Services for Mentally Retarded Juvenile Offenders Report of the Mental Health and Mental Retardation Authority of Harris County Interagency Task Force on Services for Mentally Retarded Juvenile Offenders

Harris County Mental Health and Mental Retardation Authority, Houston, TX

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Interagency Task Force Report

Services for

Mentally Retarded Juvenile Offenders

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REPORT OF

THE MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY

INTERAGENCY TASK FORCE ON SERVICES FOR MENTALLY RETARDED JUVENILE OFFENDERS

September 1, 1976

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"The true measure of a society can be seen in what it does for its members who are least endowed."

John F. Kennedy

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Introduction

The care and treatment of the mentally retarded juvenile offender are complex issues which present complicated problems of philosophical and service orientation. Although the field of mental retardation services in its entirety has undergone massive, rapid growth during the past twenty-five years, a concerted effort toward positively treating the mentally retarded juvenile offender has nationally come about over the past five years.

The State of Texas, however, has only recently begun to address this problem. In 1973, the Texas Department of Mental Health and Mental Retardation and Sam Houston State University published the Project Camio study of the mentally retarded offender (MRO) in Texas. This extensive eight-volume research project made numberous recommendations concerning legislative and service delivery to the MRO. Unfortunately, only a few of these recommendations have been acted upon in the past three years. Among the

reasons for this inaction are lack of funds to provide needed services, lack of service expertise, confusion over legislative mandates, and, perhaps most important, lack of advocacy for the mentally retarded juvenile offender. None of these reasons, however, provides justification for ignoring the needs of these children any longer.

At this time, existing services for a mentally retarded child in trouble with the law are commitment to the Texas Youth Council (despite the fact that this violates Section 30 of the TYC Act, it has, until recently, been an accepted practice), commitment to a state school for the retarded or to a state hospital, incarceration in a detention facility, or release to the streets.

There is common agreement that the facilities of the Texas Youth Council do not provide proper therapeutic or habilitative care of mentally retarded juveniles. State schools (with the exception of Mexia which has a special detention facility) and state hospitals are not organized to care for them either. In fact, this population occasionally is a real threat to the safety of other residents of these institutions.

Juvenile detention facilities are more or less holding centers, providing little more than custodial care. It is indeed a tragedy that, due to the lack of other resources, some mentally retarded juvenile offenders remain incarcerated in juvenile detention facilities for months at a time. Release to the streets, often the very environment which produced antisocial behavior in the first place, is no solution at all. It only perpetuates the cycle of frustration, antisocial behavior, crime, arrest, and incarceration.

Clearly, none of the existing service options for the mentally retarded juvenile offender is appropriate. Further, each of these options has discernible characteristics which are detrimental to the therapeutic habilitation of the mentally retarded juvenile offender (MRJO).

In late February, 1976, the Texas Department of Mental Health and Mental Retardation convened a Task Force on Services for Mentally Retarded Juvenile Offenders. Assuming a philosophical stance which affirmed treatment at the community level, the use of the least restrictive alternatives, and the development of a continuum of services to support these positions, the Task Force published a report outlining priorities for the treatment of the mentally retarded juvenile offender.

In this report, the Task Force established the following as the first priority:

> PRIORITY #1 - Therapeutic programming for the mentally retarded juvenile offender should be provided by region in community operated facilities of the smallest feasible size where such facilities are understood to be exclusive of state schools, state hospitals, and Texas Youth Council facilities within the region. A full continuum of facilities/programs should accomodate the needs of all mentally retarded juvenile offenders regardless of severity of behavior. . . (Report of the Task Force, 1976, 4).

Subsequent to the publication of this report, it was decided that a pilot program of services for MRJO's would be developed and delivered in Harris County. The Texas Department of Mental Health and Mental Retardation made a grant to the Mental Health and Mental Retardation Authority of Harris County (MHMRA) for the purpose of developing a service plan and program design. This document is the result of that action.

MHMRA, realizing that such an undertaking would require the expertise of several different disciplines and the cooperation of other community agencies, also formed an Interagency Task Force consisting of Eugene Williams, M.H.A., Executive Director of MHMRA; James R. Hale, Ph. D., Director for Mental Retardation Services of MHMRA; R. O. D. Schoenbacher, Chief Probation Officer of Harris County Juvenile Probation Department; Gene Lege, Director of the Harris County Child Welfare Unit; The Honorable Criss Cole, Judge of Juvenile Court #3; Frank Borreca, Ed. D., Executive Director of Harris County Center for the Retarded; Katie Harrop, Community Agency Coordinator, Region IV Education Service Center, and William B. Schanpp, Executive Director of the Houston Association for Retarded Citizens.

In late May of 1976, this second Task Force met initially and immediately began to formulate this document. This plan represents the thinking, the commitments, and the hopes of the Interagency Task Force members and the agencies which they represent.

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Philosophical Orientation: A Statement of Rights

As separate and distinct problems, both mental retardation and criminal behavior present complex sociological and therapeutic difficulties. When they are viewed collectively, a unique and perplexing array of service development and delivery problems arise, and confusion results. The criminal justice mentality, with its roots in an adversary system, together with a general ignorance of mental retardation oftentimes is insensitive to the needs of a mentally retarded juvenile. The therapeutic mentality, with its occasional unfortunate bent toward paternalistic altruism, together with its ignorance of criminal behavior is oftentimes frightened of the mentally retarded juvenile offender.

The positive coordination and cooperation of both mentalities for the fair and therapeutic habilitation of the mentally retarded juvenile offender is a new and long overdue occurrence. Yet, because of the basic differences in thinking and the newness of the cooperative relationship, abuse of the rights of the mentally retarded juvenile offender may result. Therefore,

the Interagency Task Force believes that a Statement of Rights placed early in this document may serve to protect and preserve the rights of those mentally retarded juveniles who will subsequently benefit from its findings.

The basic rights of all mentally retarded persons are aptly described by the American Association on Mental Deficiency.

> Mentally retarded citizens are entitled to enjoy and to exercise the same rights as are available to non-retarded citizens, to the limits of their ability to do so. As handicapped citizens, they are also entitled to specific extensions of, and additions to, these basic rights, in order to allow their free exercise and enjoyment. When an individual retarded citizen is unable to enjoy and exercise his or her rights, it is the obligation of the society to intervene so as to safeguard these rights, and to act humanely and conscientiously on that person's behalf.

Basic Rights

I. The basic rights that a retarded person shares with his or her non-retarded peers include, but are not limited to, those implied in "life, liberty, and the pursuit of happiness," and those specified in detail in the various documents that provide the basis for governing democratic nations. Specific rights of mentally retarded persons include, but are not limited to:

   A. The right to freedom of choice within the individual's capacity to make decisions and within the limitations imposed on all persons.

   B. The right to live in the least restrictive individually appropriate environment.

   C. The right to gainful employment and to a fair day's pay for a fair day's labor.

   D. The right to be part of a family.

   E. The right to marry and have a family of his or her own.

   F. The right to freedom of movement, hence not to be interned without just cause and due process of law, including the right not to be permanently deprived of liberty by institutionalization in lieu of imprisonment.

G. The right to speak openly and fully without fear of undue punishment, to privacy, to the practice of a religion (or the practice of no religion), and to interact with peers.

Specific Extensions

II. Specific extensions of, and additions to, these basic rights, which are due mentally handicapped persons because of their special needs, include, but are not limited to:

A. The right to a publicly supported and administered comprehensive and integrated set of habilitative programs and services designed to minimize handicap or handicaps.

B. The right to a publicly supported and administered program of training and education including, but not restricted to, basic academic and interpersonal skills.

C. The right beyond those implicit in the right to education described above, to a publicly administered and supported program of training toward the goal of maximum gainful employment, insofar as the individual is capable.

D. The right to protection against exploitation, demeaning treatment, or abuse.

E. The right, when participating in research, to be safeguarded from violations of human dignity and to be protected from physical and psychological harm.

F. The right, for a retarded individual who may not be able to act effectively in his or her own behalf, to have a responsible impartial guardian or advocate appointed by the society to protect and effect the exercise and enjoyment of these foregoing rights, insofar as this guardian, in accord with responsible professional opinion, determines that the retarded citizen is able to enjoy and exercise these rights (Mental Retardation, 1973, 56-58).

In addition to these rights, the Interagency Task Force saw the need for the delineation of certain additional rights that have specific importance in serving the mentally retarded juvenile offender. The following

list of rights represents the therapeutic and administrative perspective of the Task Force.

Additional Rights

- The right to possess and exercise the same human and legal rights as those persons with average intelligence.
- The right to special consideration and assistance in the maintenance and actualization of all human and legal rights.
- The right to live in an environment free of those noxious physical, psychological, and sociological influences which promote criminal and other forms of antisocial behavior.
- The right to fail as it pertains to the dignity of risk and promotes individual growth.
- The right to care and treatment from those whose philosophical emphasis is therapeutic and habilitative and not punitive.
- The right to care and treatment in his or her own community where there is easy access to family and a normalized existence.
- The right to a complete continuum or appropriate services delivered in a coordinated manner befitting each individual's needs.
- The right to be free from any administrative system or protocol which prohibits or frustrates the provision of a needed service.
- The right to a diagnosis and treatment planning philosophy that places emphasis on each individual's well-being and needs as opposed to placing emphasis or undue reliance on administrative protocol.

The Task Force is dedicated firmly and completely to the protection and preservation of these rights as fundamental principles of philosophical perspective and service delivery.

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Statement of Need

This section consists of brief overviews of relevant studies of the incidence of mentally retarded juveniles (MRJ) with criminal and/or antisocial behaviors. It summarizes the findings of four studies: Project Camio Volume Five - The Mentally Retarded in a Juvenile Correctional Institution (1973); Project Camio Volume Six - The Delinquent in a State Residential Facility for the Mentally Retarded (1973); Report of the Task Force on Services for Mentally Retarded Juvenile Offenders (1976; and finally, the incidence findings of the Interagency Task Force on Services for Mentally Retarded Juvenile Offenders (1976). Although each of these studies utilizes a different methodology for incidence determination and, on some occasions, is not completely reliable, it is believed that, collectively, they present a foundation for assessing the incidence and therapeutic needs of the MRJ who exhibits antisocial behaviors.

It should be noted from the beginning that the antisocial MRJ has presented special therapeutic problems to service providers, and, therefore, incidence determination at best is difficult and at worst is of questionable reliability. This underscores the close correlation between a general lack of a specialized service and a lack of reliable needs assessment data on the population in need of that specialized service. Simply put, due to ignorance and a general lack of programmatic expertise, no specialized services exist in Texas for the antisocial MRJ. Therefore, there is no served population to survey and no waiting list to analyze. Hence, a significant assessment problem exists.

The Mentally Retarded in
A Juvenile Correctional Institution
(Project Camio Volume Five)

This study surveyed all newly admitted juveniles to the Texas Youth Council between September, 1969, and August 31, 1970. The resultant sample consisted of 1,666 juveniles of which 1,491 were males and 176 were females.

Utilizing a Full Scale IQ of 69 or less on the Wechsler Intelligence Scale for Children (WISC) as a base criterion, this survey found that 192 males (12.9%) and 29 (16.5%) females in the sample were mentally retarded. This indicates that approximately one out of every seven juveniles committed to the Texas Youth Council has an IQ below 70.

It was also found that a majority of MRJ's, regardless of sex, were minority group members. Approximately nine out of every ten MRJ's, regardless of sex, were either Black or Mexican-American; while of the non-retarded group, only six out of every ten males and three out of every ten females were minority members. Further it was found that the MRJ had poorer school

attendance, came from more financially impoverished families, and came from larger families than their non-retarded counterparts. However, a study of delinquent history demonstrated that, in the area of delinquent acts, mentally retarded delinquents are more similar to their non-retarded counterparts than they are dissimilar.

This study concluded:

(1) The high incidence of mentally retarded youngsters in the Youth Council is related to the absence of diversionary options available to the juvenile court (Strategies for the Care and Treatment of the Mentally Retarded Offender, Project Camio, I, 37; cited hereafter as Project Camio).

(2) The Youth Council is probably in violation of the Youth Council Act (Section 30) since it specifically requires the return of "feeble minded" youngsters to the committing court for appropriate disposition (Project Camio, I, 38).

The Delinquent in a State Residential Facility for the Mentally Retarded (Project Camio Volume Six)

This study screened all new admissions for mental retardation to the Texas Department of Mental Health and Mental Retardation to determine the number of delinquent admissions. Individuals who (1) were non-ambulatory, (2) had IQ's below 35, (3) had profound sensory and physical disabilities, or (4) were below 10 years of age were excluded. This exclusion was based on the theory that in the unlikely possibility that an individual fitting any one of the above excluding criteria were guilty of a criminal act, this individual would automatically be diverted from the criminal justice system. This process produced a sample of 430 subjects composed of 362 juveniles and 68 adults.

Two criteria were developed to define delinquency among the subjects of the sample. The first criterion entailed a determination as to whether a subject had been formally processed through the criminal justic system prior to admission to a state residential facility. The other criterion consisted of an incidence identification of antisocial or delinquent acts committed while in residence at a state facility. These acts, defined as incorrigibility, included such behaviors as aggressiveness, petty thievery, lying, and other disruptive behaviors.

Antisocial behavior in the form of temper tantrums occur in at least one out of every four individual studies. Lying, another common behavior, was exhibited by one-third of the juveniles. The study found that assaultive behavior was characteristic of one out of every four juvenile males and approximately one out of every seven juvenile females. This behavior was primarily directed at other patients. Other common antisocial behaviors included theft, heterosexual acting out, and sexual aggressiveness of an assaultive nature.

This study concluded that antisocial behavior was a significant problem among new admissions to state facilities and recommended the development of special facilities for the acting-out retardate as one solution for the problem, while also recommending that great care must be exercised in assuring that the civil liberties of these individuals are not violated by such segregative policies (Project Camio, I, 45).

Report of the Task Force on

Services for Mentally Retarded Juvenile Offenders

Although this report addresses the general problem of the MRJ offender in Texas with numerous recommendations on the establishment of a state-wide service system, the primary focus of this document will be on the section entitled "Extent of Need for Services" which is reprinted here in its entirety.

Extent of Need for Services

A. Definitions

Mental retardation means significantly subaverage general intellectual function existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Offense against the person means abuse or assault of an individual. Examples include murder, battery, rape, etc.

Offense not against the person means such acts as burglary, theft, destruction of property, etc.

Offender means a person who has been accused of committing an offense and does not require that formal changes have been filed.

B. Projected Mental Retardation Population

Available Data - based on statistical data obtained from the Department of Public Safety for one year and certain additional assumptions, the following in-need population was identified.

	Age		
	0-14	15-17	Total
All Offenders	107,495	147,099	254,594
Mentally Retarded Offenders	10,750	14,710	25,460

This figure of 25,460 is subject to a number of limitations:

1. The definition of mental retardation was IQ less than 69.

2. The Texas Youth Council has indicated that its policy is to provide services for individuals whose IQ is 59 and above.*

3. This figure is based only on certain felony offenses referred to as "index crimes." Index crimes include murder, manslaughter, rape, robbery, assault, burglary, larceny, and auto theft.

4. The Department of Public Safety figure did not include misdemeanors and "status crimes" which would substantially increase the "in-needs" population from the present projected population.

Given the present limitations from which to arrive at a projected "in-need" population, the Interagency Task Force decided that the figures are probably a conservative estimate and that the "in-need" population is considerably higher. However, the recommended alternatives for service delivery systems to follow are sufficiently feasible to provide varying levels of services depending upon the identified need.

Although not included as a part of the final report, the following table provides incidence projections by age and by service need for Harris County. The methodology utilized above also applies to these projections.

* According to a policy directive approved at the January 15, 1976, meeting of the Board of Directors, Texas Youth Council, the IQ score should be 60 and above.

Estimated Number of Retarded Juvenile Offenders
in Harris County*

	Ages		Total
	0-14	15-17	
Total	2,060	2,820	4,880
Needs			
24-Hour Care	103	282	385
Alternative Living	206	564	770
Screening, Referral & Evaluation	2,060	2,679	4,739
Outpatient Care	206	282	488
Vocational Training	0	2,820	2,820
Special Education	2,060	2,820	4,880
Day-Evening Program	1,030	1,410	2,440

*TDMHMR Projections - 1976

The primary recommendations of this report emphasized the principles of the least restrictive service alternative and the availability of services in the MRJ's own community.

Harris County Incidence of Mental Retardation:
Juvenile Probation and Child Welfare

In order to refine the incidence findings, the MR case loads of the Harris County Juvenile Probation Department and the Harris County Child Welfare Unit were surveyed. The survey identified a total population of 151 juveniles of which 114 were males and 37 were females. Summaries of the following characteristics are presented on the following pages: age, ethnic origin, Juvenile Probation and Child Welfare classes, mental retardation level, primary presenting problem, and ideal treatment plan.

Of particular interest is the Ideal Treatment Plan section. It indicates the strong and fairly equal (as far as numbers of clients in need are concerned) needs for Day Programs, Minimum Supervised Residence, and Maximum Supervised Residence. It should also be noted that the survey indicated a great need for pre-vocational and vocational training.

MENTALLY RETARDED JUVENILES
Incidence Survey
HARRIS COUNTY JUVENILE PROBATION DEPARTMENT
and
HARRIS COUNTY CHILD WELFARE UNIT
6/75 to 6/76

Sample Total	151
Sex	
Males	114
Females	37
Age	
10-13 years	39
14-17 years	106
Unknown	6
Ethnic Origin	
Anglo	48
Black	77
Mexican-American	26
Juvenile Probation Class	
Delinquent	77
CHINS	41
Custody	10
Non-custody	22
Unknown	1
Mental Retardation Level	
Over 60	106
51-59	31
31-50	13
Below 30	1
Primary Presenting Problem	
Danger to Self	54
Danger to Society	36
Danger to Self and Society	42
Other	19
Ideal Treatment Plan	
Outpatient Care	6
Day Program	47
Minimum Supervised Residence	59
Maximum Supervised Residence	39

MENTALLY RETARDED JUVENILES
Incidence Survey
HARRIS COUNTY JUVENILE PROBATION DEPARTMENT
6/75 to 6/76

Sample Total	111
Sex	
Males	94
Females	17
Age	
10-13 years	24
14-17 years	82
Unknown	5
Ethnic Origin	
Anglo	28
Black	63
Mexican-American	20
Juvenile Probation Class	
Delinquent	72
CHINS	39
Mental Retardation Level	
Over 60	85
51-59	15
31-50	11
Below 30	None
Primary Presenting Problem	
Danger to Self	44
Danger to Society	27
Danger to Self and Society	28
Other	12
Ideal Treatment Plan	
Outpatient Care	3
Day Program	40
Minimum Supervised Residence	41
Maximum Supervised Residence	27

MENTALLY RETARDED JUVENILES
Incidence Survey
HARRIS COUNTY CHILD WELFARE UNIT
6/76

Sample Total	40
Sex	
Males	20
Females	20
Age	
10-13 years	15
14-17	24
Unknown	1
Ethnic Origin	
Anglo	20
Black	14
Mexican-American	6
Child Welfare Unit Class	
Delinquent	5
CHINC	2
Custody	10
Non-custody	22
Unknown	1
Mental Retardation Level	
Over 60	21
51-59	16
31-50	2
Below 30	1
Primary Presenting Problem	
Danger to Self	10
Danger to Society	9
Danger to Self and Society	14
Other	7
Ideal Treatment Plan	
Outpatient Care	3
Day Program	7
Minimum Supervised Residence	18
Maximum Supervised Residence	12

MENTALLY RETARDED JUVENILES

Incidence Survey

HARRIS COUNTY JUVENILE PROBATION DEPARTMENT
and
HARRIS COUNTY CHILD WELFARE UNIT

Correlation of Ideal Treatment Plan

with Mental Retardation Level

Needs of Juveniles with an IQ of 60 and Over:

Outpatient Care	6
Day Program	35
Minimum Supervised Residence	37
Maximum Supervised Residence	28
Total	106

Needs of Juveniles with an IQ of 59 and Below:

Outpatient Care	0
Day Program	12
Minimum Supervised Residence	22
Maximum Supervised Residence	11
Total	45

Conclusions

As was noted in the beginning of this section, mentally retarded juvenile offender incidence assessment is difficult. The wide discrepancies between studies cited dramatically bear this out. Perhaps the most striking inconsistency lies within the contrast of the Texas Department of Mental Health and Mental Retardation projections for Harris County and the surveys of the current MR population at Harris County Juvenile Probation Department and Harris County Child Welfare Unit. Whereas TDMHMR projected 4,880 mentally retarded juvenile offenders for Harris County, only 151 actual mentally retarded juvenile offenders were identified. Taken at face value, this means that only 3% of the projected population has been identified or that there are more than thirty-two times as many mentally retarded juvenile offenders in Harris County as is reflected in the probation and welfare case loads.

The Interagency Task Force is inclined to view the TDMHMR findings as overestimates and, as projections, exceeding the actual number of mentally retarded juvenile offenders in Harris County. This opinion is based not only upon the questionable methodology used in projecting incidence but also upon the disproportionate number of retarded juveniles projected for Harris County. Should the TDMHMR figures for this latter projection be accurate, of a county-wide population of approximately 12,000 mentally retarded juveniles, 4,880 or 40.6% would be charged with criminal offenses. It is difficult to believe that nearly half of the mentally retarded juveniles in Harris County are offenders.

While the Task Force believes the TDMHMR projections to be excessive, it views the incidence findings of the probation and welfare case loads to be an underestimate with as questionable a reliability as the TDMHMR projections. Therefore, it is the considered opinion of the Task Force that, while the incidence of mentally retarded juvenile offenders in Harris County is not subject to precise assessment at this time, this population does exist in significantly high numbers.

The Task Force is in agreement with the finding of the Project Camio studies that Texas Youth Council facilities, state schools, and state hospitals are inappropriate settings for the therapeutic habilitation of the mentally retarded juvenile offender.

The Task Force takes note of the especially high incidence of ethnic minority members in the Texas Youth Council and Harris County Juvenile Probation Department and Harris County Child Welfare Unit MR populations (i.e., 90%, 75%, and 50%, respectively). Although there is general agreement that there is a high correlation between poverty and mental retardation and poverty and minority groups, it should be noted that IQ tests are often not culture free and may be biased against Blacks and Mexican-Americans. Therefore, the Task Force strongly believes that special care should be taken in the assessment and possible subsequent diagnosis of mental retardation for individuals within these groups.

The Task Force takes note of the high prevalence of antisocial behavior in state schools (Project Camio, Volume Six), and, while it does not believe state schools provide a proper setting for the mentally retarded juvenile offender, it intends to seek the advice of state school personnel experienced in dealing with such behavior.

As noted earlier, the Task Force takes exception to the incidence projections of TDMHMR. However, it applauds the TDMHMR recommendations concerning "community based care" and "the principle of least restrictive service alternative."

In viewing the incidence findings of the Harris County Juvenile Probation Department and Harris County Child Welfare Unit, the Task Force finds the following facts to be of particular programmatic interest.

1. Males comprise in excess of two-thirds of the sample.
2. In excess of two-thirds of all juveniles surveyed fall between the ages of fourteen and seventeen years.
3. In excess of 67% of all juveniles surveyed had IQ's above 60, with 20% falling within the 50 to 59 IQ range.
4. In excess of 35% of those surveyed were a danger to themselves.
5. In excess of 23% were a danger to society.
6. In excess of 27% were both a danger to self and to society.
7. Although the greatest categorical service need is "Minimum Supervised Residence," there is significant need for day programs and maximum supervised residential care.

The Mentally Retarded Juvenile Offender: A Community Service Structure

This section describes in detail the proposed Harris County service structure for a pilot program for the therapeutic and habilitative care of the mentally retarded juvenile offender. This program represents a design for a special combination of existing resources altered slightly to fit the specific needs of the MRJO and recommended additions of new services. This unique system provides a solid foundation for quality service while allowing the flexibility necessary for a developmental pilot program. Included in this section are the following sub-sections:

A. Service Principles

B. Clientele Priorities and Definition

C. Juvenile Court and Juvenile Probation Procedures

D. Diagnosis, Evaluation, and Treatment Planning

E. Outpatient Care

F. Residential Treatment Program

G. Proposed Residential Expansion

H. Evaluation

A. SERVICE PRINCIPLES

In keeping with the rights outlined in Section 2 of this document, the Task Force utilized the following principles in developing services for the MRJO.

All service components must function in harmony to promote collectively the maximum feasible continuum of care.

The proposed continuum of services for the MRJO represents a pilot program. It is, therefore, experimental and, thus, requires an extraordinary service commitment on the part of all involved agencies.

Service provision must adhere to the principle of normalized care.

The principle of the least restrictive alternative of service must be utilized in the development of treatment planning and juvenile court recommendations.

Individualized care must be insured through the development of residential, educational, and partial care facilities of the smallest feasible size.

Cost effectiveness must be insured through maximum utilization of existing service resources.

These principles represent the foundation upon which the following continuum of services is to be developed: juvenile court procedures, diagnosis, evaluation, treatment planning, outpatient care, and residential care.

B. CLIENTELE PRIORITIES

As this is a pilot program necessitating a finite budget, the Task Force has categorized MRJO's into three distinct populations. According to the severity of need, these categories are ranked into the following priorities.

First Priority: (a) Those MRJO's (ages 14 through 17) who have come into contact with any facet of the juvenile justice system and who are a danger to themselves and/or society. (b) Those MRJO's (ages 10 through 17) who have come into contact with any facet of the juvenile justice system and who are a danger to themselves and/or society.

Second Priority: (a) Those MRJO's (ages 10 through 17) whose antisocial behavior causes them to be a danger to themselves and/or society, who have not had contact with any facet of juvenile justice system.

Third Priority: Those mentally retarded children (ages 1 through 17) whose behavior and/or environment indicate a potential for, or involvement in, antisocial behavior.

According to Texas statutes set forth in the Mentally Retarded Persons Act, a mentally retarded person is any person, other than a mentally ill person, so mentally deficient from any cause as to require special training, education, supervision, treatment, care or control for his own or the community's welfare.

In order to refine this definition, the American Association for Mental Deficiency definition for mental retardation shall receive emphasis. It states that

Mental retardation refers to substantially sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

In accordance with certain of the rights in Section 2 of this document, these definitions shall be utilized with humane flexibility. Simply put, the best interests of the child supercede the abuse, direct or indirect, of administrative protocol.

In order to clarify these priorities further, the chart below provides some general behavioral characteristics and service needs for each priority.

Priority	Type of Behavior	Service Need	Example of Offense
First Priority	EXTREME: Violent behavior, impulsive, little or no self control	Intensive Residential care with behavior modification	Crimes against persons
Second Priority	MODERATE: Inappropriate behavior, not a physical threat to people	Halfway house or day program setting with training and some behavior modification	Petty theft, mild malicious mischief
Third Priority	MINIMAL: Mild or no behavior problem	Outpatient counseling, foster home	Status offense

It has been noted earlier in this report that more than two-thirds of the juveniles surveyed fell between the ages of fourteen to seventeen years. In keeping with this finding, the highest service priority shall be given to this age group. It should be noted, however, that this targeting of an age group is a general guideline and not a rigid dictum.

These priorities, while providing a specific target population of those juveniles with the greatest need (First Priority), allow the flexibility to address the needs of juveniles with fewer problems (Second and Third Priorities) as funds are available. This is important in that juveniles falling into the second, and even the third, priority populations are continually at great risk of reaching first priority status if they are not served in time.

C. JUVENILE COURT AND JUVENILE PROBATION DEPARTMENT

This sub-section shall briefly describe the procedures to be utilized by the Juvenile Justice System in serving the MRJO.

There are basically three referral sources from whence the Probation Department receives the children that will be in custody. They are law enforcement, parents, or public and private agencies.

All new referrals are processed through the Intake Division where they are divided between two teams, one of these teams handles children taken into custody for alleged felony offenses and the other team handles children charged with misdemeanors and children classified as Children in Need of Supervision (CHINS).

Each team goes through the following procedure:

1. Immediately brief the case
2. Immediately contact the parent or guardian
3. Schedule an appointment with the parent or guardian as soon as possible
4. Immediately interview the child

5. Contact school as necessary
6. If necessary, assist in facilitating emergency medical or psychological treatment
7. Explain the Juvenile Court process
8. Release and refer as necessary
9. Have parents sign "Conditions for Release" form
10. Submit a Court Investigation Report to the District Attorney

If a child is already on probation and is re-referred to the Probation Department, the Community Unit Probation Service (CUPS) worker will follow the same basic procedure.

If, during the course of conducting a Court investigation, the Juvenile Probation Officer has reason to believe that a child may be mentally retarded, the officer shall present these findings to the Juvenile Court in written form. This report to the Court shall include a social study, a Full Scale IQ of less than 60, or any other clinical criteria which may indicate mental retardation.

The decision to report such findings to the Court must be based on testing results of two evaluations administered by two different agencies within the last year. This testing shall be coordinated with Diagnostic Services of Juvenile Probation Department.

Based on these findings, the Court may then order an application alleging the child to be mentally retarded be filed. This can only be done if there is a pending delinquency or CHINS petition. The Chief Court Administrator or a Court Administrator shall file or cause to be filed an application for a mentally retarded child.

After the filing of an application, the Juvenile Court may order a diagnosis and evaluation be made by TDMHMR through the local authority or any other appropriate agency approved by the Court.

The Court Coordinator, on notification by the applicant, shall prepare service on the application for the child and parents and shall set the hearing at the earliest possible date. The child shall be represented by an attorney at the hearing on the application. The process server of the Juvenile Court shall serve the parents and the child with notification of the hearing. The date, time, and place of the hearing shall be shown on the application.

The Court Coordinator shall notify the local MHMRA of the order for diagnosis and evaluation and the date of the hearing. It shall be the responsibility of the Probation Officer to follow through with the responsibilities outlined in the order for diagnosis and evaluation.

After physical transfer of the child from the Probation Department to the appropriate agency, the responsibility of the Probation Officer to the child is terminated until treatment is completed unless otherwise specified. If contact is temporarily terminated, the Probation Officer shall re-establish contact with the child after treatment is completed and set the case back on the docket for disposition of the delinquency of CHINS petition.

If it appears to a Child Welfare Unit worker during the course of a welfare investigation or in the course of servicing a child in their custody that the child may be mentally retarded, the Child Welfare worker shall then consult with the Juvenile Probation Department as to whether or not a petition can be filed. If filing is advisable, a referral shall then be made

to the Juvenile Probation Department for filing of the petition. The Probation Officer shall then prepare the case for the Court according to the procedures developed by the Probation Department.

It shall be the prerogative of the Juvenile Court at the hearing on the application to place the child in the custody of the agency which can offer the most service to the child for his treatment, care, and habilitation.

The procedures outlined above represent standard procedures for the Juvenile Courts and Juvenile Probation Departments. These procedures are in full compliance with Texas law and are adequate to meet the judicial needs of the MRJO.

Recommendations:

1. Continue the use of the existing Juvenile Court and Juvenile Probation procedures.
2. Publish a synopsis of this document detailing the proposed expanded service capabilities.
3. Distribute the synopsis to the Juvenile Courts and other relevant personnel.
4. Convene an interdisciplinary team to review, evaluate, and make specific policy and procedural recommendations for the improvement of the care of the MRJ's in the Harris County Juvenile Detention Home.
5. Provide inservice training for probation officers and child welfare workers in the unique problems and specific therapeutic needs of the MRJO.

D. DIAGNOSIS, EVALUATION, AND TREATMENT PLANNING

In the event that the Juvenile Court determines that the Mental Health and Mental Retardation Authority of Harris County (MHMRA) is the proper agency to serve the child and subsequently places the child in MHMRA's custody, the following procedure for diagnosis, evaluation and treatment planning shall be utilized.

Step 1: Upon conferring with MHMRA as to the best available placement, the Juvenile Court so orders the placement of the child in MHMRA's custody.

Step 2: Within thirty days of the initial placement date, MHMRA shall perform a comprehensive diagnosis and evaluation.

MHMRA shall also design a detailed individual treatment plan for the child. This activity shall be a joint function of an interdisciplinary team consisting of the following professionals:

a. Medical Doctor

b. Special Education Teacher or Educational Diagnostician

c. Psychologist

d. Master of Social Work

e. Speech Pathologist

f. Pre-vocational Counselor

g. Clinical Nurse

h. Parent or Guardian of the MRJO

Other professionals (such as an Occupational Therapist, Physical Therapist, Recreational Therapist, Dentist, etc.) shall be called upon as necessary.

Step 3: The Treatment Plan shall be re-evaluated and revised, if necessary, every ninety days.

Step 4: MHMRA shall notify the committing Juvenile Court ten days prior to releasing the child from its custody.

This Diagnosis, Evaluation and Treatment Planning procedure shall be utilized without exception for every mentally retarded child committed by the Court to MHMRA.

Recommendations:

1. Great care should be taken to avoid faulty diagnosis. The limitations of Intelligence Quotient testing are numerous and, therefore, should be utilized with an awareness of its faults (i.e., it is not culture free; it is subject to great fluctuation on occasion, etc.).
2. The Diagnosis, Evaluation and Treatment Planning portion of the MRJO service continuum is vital to the effective direction of the treatment of the MRJO, and, therefore, it is recommended that at all times the person performing this service strive diligently for excellence in the performance of duties.

E. OUTPATIENT CARE

Occasionally, the needs of an MRJO can best be met on an outpatient basis. In keeping with the principle of "the least restrictive service alternative," outpatient care should be utilized whenever it is sufficient to meet the needs of the MRJO.

MHMRA provides outpatient care through a de-centralized service delivery system of six Community Service Centers (CSC). These CSC's are

strategically located in various communities in Harris County. They provide the usual outpatient services such as information and referral, counseling, group therapy, and recreation. These services are invaluable to the MRJO who does not require more intense forms of treatment. They are of even greater importance to the MRJO who has graduated from a residential care facility and requires follow along outpatient services.

It should be noted that outpatient care is delivered by community agencies other than MHMRA. These resources will be utilized as is appropriate. It should also be noted that, due to the continual contact that Juvenile Probation Officers and Child Welfare case workers have with MRJO's, these professionals can play an important role in outpatient care by providing direction and counseling.

Recommendations:

1. MHMRA should provide its CSC staff with inservice training in the unique problems and specific therapeutic needs of the MRJO.
2. The Juvenile Probation Department and the Child Welfare Unit should provide its staff with inservice training in the unique problems and specific therapeutic needs of the MRJO.
3. The CSC's should be required to give high service priority to the MRJO, especially in the area of follow along services.
4. All relevant parties should be apprised of the existence, function, and location of each CSC.

F. RESIDENTIAL TREATMENT PROGRAM

This sub-section shall describe the residential treatment program to

be utilized in caring for the MRJO in community-based halfway house facilities. The primary goal of this residence is the positive habilitation and subsequent reintegration into a productive normal community setting of each MRJO. The goal will be reached by the provision of a short-term (six months to one year on the average) intensive therapeutic program which employs a developmental-educational mode of human management in meeting the individual service needs of each MRJO.

Treatment Setting

The residential Treatment Program will be delivered in houses within the community that meet the standards described in Section 5 of this document. These houses will be architecturally normal in every aspect and will be independent units. This is to say that each house will have a comfortable leisure area, bedrooms, a kitchen and dining area, indoor and outdoor recreational space, as well as space for educational pursuits. The justification for this emphasis on a normalized residence is that it is the best setting for short-term habilitation of the MRJO. No aspect of these houses shall in any way resemble an institutional setting. No facility shall have more than fifteen residents at any time.

Staff

Houses shall be staffed by a director, various case workers, a special education teacher, and an aide and shall have constant access to the Interdisciplinary Team described in sub-section D of Section 4. Staff members shall receive specialized training in the nature and specific problems of

the MRJO and in techniques for modifying the antisocial behaviors of the MRJO.

Treatment Orientation

The Treatment Plan described in sub-section D shall detail the strengths and weaknesses of each MRJO. The Treatment Plan shall propose strategies for maximizing strengths and correcting weaknesses. Emphasis shall be placed upon problems arising from both the handicapping nature of mental retardation and the environmental factors which precipitated the antisocial behavior. This Plan shall act as a guide for the individual treatment orientation of the MRJO.

The following principles will be utilized in treating the MRJO.

- Always reward appropriate behavior.
- Whenever possible ignore inappropriate behavior.
- House rules should be few in number and simple.
- Respect for the worth and rights of each individual should be fostered.
- Positive self determination and control should be instilled in each MRJO by always respecting his integrity.
- The individual families of each MRJO should, whenever possible, be an integral part of treatment.
- Emphasis will be placed on activities which promote camaraderie and team work.

Developmental Curriculum

A developmental curriculum is an outline of broad objectives covering developmental areas important to the achievement on the part of the MRJO of both academic knowledge and the development of competence in activities of daily living.

Communicative Development

Provides appropriate training in speaking, writing, reading, listening, and expression.

Services are provided or procured to correct structural or habitual deficits that interfere with communication.

Provides specific opportunities for the use of functional communication skills in activities of daily living.

Cognitive Development

Provides initial activities in the development of cognitive skills at the most basic developmental level.

Specialized services are provided to remediate or compensate for specific barriers to learning.

Provides opportunities for the student to evaluate the consequences of his decisions.

Social Development

Provides for the development of culturally normative behavior.

Provides opportunity for social development appropriate to the

student's chronological age.

Provides activities that promote the development of socially adaptive relationships with the opposite sex.

Activities are provided for social interaction outside the training program.

Provides programs to assist the student with clothing selection.

Provides training relating to safety in all activities of daily living.

Counseling with the student and his family concerning interpersonal conflicts or conflicts arising from other causes.

Affective Development

Develops for the student a plan for the expression of appropriate emotional behaviors.

The staff provides a warm, accepting environment that is conducive to the development of positive feelings.

Opportunities are provided for the expression of appropriate feelings by the student.

Provides for the development and enhancement of the student's self-concept through activities that promote awareness of self and the experience of success and security.

Students displaying maladaptive behavior have specified training objectives that lead to more adaptive behavior.

Records are kept of significant maladaptive behavior and of actions taken by staff as a result of such behavior.

When necessary, specialized therapeutic techniques to develop constructive adaptive behaviors are provided or procured by the program.

Sensorimotor Development

Objectives relating to development of balance and posture, locomotor skills, manipulative skills, body image, and perceptual skills.

Activities proceed from the simple to complex in logical sequence.

Activities are modified in accordance with the student's progress in motor development.

Individual plan is directed to maximizing the independence of the student.

Program directed toward employability or self-support or other meaningful occupation.

Establishing seven basic pre-vocational training programs within the facilities.

Establishing locations in the community where on-the-job training takes place.

Facilitating the placement of students in full-time employment when age and skill permit.

Obtaining sheltered work stations in industries or service locations in the community.

Further support will be provided the student by:

Helping him/her make constructive use of leisure time.

Assisting in the development of peer relationships in leisure time activities.

Maximize opportunities for independent living by minimizing disabilities.

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During the past year, MHMRA has served certain MRJO's in the Northwest Group Living Center. At this time, this residence serves mentally retarded boys with emotional disorders in the twelve-to-fifteen year age group. It has a static capability of twelve beds. This community-based facility provides normalized care and treatment utilizing a developmental model. The proposed residential treatment program described earlier is based upon experience gained at the Northwest Group Living Center.

The Northwest Group Living Center (GLC) is currently in the process of expanding its capabilities in several areas to meet the special needs of the MRJO. Among these areas are upgrading the staff (both in number and in expertise), increasing its bed capacity to include three additional emergency beds, and expanding its family counseling capability. These and other innovations at the Northwest GLC will allow this facility to treat the most difficult of the First Priority class of MRJO's.

Recommendations:

1. In order to meet the residential needs of the MRJO, MHMRA should expand its static bed capability by at least thirteen additional beds.
2. The Residential Treatment Program and the Educational Program

described above should be utilized in the pilot program.

3. The age range criteria of the juveniles at Northwest GLC should be changed to fourteen through seventeen to meet First Priority status.

4. It is recommended that the Harris County Child Welfare Unit immediately acquire additional foster homes for the MRJO's placed in its custody and for other mentally retarded children requiring this placement.

G. PROPOSED RESIDENTIAL EXPANSION

It is proposed that MHMRA utilize TDMHMR Special Project Funds and other funding sources to establish two additional residential facilities for the MRJO of First Priority status. These facilities are described below.

Group Living Center Number One

Client Eligibility

Age: Fourteen through seventeen years of age

Sex: Male

Behavior Class: Extreme to Moderate

Static Bed Capability: Eight

Dynamic Bed Capability (per twelve month period): Fourteen

Program Description: This twenty-four hour residential facility will provide comprehensive habilitative services to the MRJO and his family. It will utilize the policies, procedures, and curriculum set forth in this document.

Staffing: 1 Vocational Rehabilitation Counselor II
7 Case Worker Assistants

Group Living Center Number Two

Client Eligibility

Age: Fourteen through seventeen years of age

Sex: Female

Behavioral Class: Extreme to Moderate

Static Bed Capability: Five

Dynamic Bed Capability (per twelve month period): Eight

Program Description: This twenty-four hour residential facility will provide comprehensive habilitative services to the MRJO and her family. It will utilize the policies, procedures, and curriculum set forth in this document.

Staffing: 1 Vocational Rehabilitation Counselor II
7 Case Worker Assistants

The Interdisciplinary Team described in sub-section D above shall act as a support unit to the staff of both of these group living centers.

The annual unit cost for this program during the first fiscal year is projected at $15,385.00 per child. This cost is comparable with a similar program for the MRJO provided by ENCORE in Nebraska. It is also comparable to an annualization of the state median daily unit cost for 24-hour residential programs for mentally retarded persons.

The first year budget is designed to accomodate all necessary start up costs including extensive building renovations, furniture and equipment and household supply purchases and purchase of a vehicle. These costs will be much lower in subsequent fiscal years. Therefore, to offset these costs and to provide time for preparing the facilities for operation, most of the personnel have been budgeted to begin employment during the second and third

months of the fiscal year. The second fiscal year will show all personnel employed for the entire twelve-month period and no start up costs. Both the first and second fiscal years will require an approximate $200,000.00 operations budget.

H. EVALUATION

Sound principles of management and research dictate that human services must be evaluated for their ability to meet their specific goals. The piloting nature of this program increases the need for evaluation. As has been noted throughout this document, the MRJO presents unique problems to the service provider. Due to a lack of experience in dealing with this population, the therapist encounters numerous service unknowns. These and other factors dramatically underscore the need for continual, comprehensive evaluation of all the services mentioned above. Therefore, the following indicators will be monitored closely.

1. Number of MRJO's served in each service area
2. Cost per MRJO per service
3. Length of stay per MRJO in a residential facility

In addition, the following factors will be analyzed in detail.

1. Pre-entry case histories
2. Treatment plans
3. Therapeutic modalities
4. Client flow throughout the system
5. Client disposition
6. Recidivism rates

This evaluation methodology will be refined and expanded as the service program progresses.

Recommendations:

1. It is recommended that MRJO program evaluation be given high priority by MHMRA.
2. The independent MHMRA Human Rights Committees should diligently protect the rights of each MRJO in the service continuum.
3. It is recommended that the Research Section of the Legal Rights Resource Center of the Houston Association for Retarded Citizens undertake the responsibility for third party evaluation of the MRJO service continuum.

   It is further recommended that the findings of HARC's evaluation be transmitted to TDMHMR, MHMRA, The Interagency Task Force on MRJO's, and other interested parties.

5

Accreditation and Licensing Standards

In order to insure the safety, well being, and proper program service of the MRJO clients of the Residential Treatment Program described in Section 4, the following accreditation and licensing standards will be met:

The Texas Department of Mental Health and Mental Retardation Rules, Regulations and Standards

The Joint Commission on Accreditation of Hospital Standards For:

--Residential Facilities for the Mentally Retarded
--Community Agencies

The Department of Public Welfare Minimum Standards for Residential Treatment Centers (i.e., Intermediate Care Facilities for the Mentally Retarded)

Appropriate Life Safety Code of 1973 Certification (includes both Safety and Fire)

Appropriate Municipal or County Building Code Certification

6

Review of Funding Sources

In addition to the Texas Department of Mental Health and Mental Retardation Special Project, the following sources of funding shall be sought for individual MRJO's:

Texas Rehabilitation Commission

Supplemental Security Income

Aid for Families of Dependent Children

Intermediate Care Facilities for the Mentally Retarded

Title XX -- Department of Public Welfare

Educational Services (Region IV of the Texas Education Agency)

County Bond Funds allocated to TRIAD (a child-serving consortium composed of MHMRA, HCJPD, and HCCWU)

Texas Youth Council

The first four sources mentioned above will be sought as services are delivered to individual MRJO's.

At this time:

1. MHMRA has negotiated a $200,000 contract with DPW for Diagnosis and Evaluation. Some of these services will be available for the MRJO.
2. Region IV, Educational Service Center, has committed three Teacher Units, three certified special education teachers, and three Aides to the MHMRA MRJO Program. In addition, Cypress-Fairbanks Independent School District has committed one teacher.
3. Harris County Bond Funds have been committed for the purchase of two facilities.
4. TYC funding ($15.00 per day for residential and $3.00 per day for diagnosis and evaluation) will be provided to MHMRA for each juvenile (IQ of 60 and above) who is subject to TYC commitment and is diverted to an MHMRA facility.

7

Summary of Recommendations

I

It is recommended that the members of the Interagency Task Force on Services for MRJO's continue to meet to monitor the development and explanation of services for MRJO's and, in addition, continue to seek out and secure new sources of funds for the expansion of services to the MRJO.

II

It is recommended that continual efforts be made to preserve and protect all of the rights delineated in Section 2 "Philosophical Orientation: A Statement of Rights."

III

It is recommended that all staff members involved in serving MRJO's be made aware of the need for diligence in the protection of the rights of their clients.

IV

It is recommended that a study be made of the actual incidence of MRJO's in Harris County in order to solve some of the inconsistencies mentioned in Section 3 "Statement of Need."

V

It is recommended that the use of the existing Juvenile Court and Juvenile Probation procedures be continued.

VI

It is recommended that a synopsis of this document detailing the proposed expanded service capabilities be published.

VII

It is recommended that the synopsis be distributed to the Juvenile Courts and other relevant personnel.

VIII

It is recommended that an interdisciplinary team be convened to review, evaluate, and make specific policy and procedural recommendations for the improvement of the care of the MRJ's in Harris County Juvenile Detention Home.

IX

It is recommended that inservice training for Probation Officers and Child Welfare workers be provided in the unique problems and specific therapeutic needs of the MRJO.

X

It is recommended that great care should be taken to avoid faulty diagnosis. The limitations of Intelligence Quotient testing are numerous, and,

therefore, should be utilized with an awareness of its faults (i.e., it is not culture free; it is subject to great fluctuation on occasion, etc.).

XI

It is recommended that since the Diagnosis, Evaluation and Treatment Planning portion of the MRJO service continuum is vital to the effective direction of the treatment of the MRJO, the person performing this service strive diligently at all times for excellence in the performing of duties.

XII

It is recommended that MHMRA provide its CSC staff with inservice training in the unique problems and specific therapeutic needs of the MRJO.

XIII

It is recommended that the MHMRA CSC's be required to give high service priority to the MRJO, especially in the area of follow along services.

XIV

It is recommended that all relevant parties be apprised of the existence, function and location of each CSC.

XV

It is recommended that, in order to meet the residential needs of the MRJO, MHMRA should expand its static bed capability by at least thirteen additional beds.

XVI

It is recommended that the Residential Treatment Program and the Educational Program described in this document be utilized in the pilot program.

XVII

It is recommended that the age range criteria of the juveniles at

Northwest GLC be changed to fourteen through seventeen years to meet First Priority status.

XVIII

It is recommended that the Harris County Child Welfare Unit immediately acquire additional foster homes for the MRJO's placed in its custody and for other mentally retarded children requiring this placement.

XIX

It is recommended that MRJO program evaluation be given high priority by MHMRA.

XX

It is recommended that the Independent MHMRA Human Rights Committees diligently protect the rights of each MRJO in the service continuum.

XXI

It is recommended that the Research Section of the Legal Rights Resource Center of the Houston Association for Retarded Citizens undertake the responsibility for third party evaluation of the MRJO service continuum. It is further recommended that the findings of HARC's evaluation be transmitted to TDMHMR, MHMRA, the Interdisciplinary Task Force on MRJO's, and other interested parties.

XXII

It is recommended that all Accreditation and Licensing Standards be accepted as set forth in Section 5.

XXIII

It is recommended that all available sources of funding mentioned in Section 6 be accepted.

Conclusion

This document is an initial statement on the proposed service continuum for the MRJO of Harris County. It is a guide by which MHMRA and other agencies will chart a service course for the habilitation of the MRJO. It has addressed the prevalence of MRJO's in Harris County, a target population of MRJO's, sources and established commitments, and implementation strategies. This document has laid a foundation for the pilot phase of service development for MRJO's.

It is the intent of the Interagency Task Force to implement this plan fully (subject to TDMHMR Special Project Funding), to test the planned service methodology, and, by trial and error procedure, to produce a program design which can be replicated in other areas of the State of Texas. The MRJO experience gained in Harris County will be made available in written form to all interested parties.

Finally, the Interagency Task Force on Services for Mentally Retarded Juvenile Offenders reaffirms its commitment to the Children of Harris County

who have been ignored too long and, with a sense of optimism, looks forward to the implementation of services proposed in this document.

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