

Jay is my son. He is 25 years old. He is a handsome, charming, witty young man. He is also destructive, violent, and sexually inappropriate. He's had various diagnoses: mild mental retardation, low-functioning Asperger's Syndrome, pervasive development disorder, paranoid schizophrenia. He has been treated with countless psychiatric medications. When my husband and I could no longer physically nor mentally take appropriate care of him in our home, we sought residential placement.

Jay has lived in two separate group homes. The first one he lived in for several years. Some of the time, he seemed genuinely content. So much of his behavior depends on the staff, and how they deal with him. This has not changed. He can tell when someone likes him for who he is, or is just basically "babysitting". Staff turnover at the group home was frequent. Just when Jay would become accustomed to someone, or attached to someone, they would leave, or be moved to a different house. When new staff would then come in, they often would be blindsided by his behavior. Many times, MANY times, the home would call me, and ask me to come over to try to calm Jay down. One of the essential keys to keeping his behavior on the right track is to keep him busy. He needs to GO and DO. These needs for constant activity were not appropriately met at the group home. His weight increased to the point of obesity; he developed high cholesterol, mild diabetes, gastrointestinal reflux. He did not get appropriate physical activity. He was exposed to inappropriate television shows, movies, language, etc. (He did not learn these things in his special needs class at school; he did not learn these things in our home.) We frequently requested that he not be exposed to violent movies or violent music. While the staff with him at that time might respect our request, the next person would not be educated in Jay's case history. The care-givers staffing group homes are not required to undergo extensive training. I will always remember going to the office of the group home one day, and personally observed "training". It went something like this: "Now repeat after me: Take your medicine. It will make you feel better." The trainees repeated the sentence. Jay had his own cell phone. He would call us every night, and I could hear background noises. It was often very disturbing. More than once, I met with Jay's case worker, and requested a change in staff. He accommodated my request, but my question is, "Why did he not already know that a change was desperately needed?" I was forced to report two caregivers to the Abuse Hotline. Why did the caseworker not already know about the problems caused by these two persons? Where was the oversight?

One day Jay told me that the staff had moved his personal television to the living room because theirs was broken. When I mentioned this to the case worker, he said "They can't do that". But they did. Where was the oversight?

We became increasingly discouraged with the level of care and inconsistency of care our son was receiving at this group home. We removed him from that group home, and planned to have him live in our home, with help from one of our daughters. His intermittent violent behavior made that impossible. We sought help from the Betty Hardwick Center. We requested admission to Abilene State Supported Living Center. They told us State School would probably not take him. They told us it was like a prison

there. They steered us to another group home. Jay's stay at this group home lasted about a week. The director called me one day and said "Come get him or I am calling the police". I picked Jay up and once again brought him home. When I spoke with the director at Betty Hardwick, and told him what had transpired, he said "They can't do that". But they did. Where was the oversight? We were told the group home was required to take Jay back. We returned him to that residence. Within 24 hours, they sent him to Acadia (a local psychiatric facility). The doctors there immediately took him off all medication. Jay developed acute gastrointestinal problems, was vomiting blood, and Acadia sent him to Hendrick Hospital. They SENT him. No one went WITH him. Jay has NEVER been without direct one-on-one supervision in his entire life. Needless to say, he was scared and disruptive. When he was dismissed, we once again brought him home, and realized we MUST find an appropriate place for Jay to live, and that the obvious place was Abilene State Supported Living Center.

Even though we were discouraged at every turn from seeking this placement, we doggedly persisted. A meeting was scheduled with several people at the Betty Hardwick Center, supposedly to proceed with the paperwork for this to finally happen. When we got to the meeting, the first thing that was said was "We think your son should go to some place in South Texas that deals with behavior problems"! Just another attempt to NOT let us make use of an excellent facility here in Abilene that could serve Jay's needs. Again, we persisted.

Now Jay has been at State School for over 3 years. His demeanor and behavior remain as they have always been. He is witty, charming one minute, and the next minute he will throw his TV, punch the staff, tear their clothes, flush his wristwatch down the toilet. When necessary, staff physically restrains him. (They are actually TRAINED in proper methods of restraint.) There is a Behavior Specialist on staff that comes to the cottage to help care-givers learn to deal with this behavior. There is a Psychologist on staff who constantly monitors Jay's behaviors, number of restraints, etc., and works on methods to help staff help Jay improve problem areas. There is a Psychiatrist on staff that can adjust his medicine at any time. Jay gets daily exercise. Under the oversight of a nutritionist, Jay is no longer obese. He no longer takes medication for high cholesterol, diabetes, or reflux caused by being overweight. There are numerous opportunities for Jay to be active: a chapel, employment, a movie theater, a swimming pool, a store where he can buy items with money he has earned at his job, a diner where he can go and order his own food with money he has earned, an activity center where he can go and play video games, exercise on a treadmill or Bowflex, a trail where he can go on a golf cart and see deer, a park on the premises; he can go on community outings with a group to the zoo, mall, garage sales, to view Christmas decorations, etc. When he becomes upset with one staff, numerous others are available to switch out. When a staff person leaves employment, there is ALWAYS someone else that remains who knows Jay, and who Jay knows. He still calls us almost every night, and I often hear LAUGHTER in the background.

This is one place where I am very thankful for rules, regulations, and oversight. Since Jay has always had severe behavior problems, I was constantly afraid of the possibility of abuse (intentional or otherwise) when someone was working with him. At ABSSLC, I am confident that my son will not be abused. When a case of abuse has been alleged, it MUST be thoroughly investigated. We are made aware of every allegation when it occurs, and again after the investigation is complete. Every staff that was present at the time of the allegation is interviewed. Cameras monitor activities in the cottages, and someone monitors the cameras. (Just as an aside, please be aware when you look at statistics showing the numbers of abuse alleged at ABSSLC, MANY of them would be from our son. He has learned how to report it, and often uses this method to get rid of a one-on-one caregiver he doesn't particularly like.)

In summary, I am certain that there are many clients who can function well and be cared for appropriately in group homes. Jay is NOT one of those. We tried it. It was a dismal failure. Persons like our son deserve a safe, secure place to live. Closing ABSSLC would take that basic right away from him.