		Nurse	Gilmer (Upshur)
Mrs. Claire Foster	Sec/Treas.	F			1	Housewife	Longview (Gregg)
Mrs. L. C. Hammons		F		1		Retired Teacher	Overton (Rusk & Smith)
Frank R. Jackson, M. D.	Vice-Chair	M			1	M.D.	Longview (Gregg)
J. Roy Kirkpatrick	Chair	M			1	Lawyer	Marshall (Harrison)
Rev. Frank M. Richardson		M			1	Clergy	Kilgore (Gregg & Rusk)
A. Y. Sturdivant, M. D.		M			1	M.D.	Carthage (Panola)
TOTALS WHERE APPLICABLE		M 7 / F 2	0	2	7		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

TABLE D-50

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: MHMR OF SOUTHEAST TEXAS — LOCATION: BEAUMONT

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Monty Sontag, Ed.D.		M	X				Director, Special Education, Lamar Univ.	P	Beaumont (Jefferson)
Leroy Polk		M		X			Retired Teacher	C	Port Arthur (Jefferson)
Carroll Bryant	Chairperson	M	X				Chemical Engineer Dupont	C	Orange (Orange)
Nick Nides	Vice Chairperson	M	X				Retired Engineer	C	Groves (Jefferson)
Vergie Musselwhite	Secretary	F	X				Counselor, Austin School, Port Acres	P	Nederland (Jefferson)
Yaleta Kudlaty		F	X				Director, Counseling Center, Lamar Univ.	P	Orange (Orange)
Frank Adams		M	X				Lawyer	C	Beaumont (Jefferson)
D. L. Winzer		M	X				Retired Rice Farmer	C	Winnie (Chambers)
Albert Culver		M	X				Hospital Supply	C	Groves (Jefferson)
TOTALS WHERE APPLICABLE		M 7 / F 2	8	1				C 6 / P 3	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: MHMR OF SOUTHEAST TEXAS — LOCATION: BEAUMONT

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Frank Adams		M			1	Lawyer	Beaumont (Jefferson)
Nick Nides		M			1	Ret. Engineer	Groves (Jefferson)
Monty Sontag, Ed. D.	Chair	M			1	Univ. Professor Lamar Univ.	Beaumont (Jefferson)
Mr. Carroll Bryant	Vice-Chair	M			1	Chemist	Orange (Orange)
D.L. Winzer	Treas.	M			1	Ret. Farmer	Winnis (Chambers)
Leroy Polk		M		1		Ret. School Teacher	Port Arthur (Jeffemon
Mrs. Vergia Musselwhite	Sec.	F			1	Public School Counselor	Nederland (Jefferson)
Fred Crouksbank		M			1	Chemical Engineer	Port Arthur (Jefferson
Mrs. Marjorie Swinburr		F			1	Ret. Financial	Orange (Orange)
TOTALS WHERE APPLICABLE		M 7 / F 2	0	1	8		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surnamed; B = Black; O = Other

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: TARRANT COUNTY REGIONAL MHMR CENTER — LOCATION: FORT WORTH

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Shirlee Gandy		F	X				Citizen's Advocate	C	Fort Worth (Tarrant)
Archie Mosley		M	X				Postal Worker U. S. Postal Service	C	"
Roy Johnson		M	X				Attorney at Law Filmore & Camp	C	"
Bonnie Siddons	Chairperson	F	X				Citizen's Advocate	C	"
Juan Maldonado		M			X		Counselor/Educator TCJC NW Campus	C	"
Harold Warsham	Treasurer	M	X				Vice President Equitable Gen. Ins.	C	"
Jim Callicutt, PhD	Secretary	M	X				Assoc. Dean, School of Social Work, UTA	P	Arlington (Tarrant)
Barry Tuchfeld, PhD		M	X				Educator, TCU	P	Fort Worth (Tarrant)
Roger Williams		M	X				Pres., Jack Williams Chevrolet-Peugot	C	"
TOTALS WHERE APPLICABLE		M 7 / F 2	8		1			C 7 / P 2	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: TARRANT COUNTY REGIONAL MHMR CENTER — LOCATION: FORT WORTH

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Joe Minor	Chair	M			1	Administrator Fort Worth ISD	Fort Worth (Tarrant & Johnson)
Shirlee Gandy		F			1	Housewife/Citizen Advocate	Arlington (Tarrant)
Archie Mosley		M			1	Business man	Hurst (Tarrant)
Doyle Harrell	Vice-Chair	M			1	Pharmacist	Fort Worth (Tarrant & Johnson)
Roy Johnson		M			1	Lawyer	Fort Worth (Tarrant & Johnson)
Bonnie Siddons		F			1	Housewife/Citizen Advocate	Fort Worth (Tarrant & Johnson)
Juan Maldonado	Secretary	M	1			Counselor/Tarrant County Junior College	Fort Worth (Tarrant & Johnson)
Harold Warsham	Treasurer	M			1	Insurance	Fort Worth (Tarrant & Johnson)
Don Weeks		M			1	Insurance	Fort Worth (Tarrant & Johnson)
TOTALS WHERE APPLICABLE		M 7 / F 2	1	0	8		

[a] SS = Spanish Surname; B = Black; O = Other

IDRA Mental Health Research Project, 1981

TABLE D-54

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: MHMR SERVICES OF TEXOMA — LOCATION: DENISON

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Tina Fernandez Johnson		F			X		Medical Assistant, Swamy Clinic	P	Sherman (Grayson)
Ewell Wainwright	Chairperson	M	X				Retired - Banker	C	"
Stan Cobbs, M.S.W.	Treasurer	M	X				Austin College	C	"
Barbara Marshall	Vice Chairperson	F	X				Special Ed. Coord. Cooke Co. Co-op	P	Gainesville (Cooke)
June Milford		F	X				Counselor Honey Grove ISD	C	Honey Grove (Fannin)
Hugh Orr		M		X			Retired	C	Van Alstyne (Grayson)
Mary Helen Yates	Secretary	F	X				Self-employed Yates Building Contr	C	Denison (Grayson)
R. D. Cawyer		M	X				Parmacist Tom Thumb-Page	P	Gainesville (Cooke)
Marianna Untersee		F	X				R.N. - not employed	C	Bonham (Fannin)
TOTALS WHERE APPLICABLE		M 4 / F 5	7	1	1			C 6 / P 3	—

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: MHMR SERVICES OF TEXOMA — LOCATION: DENISON

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Mrs. Kathleen Wright	Sec	F			1	Ret. - Supervisor Child Welfare TDW	Bonham (Fannin)
Mr. V. L. Barnett		M			1	Ret. - Manager	Bonham (Fannin)
Joe B. Walter		M			1	Ret. Owner Lumber Company	Gainsville (Cooke)
Jack Berry	Treas	M			1	Chairman, State National Bank	Denison (Grayson)
Ewell Wainwright	Chair	M			1	Ret. - Bank Exec.	Shreman (Grayson)
Virginia Morris		F			1	Vice Mayor-Sherman/ Co-Owner Day Care Co.	Sherman (Grayson)
Stan Cobbs, MSW		M			1	Ass. Dean/Austin College	Sherman (Grayson)
Barbara Marshall	Vice-Chair	F			1	Dir. Special Education for Cooke County	Gainsville (Cooke)
Jack Lilley		M			1	Independent Ins. Agent	Denison (Grayson)
TOTALS WHERE APPLICABLE		M 6 / F 3	0	0	9		

[a] SS = Spanish Surnamed; B = Black; O = Other

IDRA Mental Health Research Project, 1981

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)

CENTER: TROPICAL TEXAS CENTER FOR MHMR — LOCATION: EDINBURG

NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] W	B	MA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Rene D. Garza		M			X		Computer Analyst	C	McAllen (Hidalgo)
Carl Conley	2nd Vice Chairperson	M	X				Attorney-at-Law	C	Raymondville (Willacy)
Ramon Montalvo, III	Secretary Treasurer	M			X		Insurance Agent	P	Weslaco (Hidalgo)
D. V. Guerra, Jr.	Chairperson	M			X		Rancher	P	Edinburg (Hidalgo)
Martha Tevis, Ph.D.	Vice Chairperson	F	X				Associate Professor	P	Edinburg (Hidalgo)
David Dovalina		M			X		Pharmacist	P	Mission (Hidalgo)
Rollins Koppel		M	X				Attorney-at-Law	C	Harlingen (Cameron)
Menton Murray, Sr.		M	X				Attorney-at-Law	C	Harlingen (Cameron)
TOTALS WHERE APPLICABLE		M 7 / F 1	4		4			C 4 / P 4	

IDRA Mental Health Research Project, 1981

[a] W = White or Anglo; B = Black; MA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: TROPICAL TEXAS CENTER FOR MHMR — LOCATION: EDINBURG

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY[a] SS	B	O	OCCUPATION	CITY (COUNTY)
Gretchen B. Sorensen	Chair	F			1	Retired High School Counselor	South Padre Island (Cameron)
Grace Arredondo, Ph.D.	2nd Vice-Chair	F	1			Dir., Special Education Weslaco ISD	Weslaco (Hidalgo)
Carl Consly		M			1	Lawyer	Raymondville (Willacy)
Raymond Montalvo, III		M	1			Part owner Insurance Company	Weslaco (Hidalgo)
D. V. Guerra, Jr.	Sec/Treas	M	1			Rancher	Edinburg (Hidalgo)
Martha Tevis, Ph. D.	Vice-Chair	F			1	Univ. Prof Pan American U (Ed.)	Edinburg (Hidalgo)
David Dovalina		M	1			Pharmacist	Mission (Hidalgo)
Rollins Koppel		M			1	Lawyer	Harlingen Cameron
VACANT							
TOTALS WHERE APPLICABLE		M 5 / F 3	4	0	4		

IDRA Mental Health Research Project, 1981

[a] SS = Spanish Surname; B = Black; O = Other

TABLE D-58

COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1981)*

CENTER: WICHITA FALLS COMMUNITY MHMR CENTER — LOCATION: WICHITA FALLS

NAME	OFFICE ON BOARD	SEX	ETHNICITY* W	B	HA	OH	OCCUPATION JOB TITLE FIRM/ORGANIZATION	CONSUMER OR PROVIDER	RESIDENCE CITY (COUNTY)
Linda Cornelius		F	X				Bookkeeper Oil Company	C	Burkburnett (Wichita)
Mrs. Barbara Glickman	Secretary	F	X				Citizens' Advocate	C	Wichita Falls (Wichita)
Neil Holliman, Ph.D.	Vice Chairperson	M	X				Chairman, Psychology Midwestern University	P	Wichita Falls (Wichita)
Richard E. Milisci, M.D.	Chairperson	M	X				Diagnostician	P	" "
Jacelyn Hall		F	X				Reynolds Oil Producers	C	" "
Glenn Beck, D.D.S.	Treasurer	M	X				Dentist	C	" "
Stather Breckenridge		F		X			Homemaker	C	" "
Helen Farabee		F	X				Citizens' Advocate	C	" "
La June Lewis		F	X				Newspaper Correspondent	C	Electra (Wichita)
TOTALS WHERE APPLICABLE		M 3 / F 6	8	1				C 7 / P 2	

IDRA Mental Health Research Project, 1981

* W = White or Anglo; B = Black; HA = Mexican American; OH = Other Hispanic

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COMMUNITY MENTAL HEALTH MENTAL RETARDATION CENTERS IN TEXAS

BOARDS OF TRUSTEES (Spring 1979)

CENTER: WICHITA FALLS COMMUNITY MHMR CENTER — LOCATION: WICHITA FALLS

TRUSTEE NAME	OFFICE ON BOARD	SEX	ETHNICITY* SS	B	O	OCCUPATION	CITY (COUNTY)
Jackie Cornelius		F			1	Housewife	Burkburnett (Wichita)
Joe Fitts		M			1	Realtor Developer	Wichita Falls (Wichita)
Mrs. Barney Glickman		F			1	Housewife	Wichita Falls (Wichita)
Jim Hogan	Treasurer	M			1	Lawyer	Wichita Falls (Wichita)
Neil B. Holliman, PH.D	Secretary	M			1	Chairman, Dept. of Psy. Soc. Anthro	Wichita Falls (Wichita)
Larry Lambert	Vice-Chair	M			1	Lawyer	Wichita Falls (Wichita)
Joe B. Meissner, Jr.	Chair	M			1	Pres. Meissner Plumbing	Wichita Falls (Wichita)
Richard E. Milisci, M.D.		M			1	Internal Medicine	Wichita Falls (Wichita)
Mrs. John Swanson		F			1	Housewife	Electra (Wichita)
TOTALS WHERE APPLICABLE		M 6 / F 3	0	0	9		

IDRA Mental Health Research Project, 1981

* SS = Spanish Surname; B = Black; O = Other

APPENDIX E

REFERENCES

Note: Legal citations are not listed here but are included in the body of the text.

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