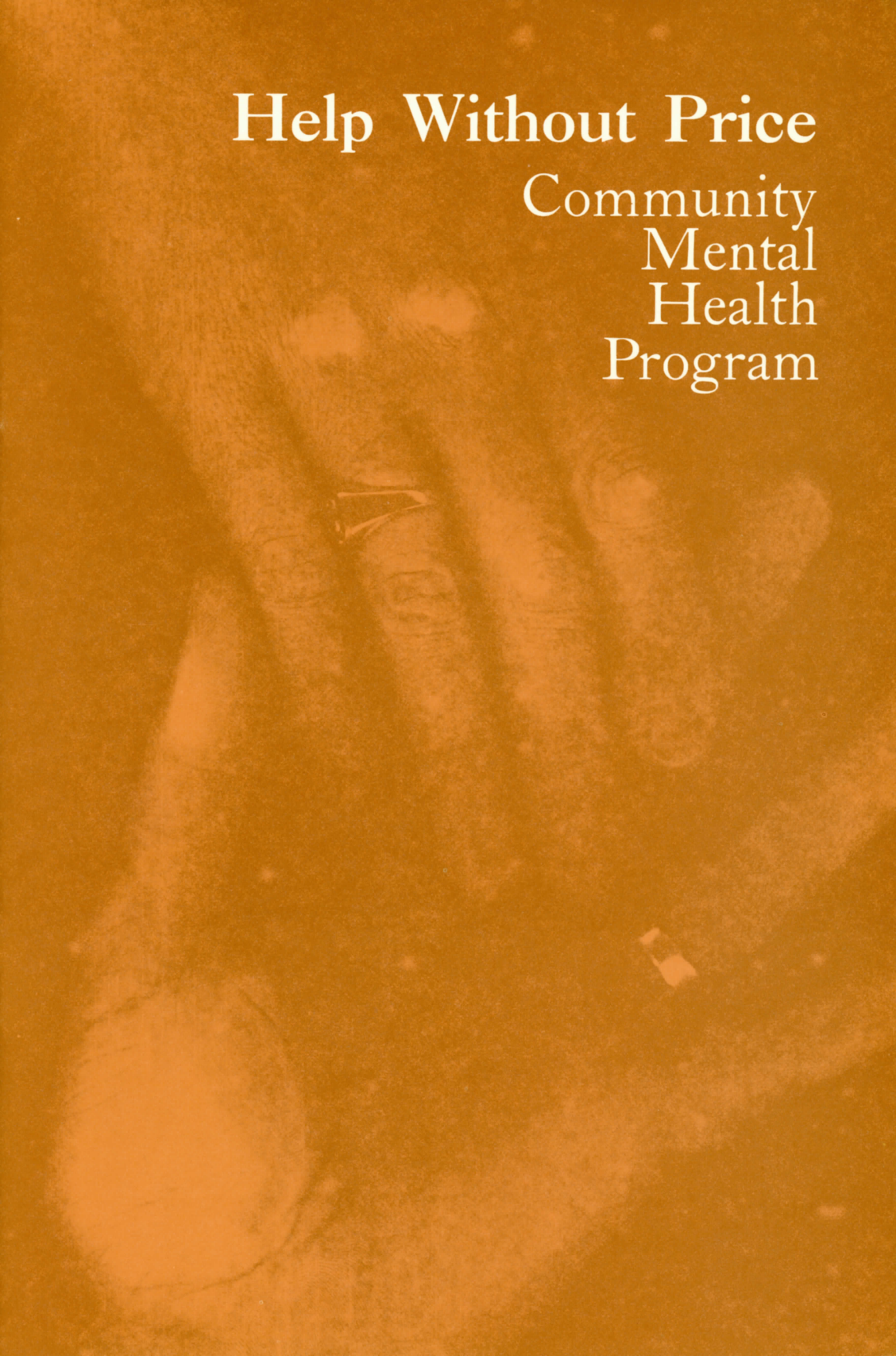

Help Without Price

Community Mental Health Program

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Introduction

The problems of living described in this pamphlet are part and parcel of the human condition made all the more acute by an increasingly complex society. How and where to get needed help is also becoming more difficult, especially for persons who cannot afford the going rates for psychological services, and whose problems and income level make them largely ineligible for community-based services.

The formation of a low-cost mental health clinic, so competently described by Mrs. Smith, represents a milestone in professional responsibility and a model for service delivery that can be replicated not only in Texas but nationally. It is innovative not only in the manner in which services are provided but also in the recognition that there exists in the United States a large number of unserved or underserved people in need of help. The willingness of a local psychology association to organize so that its members contribute one to three hours a week to the delivery of high quality services to underserved populations is commendable and represents a welcomed assumption of responsibility by the psychology profession.

The project represents the melding of an idea with the constructive use of Hogg Foundation mental health funds for the breaking of new ground in the delivery of mental health services. In years to come local professional societies of all disciplines will be faced with the problem of assisting in the delivery of services to those unable to be served from existing resources. The Austin model represents a viable approach to this problem. Mrs. Smith has, with great sensitivity, caught the flavor of the problems presented by the population served through the low-cost clinic. The problems are all too human, and the accomplishments to date should not let us lose sight of the reality that so much more yet remains to be done.

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 veryone hurts at some time. The pain may be as deep as that suffered at the loss of a close and beloved person. It may be as minor as that felt from an unkind remark.

Between the two extremes are many kinds of distress. For some people each waking morning is totally bleak, unlit by the sunlight of hope. For others the burdens of ill health, single parenthood, unhappy marriage, distasteful work, or generally poor relationships may be like weights hung around their necks.

Total happiness is an unknown for most people. Some experience it briefly and rarely.

Psychiatrists, psychologists, and others in the helping profession see multitudes of people suffering from depression—total and overall feelings of sadness and personal disability. Many of these people are married, are parents, are executives; still the pervasive emotion in their lives is one of uselessness and despair.

Many causes have been stated for the seemingly increased numbers of depressed people in our society. Some have blamed modern technology with its speeded-up processes of doing everything from preparing food to completing tasks on the job. Other have faulted the increased public concern with nuclear developments and the possibilities of war. Many consider the breakup of families to be a basic cause. The movement of people and the attendant rootlessness which evolves have been stated as primary reasons.

Bits of truth probably lie in all the statements. However, the fact remains that many people are "living lives of quiet desperation."

Stress and anxiety are common complaints in these days. Such emotions lead to physical distress or to psychological incapacity. In addition to the personal losses experienced by those people undergoing such negative emotions, the cost to society also is significant in terms of work hours lost and lack of productivity in many areas.

Who are the people needing help with their emotions?
And what might be done for them?

Such a person might be the man next door, whose job as a salesman seems dull and without lift. It might be the housewife across town, the one who battles ennui every morning to get herself out of bed to prepare breakfast and send the children off to school. Perhaps it is someone suffering from a chronic ailment; a student suddenly overwhelmed with tasks he feels he cannot finish. A person in grief. An older man or woman, isolated and frightened. Sometimes, often, a whole family is caught up in a cycle of anger and despair, tossing unhappy words around one another, likes clothes whirling in a dryer.

There are those who need some simple sense of direction or a chance to ventilate. Others are tangled into problems which have knotted around them since childhood. . . .

How do these unhappy people cope with their frustrations? In a variety of ways. Some move quickly to bottle or pill where they can find respite. Others act out their anger in ways destructive to themselves and others. Some permit the pain to settle inward, to weigh down their bodies and their spirits and to keep them heavy with feelings of hopelessness and despair.

There are some who seek help from friends. Ministers and rabbis often provide aid. Persons of means find assistance in the offices of psychiatrists, psychologists, and others.

But what of the marginal people, those who barely make it on their salaries, who almost never have enough to cover daily expenses? They cannot forego a week's groceries for an hour with a professional counselor. Often they feel trapped within their own unhappiness, wrapped in skeins of frustration which they cannot untangle.

Many people have sought assistance through community-supported mental health centers, which generally have sliding scale payments based on a person's financial status. However, the cutback of federal funds in recent years has resulted in curtailment of many services available to people of limited means. Such curtailments translate into people who are unable to obtain inexpensive services for alleviating their problems. Let's see just one of them. Come with us to one of Austin, Texas' fine restaurants.

The background music is soft. A couple at a table for two exchanges pleasantries. A dark-haired waitress, pad in hand, asks, "Do you want something from the bar? Or would you like coffee? Or tea?"

She smiles, and the man thinks, "Nice young woman. Looks pleasant. In college?"

When the entree comes, the woman butters her baked potato, looks at the waitress, and thinks, "I wonder if she's married."

To the casual observer, the scene is usual—a couple enjoying dinner, the dark-haired waitress unobtrusively bringing the wine and filling the glasses.

A customer would have to turn attention away from the food in order to see the desperation in the waitress' eyes or to note that her hands tremble ever so slightly. Such a customer might be surprised to know that the waitress is suffering from ongoing depression and that her marriage of five years is about to dissolve.

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The waitress and her plight are not unusual. What is different is the fact that in Austin she can find help before the wall of her being crumbles into rubble. And she can obtain it at a price that she can afford.

Formation of a Dream

How did such assistance come about?

Just as the longest journey starts with one step, so did this program of help begin with the concern and insight of just a few psychologists. They were having coffee together one evening when conversation turned to the

needs of people like the young waitress and her many counterparts. What could be done?

Each person had a story of calls from people who had great needs but little money. As the therapists shared experiences, they discovered that most of the people were not destitute and not well-to-do. They were the marginal people, making a small living, trying to pay their bills, trying to live their lives with some delight—and yet were caught in a great net of helplessness and despair.

Finally, one of the therapists said, "Why don't we start our own low-cost clinic?"

The question was a simple one. Implementation was intricate. No one psychologist could afford to accept a number of clients at low cost. Each one was willing to take one or two. But would there be enough psychologists who would offer one to three free hours a week and do so over a period of time?

Would the State Board of Examiners give permission to begin such a clinic? There had to be a place to offer the initial interview service; start-up money was a must, so was an intake worker, a secretary.

Answers had to be found rapidly and almost simultaneously. The small nucleus of psychologists met repeatedly. They apportioned tasks; they grew enthusiastic; they become discouraged. They were overworked, but they persisted.

A form was developed and distributed to local therapists, asking if they would be willing to donate one to three hours a week to provide low-cost therapy for one year to this group of people. When 25 positive responses were received, the planning group moved on with the next step.

The Hogg Foundation for Mental Health was approached for $15,000 in start-up funds, and a grant was made for the first year of operation. Office space remained a major obstacle (many meetings occurred with the mayor and city staff concerning space in the citywide hospital complex). The time-consuming quest was finally ended when the superintendent of the Austin State School offered space in a small house on the grounds of the School. An opening reception was held on January 20, 1981, and the Capital Area Mental Health Center was in business— first of its kind in the United States.

Services

The cups had scarcely been cleared away following the reception when the Center began its service program.

The small yellow house on the edge of the campus of the Austin State School suited the needs of the Center well. It was pleasant and homelike; coffee and tea could be made easily, and rooms off the main area could provide privacy for intake interviews.

The president of the local chapter accepted the administrative role part-time. A part-time secretary and an intake worker were hired, and an answering machine served as message taker when no person was available. Intake forms were written and revised and finally duplicated. A CPA firm donated accounting and bookkeeping service, and a local law firm agreed to provide legal services at no cost.

A Board of Directors, consisting of seven psychologists and five lay persons, was appointed to help make decisions about the Center.

Local media provided publicity. The Center was in business.

Procedure

Calls began to come into the yellow house. Each caller was invited to come to the office and to fill out a form, after which the intake worker conducted an in-depth interview. The initial interview helped to screen those clients who were appropriate for therapy and those who were not. A roster of participating psychologists was kept in the office, and clients were assigned on rotating bases. (Where a client had a particular and specific problem which was the specialty of a certain therapist, an effort was made to assign that therapist to the person in need.) With some 50

psychologists on the roster initially (and almost 70 by the end of the project's second year), the waiting time was kept at a minimum.

Clients generally were seen in the therapists' offices. They were expected to be punctual in keeping appointments and were to be terminated if they failed to do so on two occasions.

Services, it was determined, were to be short-term. If clients needed extended help, efforts were to be made for assistance elsewhere. Should the client be so severely impaired that medication was needed, then the person was to be referred to a psychiatrist for consultation. Those whose difficulties were primarily alcohol or drug-related were directed to an appropriate program.

Every person coming to the Center was to receive the same high-quality treatment that a "regular" client did. The psychologists in training—interns, advanced graduate students, Ph.D.s pending their licensure—were to be supervised carefully by experienced therapists.

The participating psychologists planned to meet on occasion to share experiences and to compare treatment modalities.

The main restrictions set up were that the clients not be referrals from the probation office and that they not be on maintenance medication. Although there were no age limitations, most clients were in the young adult group. High-risk suicidal patients were to be referred elsewhere.

Costs

Costs vary. A sliding fee scale established the guideline for determining amounts that clients pay. The lowest amount is $1 per visit. The average is $5.

Forty percent of the patients have incomes from zero to $400 a month; 39% earn from $401 to $800; 19% from $801 to $1200; and only 2% over $1200.

Overview of the Clients

The waitress described earlier needs the help the low-cost service can give. She is joined by hundreds of other people who are feeling a hunger that food cannot satisfy and a thirst which liquid cannot quench.

Have you ever wondered where they've gone? The baby boom generation, the young people who dreamed of peace, who marched for justice, who shared their hopes and living quarters, who dressed in casual manner and "did their own thing."

Are they part of the establishment, living in three bedroom, two bath homes, holding steady jobs and investing in IRAs? Do they head the Parent-Teacher Associations and the city's civic groups?

Some do, of course, Many have found their way into the establishment and, having done so, have fit into middle-class life as comfortably as they do into their tailored suits.

However, there are others still trying to "find themselves." They teeter on the thin fence between non-conformity and middle-class living. They are older now, the men thinning on top and thickening in the middle, the women looking a little tired and slightly unkempt in blouses that are wrinkled.

But even more than outward appearances are the inward confusions which mark their days. Many of them—often with bachelor's or master's degrees or even doctorates—are making their living by cleaning houses, doing carpentry, waiting tables, picking up money as they can, living precariously. Their dreams of a better world seem unfulfilled. Their hopes for a life of meaning are diminished. They suffer vague discontent. Some are now showing the effects of long-time drug use—of marijuana, amphetamines, cocaine, and alcohol. They experience mood swings, low motivation, relationship crises. Some are parents whose children frequently reflect the depressing environment in which they live.

They form the bulk of the persons seen at the Capital Area Mental Health Center. They come with various complaints.

They come because the pain they are enduring is so great that they want relief, even if relief means revelation.

One therapist described the majority of clients as those in their 30s, underemployed and depressed, experiencing a sense of loss and frustration. Many are the '60s generation caught in problems of identity.

Some of the recent problems emerging include anorexia and bulimia. Many women (especially) take the passion for thinness into an absolute compulsion for absolute thinness.

Another emerging problem is that of herpes, a venereal disease which causes serious psychological problems.

A number of the clients experience difficulties in relationships of all kinds. Some of the difficulties are subtle and long-term. Frustration often comes to these people who are coping with a career and are trying to decide if they want to pay the price that the career demands. They are frustrated, dissatisfied, unsure of their next move.

Economic problems form part of the difficulty which sends people into treatment. However, for most of the clients, problems have been incubating over a long period of time. Usually where the troubles are primarily in a marriage, both spouses are working. They have a couple of children, presenting the attendant difficulties of finding suitable child care. Then there are the daily hassles of food, rent, phone bills, and others.

There are others—many others. They come for help because the pain of living interferes with their daily existence. They come to gain insights. Sometimes the marital problems are lack of communication, and communication skills are taught in the therapy room. Frequently couples are given "homework" to do between sessions.

Some of the therapists are willing to work as long as six months with a client or clients. They continue until there is a joint agreement that the client(s) will work on the problem after leaving therapy.

Giving the client a home telephone number is a practice with certain therapists. Far from encouraging the client to call the therapist at home, the offer of "off hours" support seems to strengthen the client and help him through some of the bad hours, some psychologists say. One reported that his client said to him, "I almost called you last night but decided that I could hold on until morning." It is the idea that there is support and reinforcement which seems to shore up the client's ability to "hold on until morning."

Let us go into the offices of several of the psychologists and see a few of the clients who come to them.

Take Hannah, for example. Product of a domineering father and a critical mother, she had never felt adequate, not as a child, not as an adult. Pretty in a timid way, she had convinced herself that she could not do well in college, would not succeed in a career. And so she married Frank, the high school boyfriend. For several years existence was good enough, but Frank grew weary of a wife who had no "sparkle" and seemingly no ambition.

Within three years they were divorced. Hannah went to another city; got a job in a business office; met and married Herman. She wanted life to be great; she wanted to be the world's best wife; but her early insecurity held her in a vise of jealousy.

She could not let Herman alone in a room to read a paper. She listened in on his telephone calls. She timed him from the minute he left the office until he arrived at home. If he went to the grocery store, she questioned him about his activities and whom he had seen.

Her jealousy consumed them both. Hannah became depressed and suicidal. Herman seriously contemplated divorce.

They could not afford private therapy, but they found the Capital Area Mental Health Center. After six months of individual help, both of them were coping better with their marital problems and were on their way to making a pleasant life for themselves and for one another.

And then there was Richard, tall, Lincolnesque.

"Let me tell you about Richard," a therapist said. "He had spent his life being angry. Anger had been bred in him with his baby food. He came from a destructive family. Both his father and his mother beat him regularly—powerful people mistreating a powerless child.

"When Richard came to me, he was in his third marriage. By the set of his jaw and the look in his blue eyes, one could see the hostility that raged inside him. He sat across from me, his hands in fists, his body absolutely rigid.

"He told me that his explosive temper had caused him nothing but trouble throughout his lifetime. Now his third wife had said that if he did not have professional help, she would leave him.

"As Richard and I explored his early life, he began to see that the angry youngster in him was still flailing out at the adults in his life. Richard began to relax. Slowly he began to give up his defense of pushing people away, and he and his wife started working out problems in their relationship.

"Although Richard had therapy for less than six months, he was intelligent enough to move ahead in planning with his wife toward improving their marriage. It is working with people like Richard that makes therapists feel good about their efforts."

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Are all the stories ones of success? Of course not. The failures are as prevalent here as in any other therapeutic situation. Sometimes the problems are so great by the time a person comes for help that the negative patterns are set and almost unchangeable. Sometimes the therapy cannot prevent tragedy.

Look at Mary Helen. Trim, blonde, with a flair for dress. She could have been a model. When she came for therapy, she was fashionably dressed, a bright scarf tied smartly around her shoulders, with large earrings complementing her outfit. She talked about depression, about her concerns for her four-year old daughter, about her terminated marriage. But she never talked of suicide.

But suicide was in her mind. Mary Helen killed herself one night while her daughter slept in the next room. The therapist was shocked at the news, more shocked when he saw the apartment with its clutter of dirty clothes, messy closets, unwashed dishes in the kitchen.

"One always wonders," the therapist said, "if one might have seen the clues, might have prevented the useless killing. But Mary Helen gave evidence of being well put together, a young woman suffering a not-too-serious depression. Whether some crisis triggered her act or whether she was such a good actress that she kept me from knowing the depth of her sadness we'll never know. But a suicide is a humbling and worrisome occurrence."

How does a therapist handle such a happening?

Generally, the person will consult with peers, will talk over the dynamics of the sessions, will try to learn from others if there were clues overlooked, help that might have been given, methods by which such a person could have been aided.

Therapists know that the people who seek treatment at the Center are individuals whose problems are unique to them. Each person suffers in his own manner, copes in a fashion that he can handle.

Suffering is personal and, without help, often enduring. It may be expressed in physical ailments like headaches and stomach problems. Studies have estimated that 80% of all physician office visits are stress related. The Capital Area Mental Health Center shows that more than 15% of the clients seen have suffered with acute stress and anxiety problems.

An even greater problem than stress and anxiety is pervasive depression, which seems to be one of the most common and destructive of all mental health disorders. Studies have indicted that 23% of all women and 11% of all men will experience some significant level of clinical depression during their lifetimes. Mental Health Center statistics indicate that about 35% of the clients seen have been significantly depressed.

In addition to stress and depression, problems seem to be those of intimacy and social relationships; then come marital problems.

The client population of the Center is 64% female and 36% male. According to some therapists, more women than men seek treatment because, in our culture, men are traditionally not supposed to talk about their problems as much as women do. Men turn to work or drink. They are less able to articulate their problems, except in physiological terms.

Although percentages are only numbers, they represent human beings seeking help. Within the statistics and the percentages are the waitress, Hannah, Mary Helen, Richard, and hundreds of others.

In 1981 alone the Center provided 1,652 hours of quality therapy time and served as an important resource for close to 500 people. The gap between client payment and actual expenses was made up by donations from private sources like the Hogg Foundation (which made a second-year grant of $12,000), the Lola Wright Foundation, the Austin Community Foundation, RGK Foundation, and the Psychological Associate Division of the Texas Psychological Association.

Benefits and Lacks

The Capital Area Mental Health Center has demonstrated that it fills a need which truly exists and is doing it in a cost-efficient manner. For example, at their regular rates of $50 to $75 per hour for client service, the volunteer psychologists have contributed more than a quarter of a million dollars' worth of services.

Perhaps the Center exhibits the concept of volunteerism at its best. That such a large cadre of psychologists will give of their professional time on a regular basis exemplifies the willingness of the private sector to help fill gaps in services.

On the other hand, the very success bespeaks some of the future problems. Because the Center is becoming visible, the waiting list for services grows. The recruitment of still more therapists may need to be pursued in order to keep that waiting period to a minimum.

One serious gap exists in the services provided and that is help for minority populations. Very few blacks or Hispanics seek the aid which the Center provides. The Board of Directors is aware of the disparity in the ethnic ratio. Much of the problem emerges from the paucity of therapists who are themselves black or Hispanic or Spanish-speaking. Center members are attempting to recruit more minority psychologists to serve those populations.

Some of the recommendations made by a firm doing a feasibility study of the Center included recruitment of additional psychologists, as well as contacting new psychologists moving into the Austin area. They also suggested that thought be given to the development of a pilot outreach program, which could include collaboration with churches and civic groups and private industry for group therapy sessions.

Conclusion

The Capital Area Mental Health Center has demonstrated the force of private initiative combined with vision. The team of psychologists in the Austin area who are giving of their time to offer therapy to low-income people can well serve as a model to other communities.

Ledgers cannot show the benefits gained in any city where people needing help with problems which have grown overwhelming can find assistance at a price that they can afford.

Measurement will have to be made by the young waitress whose life has steadied and by the hundreds of other people who have learned coping mechanisms and means of facing difficulties.

It is help without price.

Design by Tom Cunningham


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