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HISTORICAL PERSPECTIVES ON THE CARE AND TREATMENT OF THE MENTALLY ILL

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An examination of the history of mental illness and its treatment over the centuries reveals that the mentally ill have few advocates except each other and that their treatment has consisted of confinement and neglect. Reformers have pioneered for change, experienced brief success, but ultimately conditions for the mentally ill regress. Society continues to abhor mental illness as though its collective consciousness still believes in possession by evil spirits. Discussion of the early history moves from banishment to ships of fools, to European asylums, and to institutions run by the states in America. More recent history focuses on the National Committee for Mental Hygiene and its campaign for child guidance clinics, the Community Mental Health Centers legislation and community support projects. Meanwhile new research provides evidence of the genetic and biological roots of mental illness and advocacy organizations composed of patients and their families pressure for continued reform, public education and research.

Care and treatment of the mentally ill are no longer parochial issues of concern only to mental health professionals, state government employees, and patients. The general public and advocacy groups, comprised primarily of families of the mentally ill, have become more involved in the plight of the mentally ill. As the situation of the millions of homeless persons has received extensive attention, the plight of the homeless mentally ill has come under particular scrutiny. What will the future hold for those who are dislocated and ill, such as the

new breed of young chronic patients, and the mentally ill elderly? It is extremely difficult to predict the future. However, an historical review of the six major movements in the treatment of the mentally ill can better prepare us to move into the next decade, when much-needed services must be provided.

This article begins by tracing the progress of treatment for the mentally ill from the early days of bloodletting and witch-hunts to long-term institutional confinement and punishment. We then turn our attention to an examination of moral treatment and humane care under the leadership of Pinel, Tuke, and Rush in the late 1700s. This is followed by a discussion of the noteworthy reform efforts of Dorothea Dix, who was influential in founding or enlarging 32 state hospitals for the insane. She is also credited with moving the mentally ill out of overcrowded jails and poorhouses and into state asylums for the mentally ill.

The mental hygiene movement, initiated by Clifford Beers in the early 1900s, led to the formation of the National Committee for Mental Hygiene as well as the gradual establishment of chapters and societies in many states. This citizen mental health movement also resulted in the development of child guidance clinics.

The next wave of reform was the community mental health movement, which began in the 1940s and received its greatest impetus from the federal legislation and funding of the 1960s. President Kennedy's bold new approach would begin the period of passive deinstitutionalization by laying out an organized structure of mental health centers in catchment areas around the country.

Finally, this article discusses the landmark legal decisions on behalf of the mentally ill and the active deinstitutionalization of the 1970s. The reforms of the late 1970s and the current decade of the 1980s include innovations in discharge planning, day treatment and community support programs, job coaching and work adjustment programs, and the family advocacy groups, as well as enormous advances in understanding the human brain and its relationship to mental illness.

As we examine the emergence and impact of each major reform movement, it becomes apparent that each movement was in vogue and flourished for a time before being replaced by the emergence of a different and more humane philosophy. Initial success would turn to overcrowding, retrenchment, scarce resources, and neglect. It is our hope that policy makers can learn from the mistakes of the past by supporting programs with a primary focus on early assessment and treatment of the mentally ill in community settings.

POINT OF DEPARTURE

From the Middle Ages through the seventeenth century, mental illness was viewed as an aberration brought on by evil spirits or witchcraft. It was not uncommon for some mentally ill persons to be executed or persecuted as witches, while others were viewed as "town fools" or "village idiots." These unfortunate individuals were the recipients of acts of charity by some persons while other townspeople treated the mentally ill as objects for their amusement, ridicule, or sadistic acts. Those suffering from mental illness were sometimes kept at home in chains while others were thrown out of their community and forced to survive on their own in the streets or the forests.

During the Middle Ages, treatment of the mentally ill included trephining the skull of the mental patient in order to allow the escape of the evil spirit believed to have caused the madness, as well as exorcism of the evil spirits through religious prayers and rituals. Apart from efforts to remove the demons from the patient by exorcism or divine healing, the patients were often beaten, chained, starved or bled to keep them under control.

According to Michel Foucault (1965), treatment of the insane grew increasingly more inhumane as Western society moved from the Middle Ages into the Age of Reason. Once objects of charity, the mentally ill were sent into the waterways on Ships of Fools and, later, confined to the asylum. The "Age of Confinement" corresponded roughly to the period of scientific enlightenment, the spirit of which permeated the new land

that was America. Moral reformers on both the European and American continents would attempt to humanize the asylum, but would not abolish it.

MORAL TREATMENT

The first major effort to provide humane care to the mentally ill occurred in the late eighteenth and early nineteenth centuries. This major reform movement has become recognized and referred to as "moral treatment." Moral treatment was initiated by three humanitarian reformers: Dr. Philippe Pinel in France; William Tuke in England; and Benjamin Rush in the United States.

In 1792, Dr. Philippe Pinel was put in charge of the Bicetre Hospital in Paris. Pinel had the chains removed from hundreds of insane patients and moved them out of the dungeons where they had been kept. He successfully changed Paris' worst asylum from a punitive and repressive institution to a progressive psychiatrically-oriented hospital (Rothman, 1971; Dain, 1964). Pinel's view (which was perceived as radical in the 1790s) was that the mentally ill were not incurable criminals but were ill persons who could be cured by being sent to a mental hospital where they would receive "considerate treatment, occupational therapy, entertainment, mild exercise, good food and comfortable lodgings" (Dain, 1964: 5).

Pinel's book, *Treatise on Insanity*, was published in 1801 and received wide acclaim. His theory of moral treatment became the basis for French laws pertaining to mental health. Pinel was appointed to a top medical school faculty position and for twenty years taught medical students the principles and practices of moral treatment of the mentally ill (Bromberg, 1975).

William Tuke, a Quaker and a layman was influential in changing attitudes toward the mentally disturbed in England in much the same way that Pinel was improving the conditions in France. Tuke rejected the punitiveness and brutality of the English wardens and became an advocate for treating mental patients with humanity and dignity. His two major accomplishments included: writing a widely read book entitled, *Treatise of the Moral Treatment of the Insane*, and founding a small

therapeutic retreat for the insane at York in Northern England in 1796.

Tuke lived at the Retreat and treated the patients as members of his family. The residents were encouraged to participate in moderate physical exercise. Social reformers and physicians from throughout Europe and America came to view Tuke's methods. Three generations of Tukes continued the work of William Tuke in treating the mentally ill with kindness, respect and humanity.

In the early 1800s, Dr. Benjamin Rush introduced the theory of moral treatment at Pennsylvania Hospital in Philadelphia, the first hospital in the United States dedicated to providing humane moral treatment for the mentally ill. This hospital was built by the Pennsylvania Quakers and patterned after England's York Retreat. The Friends Asylum in Pennsylvania was founded in 1817 and Hartford Retreat in Connecticut began soon after in 1824. By 1847, 30 asylums for moral treatment had been established along the East coast from New Hampshire to South Carolina.

The first American state mental hospital, established exclusively for the seriously mentally ill, was opened in 1773 at Williamsburg, Virginia. This institution marked the beginning of state responsibility and state care for the insane. Virginia's state Lunatic Hospital "was built entirely at state expense and the indigent patients therein were wholly supported by state funds" (Deutsch, 1949: 230).

Fifty years elapsed before other states began to follow Virginia's lead. In 1822, Kentucky opened a state mental asylum for paupers and indigent insane persons in Lexington, Kentucky. In 1833, Worcester State Hospital in Massachusetts was opened, followed by the Utica Asylum in New York State. Between 1836 and 1842, nine new public hospitals were opened (Deutsch, 1949).

Dorothea Dix, who had worked as a Sunday School teacher and was in poor physical health, began her advocacy efforts for the poor and insane in the early 1840s. Dix was able to obtain the support of elite and influential persons in New England as she became an outspoken advocate for the building of state

mental hospitals. She encouraged political leaders nationwide to introduce bills in their state legislatures for the building of mental hospitals. Dorothea Dix and her allies worked tirelessly from 1847 to 1854 in an attempt to convince Congress to pass the "12, 250,000 acre" bill (Grob, 1966; Deutsch, 1937). Enactment of this federal bill would have resulted in granting the proceeds of a federal land sale for the building of public mental hospitals. Congress did pass the bill for which she had lobbied but it failed to be enacted because of President Pierce's veto. Pierce's rationale for the veto had been that the care of the mentally ill was the province of the states not the federal government.

As a direct result of Dix's indefatigable efforts, 32 public mental hospitals were founded. Unfortunately, these institutions soon became holding pens for impoverished immigrants, people who had difficulty adjusting to rapid social changes and industrialization, and an increasing number of disabled elderly.

Moral asylums were designed to be relatively small so that staff-patient relationships could be developed and a therapeutic milieu sustained. By the 1850s, public mental asylums were transformed from small facilities into large, custodial mental hospitals. With the rapid influx of impoverished immigrant groups and the increased numbers of paupers, state governments chose to expand asylum capacities and build larger institutions for the mentally ill. The hospitals grew in size and became overcrowded—filled beyond their capacity (Deutsch, 1937). Reforms of the past had faded. The stage was set for the next social movement, which was not to begin until the early twentieth century.

MENTAL HYGIENE MOVEMENT

The next important reform movement that challenged institutional treatment was the mental hygiene movement. This reform received its greatest impetus and leadership from the fervent work of Clifford Beers, advocate for the humane treatment of the mentally ill. Beers published his autobiography, *A Mind That Found Itself*, in 1908. This groundbreaking and influ-

ential book became a classic in the field. Both the general public and the academic community paid special attention to Beers' personal account of the harsh treatment he had received during his years of institutionalization (primarily at the Connecticut State Hospital for the Insane at Middletown).

The book's strength was derived from Beers' candor in discussing his illness while also reporting that the asylum had done nothing to cure him. While Beers was institutionalized he observed that the patients who were passive and self-sufficient (requiring little attention from staff) were also generally those who least needed treatment. In contrast, the patients who were infirm or needed assistance were often abused due to the very helplessness which necessitated aid from the staff. The treatment for some of the violent or troublesome patients was a padded cell that left them half-frozen for days at a time. Other irksome patients were assigned to the violent wards where the loud noises and horrendous smells constituted an "exquisite torture" (Rothman, 1980).

Beers' goal was not to close the asylums but rather to improve the dreadful conditions and eliminate the physical abuse that was so prevalent. Accordingly, he advocated for higher salaries and improved living conditions for attendants hoping that persons with a more humane and sensitive outlook would become interested in working in an asylum.

Beers' book was of high literary quality and was endorsed with a laudatory foreword by William James. The book continues to be regarded as a classic in the field, having been reprinted 41 times since it was first published in 1908. A year after the book's publication Beers organized the National Committee for Mental Hygiene, which was the forerunner of the National Mental Health Association.

The National Committee had a directing board which included several esteemed psychiatrists, medical and public health officials, and politicians as well as lay people (Lemkau, 1982). Such well-known persons as Jane Addams, William James and Adolf Meyer became actively involved in the Committee's work. Meyer is credited with convincing Beers to extend the focus of their movement to include prevention of men-

tal illness. Meyer also worked on the development of such projects as outpatient clinics, aftercare programs, and educational outreach to warn the public about bad mental habits (Dain, 1976; Rothman, 1980).

Beers was directly involved in helping states establish their own mental health association. The primary goal of the early state associations was to organize concerned citizens into coalitions so that they could advocate for correcting the abuses in the state asylums. The first such association (the Connecticut Society for Mental Hygiene) was founded by Beers in 1908 followed by the formation of societies in Illinois (1909), New York (1910), Maryland, Massachusetts and Pennsylvania (all in 1913), and Indiana (1916). (Indiana Mental Health Memorial Foundation, 1966).

In 1922, the National Committee for Mental Hygiene launched a five-year demonstration project developing child guidance clinics in eight cities with financing from the Commonwealth fund in New York City. St. Louis was selected as the site for the first child guidance clinic (Stevenson, 1934). By the 1930s and 1940s large numbers of psychiatric social workers had been hired to work in teams with psychiatrists to treat emotionally disturbed children and pre-delinquents.

Although the clinics were usually directed by a psychiatrist, social workers formed the core of clinic operations as they worked with children, families and school and court personnel. Levine and Levine (1970) found that social workers eventually came to dominate these diagnostic, treatment and delinquency prevention clinics, if not in status then certainly in numbers and in their significant influence on practice with children exhibiting behavioral disorders. By the late 1950s, the number of child guidance clinics had grown to over 600, most of them located in large cities (Robison, 1960; Teele & Levine, 1968). Many of the child guidance clinics would later form the foundation for a community mental health program.

COMMUNITY MENTAL HEALTH MOVEMENT

The concurrent decline of the mental hygiene movement and the rise of the community mental health movement oc-

curred soon after the end of World War II. Several community-based models emerged and major legislation was passed. By 1947 extramural mental health services such as home care and outpatient clinics had been established by 15 state agencies that ran state hospitals and seven state departments of health (Lowry, 1953).

The models for brief treatment and crisis intervention, consultation and education in community settings were developed by Erich Lindemann during his early work at the Harvard School of Public Health and the Wellesley Human Relations Service in Massachusetts. Lindemann's methods were based on helping people to cope with the crisis of bereavement in the aftermath of the tragic Coconut Grove Fire in Boston in which dozens of people were killed (Lindemann, 1944; Mora, 1967). His models and techniques were used by the first community mental health centers (Caplan, 1964; Goldman & Morrissey, 1985).

The National Institute of Mental Health (NIMH)—"the national focal point of concern, leadership, and effort for the mentally ill"—was created through the National Mental Health Act of 1946 (Foley & Sharfstein, 1983: 19). The 1946 Act marked the first significant federal legislation in the mental health field. This landmark legislation authorized $7.5 million for the following purposes:

> (1) Fostering and aiding research related to the cause, diagnosis, and treatment of neuropsychiatric disorders; (2) Providing for the training of personnel for the award of fellowships to individuals, and for grants to public and nonprofit institutions, and (3) Aiding states in the prevention, diagnosis, and treatment of neuropsychiatric disorders through grants and technical assistance (U.S. Congress, 1946: 1; Foley & Sharfstein, 1983: 19).

The next significant federal legislation in the mental health arena was the Mental Health Study Act of 1955. The 84th Congress passed the Mental Health Study Act that authorized the formation of the Joint Commission on Mental Illness and Health (U.S. Congress, 1955). Congress then appropriated $1.25 million for the Joint Commission to conduct a nationwide

study of the approaches to treating mental illness and to make recommendations for improving the care and treatment of the mentally ill. The Commission completed its work in 1960 having produced ten monographs. The final report, entitled "Action for Mental Health" (1961) called for a major change in the system of care for the mentally ill. The most important recommendation of the Joint Commission's final report was in the area of secondary prevention: "If the development of more serious mental breakdowns is to be prevented . . . one fully staffed, full-time mental health clinic [should be] available [in their community] to each 50,000 of population." (In 1960, that would have amounted to some 3,000 clinics). Such clinics, the Commission stated . . . "are a main line of defense in reducing the need of many persons with major mental illness for prolonged or repeated hospitalizations" (Joint Commission on Mental Illness and Health, 1961:XIV). Upon reaching the desk of President John F. Kennedy, the final report of the Joint Commission found a highly receptive audience. With the purpose of converting the monographs into a politically persuasive set of recommendations calling for a national mental health program. President Kennedy appointed an Interagency committee on Mental Health (Sec'y. of Labor, the Sec'y of Health Education, and Welfare, the Administrator of Veterans Affairs, Representatives of the Bureau of the Budget, the Council of Economic Advisors and staff members of NIMH).

President Kennedy took the recommendations of his Interagency Committee on Mental Health (which were submitted to him in December, 1962) and embodied them in his historical call to Congress of February 5, 1963. This special message became known as President Kennedy's "bold new approach." The President's address on mental health and mental retardation was historically significant because it was the first time in American history that a president set the stage through a special speech for new legislation on mental health and illness. President Kennedy's "bold new approach" proposed a national mental health program based on comprehensive community care. Hearings began soon after the president's special message to Congress. Within a few months Congress passed

the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (U.S. Congress, 1963). This important legislation led to the development of over 760 community mental health centers in the next 18 years (Winslow, 1982: 273).

The community mental health centers legislation was to make significant progress in the delivery of public mental health services throughout the country. Most notable was their success in increasing the quantity of community-based outpatient care and partial hospitalization services. Between 1955 and 1977, the total number of episodes of patient care in the United States increased from 1.7 to 6.9 million. By 1977, CMHCs were responsible for 32 percent of patient care in contrast to none in 1955 (Dowell & Ciarlo, 1983: 97).

Despite the profound change in policy forged by the designers of the new legislation, analysts and critics have labeled it as more ideological and political than rational in its approach to the problems (Connery, 1968; Chu & Trotter, 1974). They argued that the five essential services (outpatient, inpatient, emergency, and partial hospital services and consultation and education) were not clearly linked to desired outcomes (Chu & Trotter, 1974). Planners had not anticipated the tremendous needs of institutionalized patients who may be discharged to communities and had given only limited direction as to what the goals of the policy were and how to reach them. Generally, CMHCs developed with a relatively healthy clientele in mind; chronically and severely ill patients remained in hospitals or went into the community where they "slipped through the service-delivery cracks."

DEINSTITUTIONALIZATION

Mental health policy and ideology in the 1960s reflected a conservative and optimistic approach to reform. By the 1970s, 1960s style social activism confronted the mental health bureaucracy. Civil rights lawyers and consumer advocates took a more active stance vis a vis state mental hospitals and their administrators. Pressure to grant civil rights to patients and to forsake institutional patterns of earlier years accelerated. The

bureaucracy responded by adopting policies and programs that actively addressed deinstitutionalization of chronically and severely mentally ill patients.

Backed by historical and philosophical analyses that attacked the practice of incarceration (Foucault, 1965; Rothman, 1971), civil rights advocates for the institutionalized mentally ill pushed forward to victory in case after case in courts across the land. The Wyatt versus Stickney decision in 1972 established the right to treatment in the least restrictive setting and set minimum standards for adequate habilitation (Stone, 1975; Mechanic, 1980; Prigmore and Davis, 1973). Following the Wyatt/Stickney decision came several others. Among them was the Supreme Court decision in favor of Kenneth Donaldson, who later became a public speaker for the rights of the incarcerated mentally ill (Donaldson, 1976). Donaldson's story revealed how he had been held against his will for fifteen years in a Florida institution until he was finally rescued by the attorneys and advocacy groups who helped him take his case through the courts.

Advocacy groups, such as the National Mental Health Association, assisted Donaldson with his case and with the public speaking campaign afterwards. More militant groups, like the National Alliance of Mental Patients, also emerged (Chamberlin, 1978). The names of the early mutual-aid advocacy groups—Network Against Psychiatric Assault, Fire and Rain, Coalition to Stop Institutional Violence—reflect their anger toward the psychiatric and bureaucratic establishments. The militant self-help organizations have not enjoyed wide success in efforts to sustain and assist the many chronic mental patients who were to leave hospitals in late 1970s and 1980s, but the idea that patients can help other patients survived. This concept was bolstered by the research of George Fairweather and his associates (Fairweather, Sanders, Cressler & Maynard, 1969). The Fairweather Lodge model of community care provided an opportunity for evaluation of experimental and control groups of patients following discharge. The experimental lodge program, heavily dependent on peer helping, showed positive results. New developments in mutual aid and evalua-

tion of its effectiveness were to follow throughout the next two decades.

By 1975, policy makers had been convinced that the original community mental health centers legislation would not bring about the demise of institutions nor would it guide implementation of needed services to those whose civil rights required that they be discharged to less restrictive settings. Amendments to the CMHC legislation required seven new services. Those services included: specialized services for children and the elderly, court screening prior to hospitalization, follow-up service, transitional living facilities, alcohol abuse and drug abuse treatment (Kuramoto, 1977; Foley and Sharfstein, 1983). By this time, community mental health centers had also begun to implement treatment programs for alcoholics that had been mandated by the 1970 Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act.

By 1975, the number of state hospital residents would decline from 550,000 in 1955 to less than 200,000 (Presidents Commission on Mental Health, 1978). The greater numbers of mentally ill in the community were beginning to have an impact. Community mental health workers struggled to develop new ways to serve them, often with little direction and little budgetary support. The Community Support Program (CSP), initiated in 1977 by the NIMH, would assist in developing community supports to the chronically and severally mentally ill.

The CSP attempted to develop "a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (NIMH, 1979: 1). Components of the CSP model were essentially those now considered the essence of a psychosocial rehabilitation model on the order of Fountain House in New York and Thresholds in Chicago (Beard, Propst & Malamud, 1982; Dincin, 1975). Although funding for CSPs has declined with the cutbacks of the 1980s, the psychosocial model endures and evaluation of its effectiveness has supported the model's efficacy (Bond, Dincin, Setze, & Witheridege, 1984; Stein & Test, 1978; Test, 1981).

By the end of the 1970s decade, the Mental Health Systems Act would emerge as an historic document representing the apex of the past 25 years of policy directed toward community care for the mentally ill. In addition, the 1980 act reflected the growing trend toward fiscal accountability and regulation in government. By 1981, however, the Reagan administration had repealed the act and the stage was set for the themes of the 1980s: cutback and local control.

DECADE OF SCARCITY

The 1980s have pressed mental health policy makers and practitioners to deal with scarcity and to institute accountability measures. The Omnibus Reconciliation Act of 1981 abandoned federal policy direction enforced by centralized funding and in its place came block grants to states, which allowed them to develop programs independently. Further, the new legislation cut the allocations of federal dollars and cuts have continued (Foley & Sharfstein, 1983, p. 136; Morrissey & Goldman, 1984).

One of the paradoxes of cutback is the decrease in the number of qualified professionals at a time when creativity and skill are most needed (Levine, 1979). In mental health, the use of paraprofessionals to serve the poor in public programs has raised concern for quality and prompted some to advocate for fewer but better professionals complemented by mutual self-help programs (Korten, 1981; Hansell, 1982). Moreover, cutback in funding coupled with the necessity for expensive support services to a chronically ill population presented policy makers with conflicting demands. Community mental health centers are now more likely to provide services that generate revenue. Billable services, however, are often not appropriate for low income, chronically ill mental patients. Furthermore, the reimbursement criteria have resulted in a gradual decline in the use of outpatient services because insurance companies are usually more likely to reimburse for inpatient rather than outpatient care. (Dowell & Ciarlo, 1983)

Mental health administrators in the 1980s agree that chronic mental illness is a top concern (Ahr & Holcomb, 1985). The belated public policy focus in this area has been supported by

at least three factors: (1) The publicity surrounding visible homelessness among the deinstitutionalized mentally ill, (2) Research findings that give direction for treatment, and (3) Pressure from consumer advocacy groups, such as the National Mental Health Association and the National Alliance for the Mentally Ill (NAMI).

By the mid-1980s, those receiving institutional care had decreased to approximately 125,000 (Mechanic, 1986), however, many formerly institutionalized in state hospitals had simply been transferred to nursing homes. According to the most recent nursing home survey in 1977, 100,000 formerly institutionalized mental patients now reside in nursing homes (Department of Health and Human Services, 1980). Moreover, it is suspected that many of the mentally ill have been incarcerated in jails and prisons. According to the 1980 U.S. Census there were 466,000 persons in correctional institutions. Studies of jail and prison inmates in California, Colorado, and Oklahoma indicated that 6.7, 5.0 and 5.2 percent respectively were psychotic (Lamb & Grant, 1982). When the average of these percentages is used (5.6 percent), an estimated 26,000 seriously mentally ill persons are confined in jails and prisons.

Although David Rothman predicted that institutional care and community care could not co-exist (Rothman, 1980) and despite continuing battle for the same funds, recent appraisal indicates that due to differing responses to treatment, both community and institutional care are needed (Gudeman & Shore, 1984). Psychosocial rehabilitation strategies continue to dominate community planning for high priority patients. These strategies include vocational assistance, housing in the form of group homes and other communal living arrangements, day services and self-help clubs (Beard, Propst & Malamud, 1982; Reinke & Greenley, 1986). Despite the well-supported evidence for their effectiveness, community support programs are not sufficiently funded to prevent homelessness among the mentally ill in American cities.

Although public programs have not been able to totally reverse centuries of incarceration for the mentally ill, research in biochemistry and family relationships has promised a some-

what brighter future for some patients and their families (Andreasen, 1985; Whybrow, Akiskal & McKinney, 1984; Gold, 1987; Falloon, Boyd & McGill, 1984; Taylor, 1987). Research on schizophrenia has shown brain abnormalities that are clearly biological (Taylor, 1987). Although these findings have not pointed toward cure, they have clarified the problem and given direction for more appropriate treatment and for family care. Findings on the biochemistry of mood disorders are more hopeful (Gold, 1987).

As research findings have given strength to a disease concept of mental illness, biopsychiatrists have joined with self-help advocacy groups like NAMI and the National Depressive and Manic Depressive Association (NDMDA) to form a new coalition in the field of mental health. Mutual-aid groups in mental health have expanded and multiplied (Powell, 1987; Zinman, 1986; Kurtz & Chambon, In Press). Some of these groups are therapeutic in nature and respond to gaps in public services. One group that particularly serves the severely mentally ill is GROW, recently the object of an intensive NIMH-sponsored evaluation (Rappaport, et al., 1985). Other associations, NAMI and the NDMDA, promise to become a powerful collective force in public education and advocacy for research and social policy reform (Hatfield, 1984; Kurtz, 1987).

While services to the chronically mentally ill have expanded and adapted in the 1980s, other groups of people in need of caring remain underserved (Jerrell & Larsen, 1986). The social movements and research findings that have attracted attention in the first half of the 1980s will go on to forge new directives and new policies. Those whose needs have been ignored will find a voice in the years just ahead.

THE FUTURE

Who are those groups who will attract attention in the years to come? One group will clearly be the elderly (Fleming, Rickards, Santos, & West, 1986). Another group, whose voice is being heard now, is composed of the families of the mentally ill. Research findings on depression point toward unanswered questions about why women seem to suffer from its grip more

often than do men (McBride, 1987). The needs of women require and will receive more attention. Moreover, the NIMH has just started to launch a major training campaign on the treatment of depression (Runck, 1986). Policy makers and administrators in the public arena will have to struggle with the increasing bifurcation of care: private care for the affluent and underfunded public care for the poor. Finally, perhaps the biggest question for the future concerns the continuing ability of community care programs to bring an end to centuries of incarceration for the mentally ill. Will social activists and researchers inspire policies which treat humanely those who exhibit deviant and even criminal behavior or will we see a return to confinement for large numbers of sick people?

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