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FACTORS IN THE RECEIPT OF THERAPEUTIC ASSISTANCE IN COMMUNITY CARE

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Abstract—Who gets psychotherapeutic aid in a population at risk of reexperiencing mental health problems? The study samples included 499, 18–65 year-old, nonretarded, formerly hospitalized mental patients living in 234 of California's sheltered-care facilities. The sample of residents and facilities were representative of their respective statewide populations.

At the time of the study 28.9% of the residents were receiving some form of psychotherapeutic aid. The study finds that the environmental context of sheltered-care, including the facility's philosophy of care and the composition of its resident group, is a powerful determinant of treatment status—more important than such individual characteristics as chronicity or degree of psychopathology. This finding is especially pronounced for women and older residents.

Emphasis on community care for the mentally ill has led to the release of large numbers of patients from mental hospitals. Although separated from the hospital, many still need therapeutic aid. Indeed, there has been considerable concern about the ability of former patients to adjust to community life without such assistance [1]. Unfortunately, reports of inadequate local services have become commonplace. Further, there is concern about the ability of the released patient to independently establish and maintain a beneficial therapeutic relationship.

Several studies have indirectly examined the importance of aftercare. Herz *et al.* [2], in a two-year follow-up of the effects of different approaches to in-patient treatment, found that more assistance (i.e. aftercare) during follow-up indicated fewer returns to hospital and better community adjustment. Glick *et al.* [3], reported similar findings. Those who received psychotherapy during a post-hospital follow-up period were most successful at the end of the study. Although these studies were concerned primarily with the form of in-patient treatment, both demonstrated that continued receipt of care after discharge was critical to successful adjustment.

Other studies address aftercare specifically. Burham [4] found that those receiving aggressive aftercare services were readmitted less frequently than those receiving the standard program. Grad and Sainsbury [5], studying the efficacy of community-based as opposed to hospital-based aftercare, found that traditional hospital-based care was more effective, in this case, primarily because it offered more consistent contact with helpers. Davis *et al.* [6], in a 5-year follow-up of released patients, also found that successes were more likely to have received consistent aftercare services and to have used them more appropriately than those who returned to hospital. The implications of these studies are clear: aftercare is important and it is necessary to actively contact those in need of services and to encourage them to utilize services consistently and appropriately.

Aftercare which is appropriate and acceptable to ex-patients may not always consist of psychothera-

peutic or even rehabilitative aid. It should be remembered that aftercare has two functions: first, the provision of (differentially) supervised, humane care for those unable to independently provide for their basic needs—that is, social support; second, the provision of psychotherapeutic and rehabilitative services aimed at improving the psychiatric status of an individual. In this study we are concerned with the provision of primarily psychotherapeutic aid to a population of ex-mental patients living in sheltered-care who are, by definition, already engaged in a form of social support. Our concern in this paper is with two questions: who gets help, and what facilitates the receipt of community-based psychotherapy by sheltered-care residents.

METHOD

This research was completed as part of a larger study of the mentally ill in community-based sheltered-care [7]. The major component of the study was a structured interview survey. Interviews were conducted with a sample of 499 non-retarded, sheltered-care residents between the ages of 18 and 65 with a history of psychiatric hospitalization, and with the operators of the 234 facilities in which these residents lived. The samples of residents and operators are representative of their respective California sheltered-care populations. Each sheltered-care resident (with the above characteristics) and operator in California had an equal chance of being interviewed. Formal interview data were supplemented with observations and commentary collected during the planning phase of the study and following the completion of each interview.

Survey sample

The sample is a self-weighting, representative sample [8] of all non-retarded individuals between 18 and 65 years of age with a past history of mental illness living in sheltered-care facilities (i.e. family care homes, board-and-care homes, and halfway houses for the mentally ill) in California.

To obtain the sample, the state was divided into three master strata:

- (1) Los Angeles County;
- (2) The San Francisco Bay Area: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma Counties; and
- (3) All other counties in the state.

In the Los Angeles and Bay Area strata, the sample was drawn from the total population. In each of these areas a two-stage cluster sample was designed with sheltered-care facilities as the primary sampling units and individuals within facilities as the second sampling stage.

Facilities were stratified by size in both Los Angeles and the Bay Area and a sample was drawn of paired primaries taken probability proportionate to size. Individuals within facilities were randomly sampled from specially prepared field listings. Individuals were sampled in clusters of three in those facilities with four or more residents. In facilities with three or fewer residents, one individual interview was completed.

In the third stratum, comprising "all other counties", a three-stage cluster sample was designed using counties as primary selection units, facilities as the second stage, and individuals within facilities as the third stage. All counties within this stratum with 20 or fewer facilities were arbitrarily excluded from the sample. This procedure eliminated only 3% of the population (618 residents) from consideration and allowed us to draw conclusions with respect to the other 97%. The remaining counties were further divided into two substrata: north and south. Two counties were picked as paired primaries from the north and two from the south. The facility and individual samples in this stratum were taken within each of the selected primaries using systematic random sampling in the latter and selections probability proportionate to size in the former.

Of the 499 resident interviews attempted, there was a loss of 12% due to refusal and inaccessibility. Of the 234 operators contacted, 10% refused to participate in the study.

Measures

As part of the larger study, both residents and operators responded to an extensive interview and assessment schedule [7]. In addition to items describing residents, the assessment also included items describing the sociopsychological climate of the sheltered-care facility, its setting and organizational structure, and characteristics of the surrounding community. Items were included to ascertain the resident's status in community-based therapy, the type of therapy received and the frequency of treatment. Many different types of therapy were received by sheltered-care residents. Help varied from the receipt of antipsychotic medication(s) to intensive individual psychotherapy. We considered all types of therapy in our index of getting help, though the receipt of psychotherapy constitutes the primary dependent variable in this study. Because return to the mental hospital is a traditional indicator of failure, return to the hospital for therapy has not been included among the types of therapeutic aid considered here.

Analysis

Utilizing discriminant function analysis [9], we identified those factors which best predict the treatment status of the expatient. Potential predictors were selected from all individual, facility and community environment characteristics obtained. Preliminary analyses were done with each major group of characteristics to determine those most related to the receipt of treatment. Because of the generally accepted importance of age and sex, the sample was broken into three age groups (young: 18-33 years; middle: 34-49 years; older: 50-65 years) and by sex, thereby yielding six groups. Following exploratory analyses, discriminant function analyses were completed for each group separately.

RESULTS

At the time of the study, 29.8% of the 386 sheltered-care residents responding to this question were receiving community-based therapeutic aid. Although men were as likely to receive treatment as women, there were significant differences associated with age. In the younger age group (18-33) 46.2% were receiving therapy; in the middle age group (34-49) 29.9%; and in the older group (50-65) 21.3% ($\chi^2 = 18.8$, $P < 0.001$).

Older residents are less likely to be in treatment, and even when receiving therapy they have significantly fewer therapeutic contacts. Of those in treatment, 59% of the youngest group received treatment once a week or more while 38% of the middle group and 28% of the older group received treatment this frequently ($\chi^2 = 7.35$, $P > 0.05$). Younger residents are also more likely to see different types of helpers. They not only see psychiatrists, but are likely to see psychologists, social workers and psychiatric nurses ($\chi^2 = 12.7$, $P > 0.05$). In general, men receive treatment from more varied types of helpers than women ($\chi^2 = 8.3$, $P < 0.05$).

FACTORS THAT FACILITATE AND HINDER GETTING HELP

Young women

Table 1 lists those variables which distinguish young women receiving therapeutic help from those who are not.

Of the eight variables in Table 1, four (variables 2, 3, 6, 8) are individual characteristics of the resident and four (variables, 1, 4, 5, 7) pertain to the social context in which the resident lives. The four resident characteristics are similar to those which distinguish members of the general public who seek help [10-12]. They conform to what Schofield [12] called the YAVIS syndrome: services tend to go to the young, attractive, verbal, intelligent and successful.

The strongest individual characteristic predicting therapeutic status is the socioeconomic status of the resident's father. The higher her father's SES, as measured by Reiss' Socioeconomic Index [13], the more likely it is that the young, female resident receives treatment. Second among individual characteristics is race: white females are more likely to receive treatment than non-white. The third is the resident's ability to express her symptomatic re-

Table 1. Factors that distinguish young (18–33 year-old) women who receive treatment from those who do not receive it

Variable	Standardized discriminant function coefficient
(1) Facility encourages the expression of personal problems	1.674
(2) Resident's father has high socioeconomic status	1.125
(3) Resident's race is white (vs non-white)	1.082
(4) Facility has a treatment and/or rehabilitation program	1.003
(5) Facility deemphasizes the expression of anger and aggression	0.911
(6) Resident has a high Langner Psychopathology Scale score	0.617
(7) Operator of the facility does not find services helpful	0.433
(8) Resident does not feel her freedom has been restricted	0.277

Wilk's Lambda: 0.384 ($P \leq 0.007$).

Canonical correlation coefficient: 0.784.

Percent correctly classified on basis of discriminant function score: 83% ($P \leq 0.000$).

N in treatment = 14; not in treatment = 14.

sponses on the Langner Psychopathology Scale. The Langner Scale is a 22-item paper and pencil test involving the resident's self-report of neurotic and psychophysiological symptomatology [14, 15]. Finally, the last predictor indicates that the resident who does not feel restricted by her community care situation is more likely to receive help. This suggests that a sense of autonomy or independence promotes the receipt of aid by young women in sheltered-care.

The strongest social context predictor is the facility's orientation toward the expression of personal problems. This assessment of the facility is based on residents' responses to the COPEs scales. The COPEs consists of a set of subscales made up of items which describe the sociopsychological environment of community care facilities [16]. The "Personal Problems" subscale includes items that inquire as to whether residents talk openly about personal problems, talk about their past, and whether staff of the facility encourage such expression. The second most significant social context variable refers to whether the facility had or made available a program of treatment or rehabilitation. The third predictor (also from the COPEs scales) refers to whether or not staff discourage the expression of anger and aggression (the "Anger and Aggression" subscale).

In facilities that discourage the open expression of anger and aggression, young women are more likely to be receiving treatment. While this might appear to contradict the open expression of personal problems, it should be noted that some control of the overt

expression of anger and aggression—which frequently gets out of hand in sheltered-care—is necessary to an atmosphere where personal disclosure can occur.

The final social context variable is the operator's report that community services are not found to be helpful. We found that such facilities are more likely to conduct their own therapy program, and we assume that much of the therapy received by these residents is obtained within the facility, and that this is related to the operator's low appraisal of outside services.

Young men

Of the eight predictors of treatment for young men, one pertains to the social context of the facility (variable 6) and three relate to the characteristics of facility operators (variables 1, 3, 5). Young men in therapy tend to live in facilities where the operator (1) does not live on the premises; (2) does not find outside services helpful; and (3) scores low on the Marlowe-Crowne Scale (Table 2). The Marlowe-Crowne is a self-report inventory that purports to assess the need to make a good impression. High scorers claim to: always admit mistakes, practice what they preach, never feel resentful when they don't get their way, etc.

Four resident characteristics predict therapeutic status (variables 2, 4, 7, 8). Residents in treatment also score low on the Marlowe-Crowne Scale, do not feel that their freedom is being restricted, have not participated in loud arguments during the past month, and

Table 2. Factors that distinguish young (18–33 year-old) men who receive treatment from those who do not receive it

Variable	Standardized discriminant function coefficient
(1) Operator of the facility does not live in it	0.735
(2) Resident scores low on Marlowe-Crowne Social Desirability Scale	0.601
(3) Facility operator scores low on Marlowe-Crowne Social Desirability Scale	0.559
(4) Resident does not feel his freedom has been restricted	0.483
(5) Facility operator does not find services helpful	0.376
(6) Few facility residents have been hospitalized in the last year	0.253
(7) Resident has not been involved in loud arguments	0.210
(8) Resident has low antipsychotic medication dosage	0.188

Wilk's Lambda: 0.591 ($P \leq 0.002$).

Canonical correlation: 0.638.

Percent correctly classified on basis of discriminant function score: 80% ($P \leq 0.000$).

N in treatment = 21; not in treatment = 32.

Table 3. Factors that distinguish middle-aged (34–49 year-old) women who receive treatment from those who do not receive it

Variable	Standardized discriminant function coefficient
(1) Facility factor—less complexity	0.784
(2) Resident has high antipsychotic medication dosage	0.695
(3) Facility encourages the expression of personal problems	0.499
(4) Resident has had several admissions to a mental hospital	0.463
(5) Facility factor—mutual support	0.386
(6) Facility factor—has program	0.307
(7) Resident is or has been married	0.300
(8) Facility factor—high control	0.128
(9) Facility factor—high medical	0.048

Wilk's Lambda: 0.657 ($P \leq 0.063$).

Canonical correlation: 0.58563.

Percent correctly classified on basis of discriminant function score: 78% ($P \leq 0.000$).

N in treatment = 19; not in treatment = 71.

are on a low antipsychotic drug dosage as measured in chlorpromazine (CPZ) equivalents.*

Similar to young women, young men in treatment have a sense of autonomy within the residential setting. They live in facilities where operators exercise relatively little direct control and which appear to serve a less severely disturbed population (variables 6, 7, 8). In sum, it appears that several factors combine to facilitate treatment for young, male sheltered-care residents: an independence derived from a less restrictive environment (perhaps associated with a generally healthier resident group), a mutual lack of pretense or "impression management" between operator and residents, and the likely provision of in-house treatment due to the operator's poor appraisal of outside services.

Middle-aged women

In this age and sex group we see the emergence of a pattern which characterizes the receipt of aid for all but the most youthful sheltered-care residents. As illustrated in Table 3, specific facility factors—characteristics of sheltered-care administration, program, and milieu—are important predictors of a resident's involvement in therapy.

The facility factors included as variables in our discriminant function analyses derive from factor analysis of the characteristics of community-based sheltered-care facilities. Employing Tryon and Bailey's [20] method, we identified five relatively independent dimensions which describe these facilities regardless of their formal designations (e.g. family care home, adult group home, etc.). These five dimensions are:

- I. The degree of *complexity* or structure of the facility.
- II. The *program orientation* of the facility.
- III. The extent of *control over residents* exercised by the facility.

IV. The degree of *support* residents offer each other.

V. The *medical orientation* of the facility.

Middle-aged women in treatment tend to live in small, coed, family-oriented facilities which do not employ paid staff or encourage the use of outside services. Residents feel that they look neat, and rarely become very angry or argue. Residents have little contact with the police. In short, these women live in facilities which are simply structured and at some remove from the turmoil of the world at large or the social complexities of larger institutions (variable 1).

These are also residents of facilities in which there is considerable mutuality and social support. Residents share problems (variable 3), feelings, and often help each other with tasks (variable 5). Additionally, these facilities stress rehabilitative and social programming, encourage residents to plan for the future (variable 6), and tend to have a house doctor and provide for the supervision of medication (variable 9).

Consistent with the self-sufficient, family-oriented style of the facilities in which these women live is the finding that operators exercise a fair amount of control. The facility has a schedule, residents have a curfew, and residents report that they "cannot do whatever they feel like" (variable 8).

There are also significant personal characteristics of middle-aged women in treatment. Most importantly, they appear to be in a chronic, though active phase of disorder. Although these residents tend to have had several hospital admissions (variable 4), their antipsychotic dosages are high (variable 2) even though monitored (variable 9). Finally, these are residents who may be experientially well suited to a family style placement and the intimacy it demands (variable 7).

Middle-aged men

Middle-aged men in treatment present a striking contrast to their female counterparts in sheltered-care. First, and most importantly, these are men with relatively little experience of the mental hospital (variable 1). Second, despite the relatively high degree of control exercised by the facility (variable 7), these are residents of large, complex facilities which appear to emphasize external contacts and services, perhaps at

* All antipsychotic medications taken by residents were checked and the dosage noted. Dosage of major tranquilizers was then translated into chlorpromazine (CPZ) equivalents using Hollister's [18] relative potency scale [7, 19].

Table 4. Factors that distinguish middle-aged (34–49 year-old) men who receive treatment from those who do not receive it

Variable	Standardized discriminant function coefficient
(1) Resident has had few admissions to a mental hospital	0.818
(2) Resident has had frequent discussions with neighbors	0.652
(3) Facility does not have a treatment and/or rehabilitation program	0.566
(4) Facility factor—little or no program	0.470
(5) Facility operator scores high on the Marlowe–Crowne social desirability scale	0.404
(6) Facility factor—high medical	0.239
(7) Facility factor—high control	0.223
(8) Facility factor—high complexity	0.111
(9) Facility factor—little support	0.044

Wilk's Lambda: 0.713 ($P \leq 0.043$).

Canonical correlation: 0.536.

Percent correctly classified on the basis of discriminant function score: 85% ($P \leq 0.000$).

N in treatment = 17; not in treatment = 50.

the expense of internal cohesion and communality (variables 8, 2, 3, 4 and 9). The style of these facilities appears more traditionally aggressive and masculine, perhaps reflecting the operator's emphasis on positive self presentation (variable 5). In any event, middle-aged men receiving treatment in addition to sheltered-care appear to be resident in facilities which are more like businesses than families and which are focused more on the environment beyond the sheltered-care setting than on the satisfactions and needs of the residents as a group (Table 4).

Older women

Similar to other women in sheltered-care who receive psychotherapeutic aid, older women live in facilities which encourage the expression of personal problems (variable 1) and have a high degree of mutual support (variable 9) (Table 5).

We believe that the other predictors of therapeutic involvement, when taken together, reflect a special and interesting relationship between the older woman and the facility in which she resides. The older woman in treatment has a high SES background (variable 2), would appear to have a fair amount of disposable income because her facility is relatively inexpensive (variable 4), and has a high level of external integration, a measure of involvement as a consumer, pro-

ducer and social participant in the community external to the facility independent of the operator or staff's activities (variable 6). She thus appears to be middle class, well off in her current surroundings, independent, and probably more socially competent than most sheltered-care residents. Although she is not young, she is a YAVIS type. Significantly, she resides in a facility where the other residents are fairly young (variable 7) and which has characteristics typical of facilities oriented to young residents: a low degree of control (variable 5) and a minimal medical orientation (variable 3). Although these facilities are large and employ paid staff (variable 8), they are internally coherent and supportive (variable 9).

The older woman in treatment, then, appears to be an independent, competent sort of sheltered-care resident who has found herself—or has gotten herself—placed in a facility oriented by and large to the care of younger residents.

Older men

As we have noted, older sheltered-care residents are far less likely than young residents to receive therapeutic assistance. Older women in treatment, despite advantageous placement, have significant appealing personal characteristics associated with the receipt of aid. Not so older men. The involvement of older men

Table 5. Factors that distinguish older (50–65 year-old) women who receive treatment from those who do not receive it

Variable	Standardized discriminant function coefficient
(1) Facility encourages the expression of personal problems	0.711
(2) Resident has high socioeconomic status	0.351
(3) Facility factor—low medical	0.350
(4) Facility costs less to live in	0.318
(5) Facility factor—low control	0.274
(6) Resident scores high on External Social Integration Scale	0.257
(7) Oldest resident in the facility is relatively young when compared to full age range of residents housed in sheltered-care facilities	0.238
(8) Facility factor—high complexity	0.231
(9) Facility factor—mutual support	0.211

Wilk's Lambda: 0.729 ($P \leq 0.016$).

Canonical correlation: 0.521.

Percent correctly classified on basis of discriminant function score: 82% ($P \leq 0.000$).

N in treatment = 19; not in treatment = 71.

Table 6. Factors that distinguish older (50–65 year-old) men who receive treatment from those who do not receive it

Variable	Standardized discriminant function coefficient
(1) Facility has few complaints from the neighbors	0.691
(2) Facility has a program of treatment and/or rehabilitation	0.604
(3) Oldest resident in facility is relatively young when compared to the full age range of residents in sheltered-care facilities	0.484
(4) Facility factor—high medical	0.474
(5) Facility discourages resident autonomy	0.385
(6) Facility factor—low complexity	0.172
(7) Facility factor—high control	0.120

Wilk's Lambda: 0.832 ($P \leq 0.060$).

Canonical correlation: 0.410.

Percent correctly classified on basis of discriminant function score: 85% ($P \leq 0.000$).

N in treatment = 16; not in treatment = 64.

in treatment appears to be wholly a product of fortuitous placement (Table 6).

The older man in treatment resides in a small, controlled, medically oriented facility which operates its own insulated program of therapy (variables 6, 7, 4, 2). Although oriented toward the young (variable 3), these facilities are not typical of programs geared to young residents. They discourage resident autonomy (variable 5) and, perhaps as a result of their emphasis on control, co-exist peacefully with their neighbors (variable 1).

In short, the older man in treatment has no salient personal qualities. He is an older member, perhaps an old gentlemen, in a highly supervised "family" of younger folks whose activities revolve about the facility's own program.

DISCUSSION

Typically, a resident of sheltered-care in California does not receive therapeutic assistance or aftercare beyond the social support function of the facility. Younger residents, however, are the most likely to be engaged in therapeutic aftercare. The older a resident of sheltered-care, the less likely he or she is to be receiving therapeutic assistance. Older sheltered-care residents may be getting adequate social support, but they are clearly not receiving the benefits of psychotherapy.

Even when older residents receive therapeutic attention, they appear to be the incidental beneficiaries of environments not designed to serve them. Older women in treatment appear to be those most likely to fit well in environments dominated by young, active individuals. Older men in treatment exhibit no outstanding personal characteristics, but are merely present in controlled, encapsulated facilities serving, once again, younger expatriates.

Theoretically, we would expect to find that chronic expatriates receive the least therapeutic attention. There is, after all, little in clinical experience or in the literature of rehabilitation which suggests that chronic psychiatric patients make significant therapeutic gains. However, only in the middle-aged group do we observe any relationship between chronicity and treatment status, and here the findings are contradic-

tory: middle-aged men in treatment have little hospital experience, but women are chronic patients. Moreover, only among young women do we find any relationship between treatment status and level of psychopathology, another theoretically important predictor. Thus, involvement in therapeutic aftercare appears to have more to do with a facility's philosophy of care than with a resident's chronicity or degree of disturbance. Women in treatment, regardless of age, reside in facilities which (1) encourage the expression of personal problems; (2) provide in-house therapeutic services; and (3) have mutually supportive resident groups. We find no consistent contextual pattern for men in treatment, but we observe important, though different, contextual influences within male age groups. Young men in treatment are accorded considerable autonomy and seem to be members of generally healthy resident groups; middle-aged men are resident in large, business-like facilities which emphasize external contacts and impression management; older men reside in small, controlled, medically oriented facilities with their own insulated programs of therapy and young resident groups. Finally, among younger sheltered-care residents we observe that involvement in treatment is associated with a lack of environmental restrictiveness and the availability of in-house services.

Our data describe a pattern which is neither new nor very surprising: young, attractive, verbal, intelligent, and potentially successful individuals get the bulk of therapeutic attention. Older, more passive individuals get a bed.

Is this neglect? Perhaps older residents in sheltered-care are skeptical of therapy's benefits and want no more than a comfortable bed and a few congenial companions. Perhaps this skepticism operates pervasively and independently of chronicity or degree of disturbance, thus accounting for our non-findings here. Perhaps, but we think not. Our data suggest a simpler explanation: facilities which cater to young residents make an effort to provide treatment in addition to social support; most others do not. Older sheltered-care residents are the victims of their caretakers' low expectations. They fail to receive services not because they are chronic patients or because they are too greatly or too little disturbed, but because they are old.

Especially as they concern the treatment of women and older sheltered-care residents, our findings have important implications for policy. We find that context rather than individual characteristics determines to a great extent which members of these groups get therapeutic aid. If we want to get help to these populations we must address the character of the sheltered-care environment and promote changes in sheltered-care which will emphasize the provision of therapeutic assistance.

If we are to remedy its shortcomings, we must view the sheltered-care environment as part of the larger system of community care which remains diffuse and ineffectual despite its ideals. Community care is not the necessary or automatic consequence of deinstitutionalization. To be more than decentralized neglect, community care requires not only money, but cooperative effort. In part, the neglect of older sheltered-care residents in California is a result of the professional isolation of facility operators, who are held in low esteem by many mental health professionals. Facility operators must receive recognition for difficult work, training in the appropriate use of therapeutic resources, and support for necessary change. Only then can they become full partners in community care who are committed to the best possible treatment for all of their residents.

Current licensing statutes and enforcement practices also fail to ensure the availability of treatment to sheltered-care residents. The noble sentiments of our legislation are enforced by a very few civil servants operating, of necessity, with broad assumptions of good will. Until the enforcement process is adequately funded, the usefulness of State supervision will remain unknown.

Finally, sheltered-care residents suffer from the understaffed outreach efforts of community mental health centers. Required to be everything to everyone, CMHCs are spread so thin that they have become the convenient whipping boys for every identified failure of service. We must staff our tenuous system of community mental health care in a manner which is commensurate with our high expectations of it. Otherwise we should not be surprised, much less shocked, when those in need of services fail to get them. After all, we are getting what we pay for.

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