THE ORGANIZATION OF PSYCHIATRIC SERVICES IN THE UNITED STATES

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Future, Past, Present

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The Organization Of Psychiatric Services in the United States: Future, Past, Present

The organization of psychiatric services in the United States has evolved from a system based on large mental hospitals, for the most part under state and/or federal auspices (Zilboorg, 1941), to a complicated combination of public and private services operated by a wide variety of governance mechanisms. This increased complexity of services has paralleled the increasing complexity of society, with its rapid population growth and urbanization. Society's recent stance that at least some minimum quantity and quality of human services is its right suggests that the public will expect that minimum, at least, to be available for all citizens, irrespective of geographic location, socioeconomic status, or ethnic or racial origin. As a part of this "right-to-service" development, the public is raising questions about financial or other criteria for eligibility. Should our current mental illness and medical care delivery systems become a one-class system rather than the two-class system now prevalent, based primarily on socio-economic status and income?

Current interest in a system for delivering service to maladaptive and mentally ill persons is a natural culmination of changes that took place after World War II. These changes included a reduction in the size of large mental hospitals; the establishment of psychiatric units in general hospitals; the

increasing availability of effective psychotropic drugs; the development of academic departments of psychiatry; the rapid expansion of a psychiatric manpower pool; the discovery of the effect of the therapeutic community, with its "open door" and "total push" methods of treatment; the development of the multidisciplinary team, with its increasing diversity of professional and nonprofessional manpower; and the growth of services located geographically close to and effectively in tune with the populations they serve. A first attempt to assess these advances and to plan for the development of a better and more effective system appeared in 1961 in *Action for Mental Health* (Joint Commission on Mental Illness and Health, 1961). It was legislatively encouraged by the community mental health and mental retardation legislation of the early 1960s.

After several years of experience with community mental health center programs, it is once again a time for reassessment. A number of questions may be raised about the improvement of the system of mental health and illness services. Among these questions are the following:

1. What is the minimum acceptable quantity and quality of service?

2. What varieties of organization of service will prove most effective under what circumstances in what geographic area?

3. Who will govern and administer the services?

4. How will they be financed?

5. Under what conditions should services be mainly separate, and when should they be mainly a part of other human service systems— for example, educational, legal, medical, and social services?

6. What are the optimum number, mix, and functions of manpower?

7. Should there be a national policy about mental illness services that establishes certain guidelines, requirements, and constraints?

Answers to these and related questions are not yet available; the data from research and evaluation are thus far inconclusive. However, discussions are taking place of major reorganizations of medical services such as the health maintenance organization (Elwood, 1971; Feldstein, 1971; Health Maintenance Organizations, 1971; Health Services and Mental Health Administration, 1970), the health care corporation (American Hospital Association, 1970), and the physician's foundation (Feldstein, 1971). Modification of methods of finance such as universal health insurance, catastrophic insurance, and others are also possible. As a result the public, its political representatives, and the professions and agencies and institutions cannot long delay inputs into planning and development now under way.

Origins of Psychiatric Service Systems

The development of psychiatry as a medical discipline or specialty in

the United States began with Benjamin Rush (1745-1813), a physician with broad social, medical, and scientific interests. These interests gradually became centered in the diagnosis and treatment of mental illness; Rush published the first book in the United States that related to these matters (1962). Following his lead, a small number of physicians began to specialize in these disorders, and a number of institutions that treated mental illness came into existence along the Eastern seaboard. The institutions were under both public and private auspices. Their diagnostic and treatment programs may be thought of as prescientific, but they evolved an effective form of psychiatric treatment called moral treatment. Moral treatment emphasized kind, humane, and non punitive interventions, with emphasis on good living conditions and general support measures such as proper diet, exercise, environment, regulation of body processes, and interpersonal relationships. Since the young nation was primarily agricultural in its orientation, the location of these new institutions in pleasant rural surroundings followed as a natural consequence of the existent social organization, philosophic ideals, and treatment regimens.

Not all institutions were of this nature. Many were overcrowded, understaffed, and underfinanced. The mentally ill were regarded by some as criminal, immoral, weak, and inadequate, requiring controlled and punitive circumstances for any effective treatment to occur. Dorothea Dix (1802-1887 [Marshall, 1937]), recognizing these deficiencies, led a social and political

movement that promoted change in the institutions and in their therapeutic programs. She stimulated state legislatures to accept greater programmatic and financial responsibility for the treatment of the mentally ill and the emotionally maladaptive.

This first reorganization of services led to a period during which psychiatric treatment was improved. Social change, including industrialization and urbanization, quickly disrupted the equilibrium, however, and overcrowding and social isolation began to be the rule once more in the late 19th century. The tranquil and idyllic settings for moral treatment that had joined the patient with his family and the community were replaced by the warehousing and custodial care typical of large institutions, a process that was to persist and grow more extreme for the next fifty years. Treatment optimism often gave way to treatment nihilism, and the view prevailed of mental illness as chronic, irreversible, and having a worsening downhill course. The public support provided by state legislatures was not able to maintain pace with the increased need, and personnel and physical structures gradually became inadequate in quantity and quality. As a concomitant to these developments, public attitude shifted. The predominant tendency was to want to have the mentally ill put away in these large and usually distant institutions, out of sight of and contact with society.

The Development of Psychiatry as a Science

In the late 19th and early 20th century psychiatry became established as a science. Important contributions to this development were: an improved diagnostic nomenclature; the differentiation of organic from nonorganic disorders; advances in neuropathology; a better understanding of infectious disqase processes as they affect the central nervous system; and the beginnings of different and improved psychologies (Munroe, 1955) for understanding both adaptive and maladaptive human behavior.

Although these contributions did not result in any immediate alteration of the human service system, they formed a theoretical and practical base for such changes to occur later. Physician psychiatrists began to enter fee-for-service outpatient practice as well as to work in mental hospitals, and psychiatry gradually became a recognized medical specialty, with both outpatient and inpatient functions. Although the majority of psychiatrists continued to practice in public and private institutional settings, an increasing number of professionals came to deal with the less severe disorders and with the adaptive states of the relatively more severe disorders.

The psychiatrists who functioned mainly in outpatient settings were somewhat more likely to be psychodynamic and psychoanalytic in their orientation, while those psychiatrists who functioned in public mental hospitals were more likely to be organic and biological. These two groups of professionals and their associated institutions marked the beginning of two

somewhat separate systems. One of these systems was more likely to deal with outpatients with less severe disorders on a fee-for-service payment basis, utilizing a psychotherapeutic approach based on a psychodynamic-psychoanalytic psychology. The other system was more likely to be hospital-based and financed by public tax money, dealing with a group of patients who were more severely ill, and conceptualizing disease states in biological and/or genetic terms.

In the period from 1890 to 1940, these groups of practitioners and their associated facilities and resources grew steadily but slowly. (These dates correspond roughly with the productive scientific lifetimes of Bleuler (1950), Freud (Jones, 1953), Kraepelin (1921), Meyer (1951), Pavlov (1957), and other contributors of stature.) Then, in the 1940s, this gradual change and growth was transformed into a rapid expansion of manpower and institutions. Perhaps the most significant stimulus came as a consequence of World War II. The United States was shocked at the amount and extent of psychiatric disability seen at the induction points and training centers and in combat. The public turned to leading psychiatrists to assist in managing these actual or potential casualties. Most psychiatrists had been functioning up until then within relatively separate and isolated settings, either in public or private hospitals or in individual offices. Entry into military service catapulted them suddenly onto the public scene in ways that probably could not have occurred except for World War II. They became responsible for

psychiatric treatment units within military medical facilities; and they began, in many instances, to advise military command about psychological functioning and morale issues (Grinker, 1945).

A number of important principles were rediscovered during World War II and in the subsequent Korean War. Among them were the determination that: (1) the social system and its interpersonal relationships could provide emotional supports, during periods of stress, that decreased the number of casualties and the length of the disability; (2) immediate intervention at the time of crisis, so as to maintain the casualty close to his unit and his friends, reduced the length of disability; (3) evacuation to facilities that were geographically or emotionally more distant, on the other hand, increased disability; (4) opportunities to talk about and deal with frightening experiences were helpful; and (5) programs of extended treatment and rehabilitation were more effective when careful attention was paid to the therapeutic milieu—the social system in which the casualty found himself. This last principle led to the development of the therapeutic community (Edelson, 1964; Jones, 1953), the open hospital, the day hospital (Bierer. 951), group methods of treatment, the multidisciplinary-treatment team, and improved techniques of self help.

On their return to civilian life following World War II, psychiatric leaders were influential in modifying the treatment philosophies of a large

number of institutions and agencies. As a result of these changes and of public, professional, and political recognition of the shortage of personnel and treatment resources, the National Institute of Mental Health was developed as an instrument of the federal government to promote change in education and research. Initial programs were established to train more psychiatrists and personnel and to do research into the etiology and treatment of mental illness and maladaptation. The moneys made available through this channel encouraged most medical schools to establish psychiatry departments.

Training opportunities became more widespread in university departments, private and public mental hospitals, and consortia of training facilities (including inpatient and outpatient settings). Psychiatry enjoyed a special advantage over the rest of medicine in developing these training opportunities and resources, because there was substantial federal financial support for faculty and trainee salaries. Also, trainees were better paid through federal stipends than were trainees in the remainder of medicine. Psychiatry moved from a relatively minor position among medical specialities to become the third largest medical specialty.

The development of research capacity to some extent paralleled the increasing training capacity, but it occurred somewhat later and more slowly. Again, this change was most evident in departments of psychiatry in medical schools. Since the bodies of knowledge that underpin psychiatry—that is, the

social, psychological, and biological sciences—are complex and diverse, these research developments were also complex and diverse.

During the 1940s and 1950s, the discovery of chemical compounds that had effects on human behavior and on disease states—including both natural and synthetic (Cole, 1964) and somatic treatments—further increased the capacity of mental illness personnel to deal with maladaptive behavior. These drugs reduced the length of time of hospitalization, and (if continued when indicated) the frequency of episodes of disturbed behavior that required hospitalization. Eventually drugs were available for both the excited, agitated, or anxious states and the slowed, depressed states. They enabled the treatment team to respond promptly and more effectively and they reduced the need for keeping patients locked up or highly protected. For the first time the number of psychiatric beds in hospitals began to decrease, a trend that then continued every year since 1957. During the same period admissions increased each year, so hospitalizations also tended to be brief. The overall result was that the number of beds needed for the mentally ill was reduced, and chronically ill psychiatric patients, on the average, spent much more time out of the hospital in their own communities.

These advances in the understanding of social, psychological, and biological factors in psychiatric disability fostered the development of psychiatric units in general hospitals. There was a reawakening of

professional and public interest in outpatient treatment settings that were closer to where the patient lived and/or worked and to the social fields in which his disability occurred. (The origins of psychiatry outpatient clinics date to the 1920s, with the child guidance movement and with publicly sponsored and financed adult outpatient clinics. Growth in these services paralleled and was enhanced by the developments described above.)

The community mental health center development was a logical next step and a natural outgrowth of these advances. President Eisenhower commissioned a series of studies in 1956 that eventuated in the 1961 report, *Action for Mental Health* (Joint Commission on Mental Illness and Health, 1961). As a result of the changes and the report, guidelines for services and legislation for construction and staffing grants emerged in a model called the community mental health center, a system (Bertalanffy, 1966; Holder, 1969) for mental illness care. Formally, the system was to include inpatient, outpatient, partial hospitalization, emergency, and consultation and education services. Also—and for the first time—actual prevention of mental illness was considered to be a possibility (Caplan, 1964).

The appropriations were channeled through the National Institute of Mental Health. Over the next ten years the granting agency gradually became more interested and experienced in and knowledgeable about such associated issues as: (1) methods of governance; (2) the availability of

services for broad age groupings, particularly the aged, adolescents, and children; (3) the availability of services for special problems like addiction; (4) the needs of inadequately served populations; and (5) relationships with other human service systems such as health, social, education, and legal services.

Concomitant with these changes, the availability of fee-for-service psychiatric services was also increasing. More psychiatrists were in practice and there were more facilities available for the care of their patients. Although there are many junctional points of service, the public and the private fee-for-service systems tended to be separate and distinct, with the main differentiation occurring on a socioeconomic basis. As a result, psychiatric services developed into two systems, much as did the rest of health and illness services. Psychiatric services, however, continue to be weighted more heavily in the direction of the public sector than do the services of the rest of medicine.

A Systems View of Mental Health Services Delivery Systems

An examination and evaluation of the ways in which mental health and illness services developed in the United States suggests that there are three major service delivery systems currently in use. They are in the public sphere: (1) hospital- and institution-based delivery systems such as exist in state

hospitals or in the Veterans Administration system; (2) community mental health centers; and (3) the private fee-for-service system based on individual and group outpatient activity, together with the system based on general hospitals and dependent on individual financial responsibility and third-party payment. These systems are often separated from other service systems, although they may be a part of the medical service delivery system; they have rarely been a part of the educational, legal, and social service systems.

The older public system—the large hospital system—derives from the original state hospitals built in the first half of the 19th century. During the following 100 years increased needs were met primarily by expanding existent mental hospitals or by constructing new ones, usually in rural or semirural settings.

Resources for development did not keep pace with the need, and institutional treatment programs in time became overburdened by the numbers of very sick patients. Public support for resources for these institutions and their treatment programs was limited, so they gradually became more custodial in their orientation. Their population of long-stay patients consisted mainly of chronic schizophrenics and the aged. Some patients became so well adapted to the institution that they came to be more or less permanent residents.

Gradually, fewer and fewer psychiatrists were willing to work in this kind of setting. The hospitals became dependent on general (and often foreign-trained) physicians and on other mental illness treatment personnel such as social workers, psychologists, and nurses. These personnel were also often in short supply, so that most staff-patient contact occurred with technical assistants such as mental health aides and attendants. These nonprofessional staffs often had limited training and supervision, and their capacity to deal with patient problems was frequently based only on their natural capacities. Incomes for these categories of personnel were low, and the jobs often were not competitive with other employment opportunities. Furthermore, at least during the earlier years of this period, jobs were part of a state political spoils system, so that many jobs turned over with each change in state government administration.

Outpatient facilities associated with these large state hospitals were rarely under the same management auspices as the hospital. At times they were under separate state control, but more often they were funded by combinations of city, county, community chest, or other charitable funds and were governed either by separate agencies under local political unit control or by community boards. Although typically there was some patient flow between these facilities, admission to the hospital was usually in situations of acute crisis and was often the result of commitment proceedings. Aftercare was usually limited. Patients were also occasionally seen, before or after

hospitalization, by other sections of the medical-care or social-agency systems. However, the patient flow was rarely easy or smooth, and most patients were not seen in continuity. The system, then, was incomplete and fragmented, and the services were physically and emotionally distant from those who were served.

This state-funded state hospital system remains an important part of the U.S. mental illness delivery system—a situation that will continue for the foreseeable future. The development of newer delivery systems such as the community mental health center has led some people to believe that the state hospital-based system could be phased out. However, ten years of experience with a newer system have not yet eliminated the need for the older service delivery system, and there are no indications that this situation will change in the immediate future. Several states, including California, have embarked on experimental financial incentive programs to encourage local communities to avoid sending patients to state hospitals. These experimental programs have resulted in a sharper decrease in utilization and bed requirements and a more rapid closing of such facilities.

Another major, publicly funded system for the treatment of mental illness is the Veterans Administration system of outpatient care: hospitalization in general medical and surgical hospitals (equivalent to community general hospitals); large hospitals for the mentally ill (equivalent

to state hospitals); and various types of rehabilitation services. This range of resources more nearly forms a coherent system. There are, however, problems about eligibility in various parts of the system, with service-connected disability being the most important criterion. Other difficulties in the system include the physical distance between client and service, difficulties in communication among various portions of the system, and difficulties in interconnections and patient flow.

The most recently developed publicly supported system for mental health and illness care is the community mental health center. Typically, the centers provide five services—inpatient, outpatient, emergency, partial hospitalization, and consultation and education—to a geographically defined population of 75,000 to 200,000 people. Legislation originally made provision for both construction and staffing grants, but more recently most of the available money has been allocated for staffing. Community mental health center systems are under various governance auspices, including existent institutions and agencies, consortia of existent resources, and new community or other types of corporations. Federal support is on a diminishing matching basis over a five- or eight-year period, with the expectation that local funding will be provided for the increasing local share.

The above systems have several advantages: a defined population; a comprehensive set of services; location in the community to be served; a

service system under single organizational, administrative, and management auspices and more responsive to local community needs and wishes; a common record system, with ease of flow of information and of clients; and universal eligibility. However, there are also major deficiencies: difficulties in reaching objectives; the complexity of the political and governance issues; and the problem of acquiring suitable personnel. The systems have sometimes been divided by political forces in local communities, with the struggle for control of resources becoming more important than the needs of clients. Depending on local conditions and on choice, these systems may be more or less connected with health, social service, educational, and legal systems or with the other mental illness service delivery systems.

A major part of current mental illness service delivery is within the fee-for-service system, which may be either a part of or separate from the medical care system. This service system consists of individual professionals, alone or in group practice with other psychiatrists, and/or medical practitioners providing ambulatory services. The inpatient services are usually provided in psychiatric units of community general hospitals or in privately operated psychiatric hospitals. The more usual mode of intervention in the outpatient setting is psychoanalytically-oriented psychotherapy, although there is also a widespread use of other techniques.

There has been only limited experience with modes of payments other

than fee-for-service (American Psychiatric Association, 1968; Burnell, 1971; Hess, 1966; National Association for Mental Health, 1969; Reed, 1972)—i.e., capitation, or uniform tax—or with other forms of organization such as the health care corporation or the health maintenance organization (Burnell, 1971; Goldensohn, 1969; Green, 1969). Populations thus served must be able to finance their own care, either through their own payments or through third-party payers.

The Problem of National Policy

In the late 1960s and early 1970s it was commonly recognized that desires and needs for all human services were very great but that resources were finite. Questions of gaps and overlaps in services became more urgent, and there were increasing pressures to make certain that high-quality services were being efficiently delivered. These issues became most apparent in medical care delivery, where there were serious organizational, manpower, and financial problems. The public and Congress began to examine these problems and to consider various types of universal health insurance and the possible influence of new forms of medical service organization. There were also major attempts to influence the production of manpower and sway the direction of its activities toward primary care. Thus, in the early 1970s a national policy on health services remains undefined, both as to their organization and as to their financing.

Congress and the national administration are unclear as to whether mental health and illness services need to be included within the proposed reorganization of medical care delivery. There has been even greater confusion about the more specific issue of services for the mentally ill. Congress is concerned about the potential cost of such services; it also wishes to maintain local responsibility wherever possible—historically, mainly at the state level. Thus the early proposals for universal health insurance were remarkable for their absence of coverage for the mentally ill or the emotionally maladaptive.

Further, the late 1960s saw little increase in the federal moneys available for mental health and illness services through the community mental health center model. Essentially stable amounts of money reflected both monetary shortages and uncertainty whether the community mental health center model was the best one available. As yet there is no clear-cut public decision about the methods of financing and organizing mental health and illness services, and the degree of their connectedness to medical services.

The Future Organization of Services for the Mentally Ill

The organization of services for the mentally ill is likely to remain pluralistic in the United States for a while. Financing will also probably

continue to be from multiple sources, both public and private, with combinations of personal, third party, and local, state, and federal money. However, there will be increasing pressure for a national policy for these as well as other services, and for financing. This national policy will probably establish some guidelines for and constraints on the expected diversity, quantity, and quality of services, as well as suggestions about ownership, governance, evaluation, finance, manpower, and their relationship to other human services.

Ownership, Governance, and Administration

Very little is known about the comparative advantages of various ownership arrangements. Typically, in the past, the ownership of mental health and illness services has been vested in a not-for-profit agency or institution oriented to service and/or education; a public political body such as a city, county, state, or federal structure; or a group of professionals. There has been relatively little experience with consumer, community, union, industrial, or business ownership. Recent developments have fostered community or consumer ownerships. The advocates of this model claim that such ownership will be more responsive to community needs, more innovative in the types of service delivered and the types of manpower utilized, and less bound by traditional bureaucratic constraints. The balance between these advantages and the inputs of knowledgeable, responsible, and

sensitive professionals and institutions is not yet clear. As a result there have been many tensions and conflicts in some of the new community-based systems.

Governance is closely related to ownership and many of the issues are similar. The balance between the professionals, the professional administrator, the institution, and the inputs from the lay community and consumer is critical if one wishes to establish a sensitive and sensible governance and administrative system that is flexible, responsive, responsible, and able to change.

Ownership, governance, and administrative structures must somehow be developed that balance the advocacy positions among the interested parties. These parties could well include such diverse groups as local communities and their organizations, professionals from a number of disciplines, agencies and institutions such as clinics and hospitals, educational institutions such as medical colleges and universities, the larger community with its formal and informal political organizations, and various agencies that may have roles and functions concerned with planning, development, funding, and evaluation. Clearly this is a complex, important, and relatively untapped area for careful investigation and evaluation. A current danger is that there would be premature closure of the investigation with public regulations that made a final choice among one or another of the possible

mechanisms to deal with these important functions.

Organization of Services

Current models for mental health service delivery include the large mental hospital-oriented system, the community mental health service system, the private practice-community general hospital system, and various combinations of these. These current systems have been largely separate from one another. When combined with other human service delivery systems, the health delivery system has been the most common choice. Only in recent years has there been serious consideration of combinations with educational services, legal services, or social services.

The community mental health service model will probably continue to expand its geographic and population coverage slowly. A possible competitive and potentially collaborative model would be the health care corporation, the health maintenance organization, or the physician foundation. In these delivery systems, mental health and illness services would become a part of comprehensive health services for a population defined by voluntary enrollment. Personnel could then be a part of the health and illness treatment system, or that system could purchase certain services from the nearby community mental health service system or other mental illness service systems. The likelihood of this development depends, of course, on current

discussions in Congress about national health and illness insurance and service organization possibilities. Also, it is as yet unclear to what extent mental health and illness services will be included within such systems.

The extension of mental health and illness services into other human service systems such as educational, legal, and social services has occurred in a few instances, usually utilizing a consultation model (Caplan, 1964). The mental health professionals share knowledge and expertise with the primary professionals from the other service systems. The mental health and illness interventions are mainly indirect.

A somewhat different model has occasionally been used, i.e., the mental health professionals and their services becoming a primary part of the other human service systems. Still another variant is the multiservice human service system, in which many or all of these services are available in a single organizational framework, often in a single location (Williams, 1969; The Woodlawn Organization, 1970).

These several possibilities for organization of services have not been evaluated comparatively. Under current arrangements, however, most professionals and most funding and payment agencies favor either the separatist model or the health system model. The other models are almost always financed by programmatic research moneys.

Manpower

The mental health and illness service systems have been experimenting with the types and mixes of manpower necessary to deliver optimum service. Frequently the experimentation has been based on extreme shortages of manpower and the need to make an effective delivery system operative with these limited quantities. The major disciplines involved continue to be medicine, nursing, psychology, and social work. Perhaps the most striking and the most uncertain of the new developments is the use of mental health technicians. These individuals may come from a variety of educational levels (from less than high school to four years of college) and with varying degrees of training (from specialized training programs of some duration to mainly on-the-job training). There has also been considerable experimentation with individuals having special life experiences or qualities, such as persons having origins in the indigenous community, college students, persons having successfully raised children, or middle-aged housewives. The use of these types of manpower has been largely left to local option, as has been the mix of professionals involved in a particular program. Again, the optimum arrangements are not clear, and there is no convincing evidence for a particular composition of mental health and illness service system staff.

Finance

The methods of finance are unclear, particularly for the future. The two major methods of financing services have been fee-for-service and public subsidy, usually through state and federal tax moneys. Professionals have been paid by fee-for-service and salaried arrangements. Part of the lack of clarity about method arises out of a controversy concerning what level of government is responsible for financing what service. There has been a tendency on the part of political units to displace responsibility to other levels, thereby saving a particular level's tax dollars. However, this struggle frequently results in the consumer being caught between various public groups, none of which wish to accept responsibility.

Developments at the national level brought new means of financing services during the 1960s. The mental health center moneys from the federal level supported staff salaries. Medicare and Medicaid (Somers, 1967) have frequently supported fee-for-service payments. In current discussions of universal health insurance, still another method of finance—the capitation method—is being considered. In this type of financing a payment is agreed upon in advance for a specified time period and for specified services. There is evidence, with medical care payments, that such a system decreases cost by decreasing the use of certain physician and hospital services without decreasing the quality of care or the health status of the population served. Evidence on the relationship between method of finance and the quantity, quality, and cost of mental health and illness services is not yet available,

although there is some suggestion that appropriate use of psychiatric consultation and services may reduce the overall use of medical services.

Finance becomes an extremely important factor in the quantity and quality of service provided, because service may be limited or defined by the extent of financial eligibility for service. Therefore the current and legislative activity on universal health insurance and the question of inclusion of psychiatric and mental illness coverage become extremely important factors in determining the organization of the mental illness service intervention system and the overall service system in which it will reside. Some data are available to suggest that the inclusion of service in any benefit package is socially and economically feasible.

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