A. F. Leuchter,[1] *M.D.*

The Responsibilities of the State for the Prevention and Treatment of Mental Illness Among Prisoners

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ABSTRACT: There is mounting evidence that severe stress may produce profound psychophysiologic disturbances that can persist for many years. Imprisonment may be viewed as one such stress. The prison population has a high baseline incidence of mental illness, reflecting the societal groups from which most prisoners are drawn. The great stress of imprisonment may thus be a significant factor in the exacerbation of existing psychoses or in the precipitation of first psychotic episodes in certain prisoners. The responsibilities of the state in the prevention and treatment of mental illness among prisoners are not clear. United States Supreme Court rulings on sentencing procedures could be interpreted as requiring psychiatric evaluations of all prisoners. Furthermore, court rulings on the adequacy of medical care in prisons could be construed as requiring therapy for all prisoners suffering from major mental illnesses. Failure of the state to take reasonable steps to prevent and treat mental illness in the prison population may constitute cruel and unusual punishment under the Eighth Amendment of the Constitution.

KEYWORDS: psychiatry, jurisprudence, mental illness

The state has developed two primary mechanisms for the identification of mentally ill criminals: the examination for competency to stand trial and the evaluation for criminal responsibility. These evaluative processes do not systematically ferret out mentally ill criminals. These mechanisms identify and protect only those most seriously and obviously mentally ill, whose constitutional rights preclude their being processed by the criminal justice system.

There appear to be large numbers of individuals, seriously impaired by mental illness, who escape diagnosis during criminal justice proceedings. Some of these individuals probably suffer from mental illnesses that are not plainly manifested in the interval between arrest and sentencing. Other criminals may be plainly identified as mentally ill; however, if their illnesses are not clearly related to their offense or do not impair their competency, they too may be processed by the courts and sentenced to conventional incarceration. Another group of criminals may develop mental illness after imprisonment. An increasing body of evidence indicates that, for many inmates, conventional incarceration may be a factor in the precipitation or exacerbation of serious psychiatric disturbances. Psychiatrists are now discovering that such illness may produce long-lasting, or even lifelong, incapacity.

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[1]Resident, Department of Psychiatry, University of California at Los Angeles Neuropsychiatric Institute, Los Angeles, Calif. 90024.

Recent court decisions have begun to establish the responsibilities of the state with regard to the mental health of inmates. First, the courts and prisons must identify and treat those individuals in need of psychiatric care. Second, the prison system must, when possible, operate under conditions that do not predispose inmates to develop mental illness. Failure of the state to fulfill either responsibility may constitute cruel and unusual punishment.

Mental Illness and Criminal Behavior

The relationship between mental illness and criminal behavior has never been clear. It is predictable, however, that there would be a high incidence of mental illness among criminals. There are great similarities between the socioeconomic conditions that nurture criminal behavior and those that foster mental illness. Criminologists have long recognized those social and economic conditions that give rise to criminal behavior. The concentration of criminals has frequently been noted to be greatest in the core of the large city, where the population has a "low social status, with little to use, little to respect, and little to sustain efforts at self-advancement" [*1*]. Shaw and McKay [*2*], in their studies of inner-city Chicago, found that "attitudes which support and sanction" crime were virtually inherent to the social structure of "low-income areas," where social values and economic conditions placed individuals at high risk for developing criminal behavior.

In this century, psychiatrists also have recognized that life in the poor areas of the central city also places individuals at high risk for the development of serious mental illness. This observation was originally made by Bleuler [*3*]. The fact was later corroborated by Srole and his co-workers [*4*] in the Midtown Manhattan Study, which quantified the effect of low socioeconomic status on development of mental illness. Nearly half of the members of the lowest socioeconomic stratum surveyed were determined to have serious mental illness, as compared to less than one eighth of those from the highest stratum. Less than 5% of members of the lowest socioeconomic group were classified as mentally "well."

Attempts to determine the incidence of mental illness in the prison population have been fraught with difficulties. Inadequate documentation of psychiatric histories, difficulty of follow-up after initial evaluation, lack of subject cooperation, and the squalid conditions of many prisons have discouraged many investigators from evaluating the prison population [*5*]. Even among those studies that have been performed, comparative analysis of results is difficult. It is difficult to find two studies with similar diagnostic criteria and approaches. Furthermore, the particular prison population studied may significantly influence the results of a study. The population of a maximum security federal penitentiary contains a large proportion of recidivists and "lifers"; such a population might be expected to have higher rates of mental illness than that in a minimum security state facility [*6*]. In addition, the incidence of mental illness among criminal offenders may vary with the nature of crime committed [*7*].

Despite these difficulties, there is much evidence to indicate a high incidence of major mental illnesses among prisoners. Circumstantial evidence was discovered more than 40 years ago by Penrose [*8*], who found an inverse relationship between the number of persons institutionalized for mental illness and those incarcerated for crime in any given country. Systematic evaluation undertaken in recent years has begun to quantify the problem. Sutker and Moan [*9*], after psychologic evaluation of a large number of Louisiana prison farm inmates, found that approximately 15% of those criminals demonstrated psychologic testing patterns indicative of psychoses. Roth and Ervin [*6*] reviewed the records of more than 1000 prisoners in a federal penitentiary and found that 8% had at some time been diagnosed as psychotic. Six percent had been diagnosed as schizophrenic, more than six times the incidence found in the general population. In the Alabama state prison system, it has been estimated that 10% of the inmates are psychotic and another 60% have "severe" psychiatric disturbances [*10*]. Most studies have found that "overall psychiatric morbidity

in criminal populations is probably somewhere between 15 and 20 percent" [*11*], and for certain incarcerated subpopulations the rate may be even higher. Abrahamsen [*7*] found that approximately 12% of sex offenders could be labeled "schizophrenic" and that a much larger number had serious mental illnesses.

Influence of Imprisonment

These statistics yield little information regarding the influences of imprisonment on the natural history of mental illness. Incarceration conceivably could have beneficial effects on mental illness, just as the structured environment of the mental hospital can be supportive to those committed through civil procedures. Available evidence indicates, however, that imprisonment has significant deleterious effects on the mental health of prisoners. Roth and Ervin [*6*], in their study of a medium security federal penitentiary, reported that 4% of all inmates suffered onset of a psychosis (usually of the schizophrenic type) for the first time during their imprisonment. This number constituted one half of all inmates labeled psychotic. Thomas [*12*] cited a study in an unnamed maximum security prison where a similar incidence of initial psychotic reactions was noted.

Such psychotic reactions might represent one of two phenomena. First, it is possible that these reactions are indeed an initial psychotic break in an individual predisposed to mental illness. Second, such reactions might represent the surfacing of a psychosis previously in remission. In either case, a causal link might exist between imprisonment and the onset of mental illness. Empirical evidence indicates that the stress of imprisonment may precipitate or exacerbate serious mental illness.

It is well established that acute and dramatic changes in an individual's living conditions are associated with the onset of serious mental illness. The work of Brown and Birley [*13*] clearly demonstrated that "life crises" were related to the onset of acute schizophrenia. These researchers discovered that in the three months before the onset of mental illness, schizophrenic patients had a much higher incidence of crises and change in their lives than did the general population. Typical changes were loss of support or contact with friends or family members, or change in economic status resulting from loss of employment. The Manhattan Study [*4*] attempted to quantify this relationship between mental illness and changes in an individual's social and economic environment. Srole and co-workers demonstrated that those who were downwardly socially mobile (that is, those who moved to a socioeconomic class beneath their origin) were at $7\frac{1}{2}$ times the risk for serious mental illness of those who were upwardly mobile. Clausen [*14*] identified two features of downward social mobility that may account for the precipitation of mental illness: loss of useful social role and traumatic loss of significant social ties.

I believe that imprisonment should be considered as a "life crisis" that can precipitate serious mental illness. Imprisonment earned a rating of 63 "life change units" on Holmes and Rahe's social readjustment scale [*15*], which gave incarceration a high propensity (in conjunction with other life events) for causing illness in general. There certainly are specific aspects of the phenomenon of long-term imprisonment that correlate well with those factors known to precipitate mental illness. Imprisonment rends individuals from their meaningful social ties suddenly and traumatically. Furthermore, in many prisons, incarceration deprives individuals of a useful social role. Thomas [*12*] cites one state prison where "only 828 men of a total of 1285 had jobs of any kind ... [and] all the prison work could be done efficiently by approximately 500 men." Most inmates have little constructive work with which to occupy their time, according to Thomas, and "enforced idleness" is the rule in many prisons. Imprisonment can in many ways be viewed as the ultimate form of downward social mobility, where the prisoner becomes isolated from his previous social contacts, suffers a rapid and marked decline in his social and economic status, and becomes totally dependent on the state for his day-to-day needs and welfare.

Retrospective Studies

A second body of empirical data may be more directly relevant to the stresses of imprisonment and establishment of a causal link to mental illness. These data have been gathered from retrospective studies of individuals subjected to extreme stress: prisoners of war (POWs) released from North Vietnam, research personnel stationed at Antarctic scientific stations, and survivors of Nazi concentration camps.

Clearly, felons incarcerated in American prisons do not experience the total cultural disenfranchisement of the POWs; they do not experience the extreme hostility and monotony of the Antarctic environment; and they certainly do not experience the horrors and atrocities of Hitler's death camps. There are certain threads, however, that tie these three extreme situations together, linking them with the experience of the imprisoned criminal: confinement to a small living area; restrictions of movements and excursions; crowded living conditions; interactions with limited numbers of individuals; hostility of the surrounding environment; monotony of activities and sensory input; and physical stresses and threats. Not surprisingly, there appears to be a similar psychiatric response to all of these experiences. The former Antarctic personnel and liberated POWs experienced marked cognitive slowing, emotional withdrawal, reactive depressions, and generalized regressive behavior upon termination of their experiences. In many cases, these psychiatric disturbances persisted for several years after the termination of the stressful experience [*16,17*]. Eitinger and Strom [*18*], in their study of Norwegian concentration camp survivors, found a much higher incidence of cognitive difficulties and neuroses than was found among the other two groups. They also found an increased incidence of psychosis that was not noted among either Antarctic personnel or POWs. Furthermore, they noted that in many instances the concentration camp experience had induced lifelong mental illness in the survivors.

The subjects in each of these "survivor" studies were subjected to disparate forms of isolation and confinement. The Antarctic subjects entered their confinements voluntarily, whereas the others did not. The subjects in all three studies were drawn from high socioeconomic classes, and thus were generally lacking particular propensities to develop significant mental illness. Yet under conditions of extreme stress, large numbers of these individuals developed significant psychiatric illness.

One could postulate that individuals from low socioeconomic strata, or who were otherwise predisposed to the development of mental illness, might suffer a high rate of mental illness with even less stressful situations. This theory is supported by the stress response work of Horowitz [*19*]. He has concluded that "all persons would tend to develop [psychiatric illness] after major external stress in adult life, although they would [vary in the manifestations] ... according to their individual predispositions. Persons with certain latent neuroses or predisposition ... may respond at lower levels of external stress."

It is clear from these data that inmates suffering from major mental illnesses are not a homogeneous group. Some may have mental illness manifest at the time of incarceration; others can be expected to develop mental illness while in prison. The temporal variability in the onset of mental illness implies that efforts to decrease psychiatric morbidity among prisoners must not focus on a single segment of the criminal justice process. Instead, such efforts must involve both the prison and the court systems. These systems jointly share three responsibilities: (1) the treatment of prisoners suffering from serious mental illness; (2) the systematic identification of inmates whose mental illness is sufficiently serious to warrant treatment; and (3) the prevention of psychiatric morbidity among inmates where possible. Some court decisions have begun to establish responsibilities of the state in all three areas.

Court Decisions

The responsibility of the prison system to treat obvious mental illness is well recognized. In *Newman v. Alabama* [*10*], treatment of mental illness was included among the "basic

elements of adequate medical treatment" that the federal district court stated must be provided to inmates. Deprivation of any of these basic elements was construed to constitute cruel and unusual punishment. In *Newman*, the court observed that "the large majority of mentally disturbed prisoners received no treatment whatsoever. It is tautological that such care is constitutionally inadequate [under the Eighth Amendment]."

It appears that, in large part, the failure to treat mental illness is due to a failure to identify its presence. The dearth of accurate statistics on the incidence of mental illness demonstrates how little diagnostic effort has been expended. Failure to identify mental illness, however, does not exculpate the prison system from its responsibilities to treat mental illness. First, accurate diagnosis constitutes one of the basic elements of adequate medical care that must be afforded prisoners. Second, failure to diagnose illness would probably constitute "deliberate indifference" to medical needs. Such indifference was proscribed by the Supreme Court in *Estelle v. Gamble* [*20*]. Gamble, suffering from severe back pain, alleged failure of prison physicians to both diagnose and treat his illness:

> Deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain" proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs [or in other ways]. ... Regardless of how evidenced, deliberate indifference to a prisoner's serious illness states a cause of action.

Some courts have held that it is incumbent upon the prison system not only to identify inmates suffering from mental illness, but also to assign them to prison facilities and rehabilitation programs based on their mental capacity. In *Pugh v. Locke* [*21*], the court condemned the arbitrary confinement of mentally ill criminals under the same conditions as all other prisoners. Such arbitrary procedures for incarceration that did not take into account mental illness were one of many factors judged to constitute cruel and unusual punishment:

> Inmates are assigned to the various institutions, to particular dormitories, and to work assignments almost entirely on the basis of available space. Consequently the appreciable percentage of inmates suffering from some mental disorder is unidentified, and the mentally disturbed are dispersed throughout the prison population without receiving treatment. ... Some of these inmates should, according to the undisputed evidence presented in these cases, be transferred to a facility for the criminally insane, and many others should be treated within the penal system. ... Further effects of failure to classify are manifold. Violent inmates are not isolated from those who are young, passive or weak. Consequently, the latter inmates are repeatedly victimized by those who are stronger and more aggressive. ... Emotional and physical disabilities which require special attention pass unnoticed. There is no rational basis on which to assign inmates to the few vocational, educational and work opportunities which do exist. All of this contributes to the apathy, tension and frustrations which pervade Alabama prisons.

Court decisions can be interpreted as requiring the use of the tools of psychiatric diagnosis by the sentencing court as well as by the prison system. The necessity for establishing accurate psychiatric diagnoses before sentencing is an extension of the concept of graduated punishment. This requirement is based on the belief that justice is best served when the sentence takes into account both the history and the needs of the individual offender. This precept was first established by the Supreme Court in *Pennsylvania ex rel. Sullivan v. Ashe* [*22*]:

> In the determination of sentences, justice generally requires consideration of more than the particular acts by which the crime was committed and that there be taken into account the circumstances of the offense together with the character and the propensities of the offender. His past may be taken to indicate his present purposes and tendencies and significantly to suggest the period of restraint and the kind of discipline that ought to be imposed upon him.

This concept was developed further by the Court of Appeals for the District of Columbia, in the matter of *Leach v. United States* [*23*]. Leach, a recidivist convicted of robbery, had

a history of mental illness. The trial court had imposed the maximum sentence on the defendant without the benefit of a psychiatric examination and without taking into account the defendant's history. The case was remanded to the district court for reconsideration of sentence, because "there is no indication [that the court] ... made any use of the aids to sentencing placed at its disposal, [such as psychiatric evaluation]." In remanding the case, the appellate court reaffirmed the fact that sentencing must take into account the broader interests of the convicted criminal, in part through psychiatric evaluation:

> In sentencing, the judge must consider a program of rehabilitation designed to preclude, so far as current learning can furnish as guide, a repetition of the crime. ... [In this task, the judge may utilize] commitment prior to sentence to a hospital for examination to determine mental competence of the offender, and ... appointment of [a] psychiatrist and psychologist.

Both the prison and the court systems must attempt to recognize extant psychiatric disturbances and make some special provisions for those suffering from mental illness. The *Pugh* decision [*21*] can be construed as extending the responsibility of the prison system further, however, to include the prophylaxis of mental illness. The court appeared to acknowledge a causal link between environmental stress and the precipitation or exacerbation of psychiatric illness. The *Pugh* court found that certain specific conditions prevalent in Alabama prisons constituted severe environmental stress: crowding, idleness, lack of sanitation, and the constant threat of physical violence from inmates and guards were among the factors. The court concluded that the combination of these factors contributed to the mental deterioration of inmates:

> These conditions create an environment in which it is impossible for inmates to rehabilitate themselves—or to preserve skills and constructive attitudes already possessed. ... [This environment] makes dehabilitation inevitable ... and contributes to [inmates'] mental and physical degeneration.

This responsibility of the prison system for the prevention of mental illness can be construed as a constitutional requirement. The confinement of inmates in an environment that might precipitate or exacerbate mental illness was held to violate their constitutional rights under the Eighth Amendment [*21*]:

> It is clear that a penal system cannot be operated in such a manner that it impedes an inmate's ability to attempt rehabilitation, or simply to avoid physical, mental or social deterioration. ... [It is] cruel and unusual punishment to confine a person in an institution under circumstances which increase the likelihood of future confinement.

The courts have made no effort to define what specific types of mental illness among inmates must be treated. Some criteria must be established to delimit mental illness that is severe enough to warrant treatment. Clearly, the state cannot devote great resources to the treatment of each complaint of depression or anxiety among inmates. I have constructed two general criteria that define a serious mental illness requiring treatment. First, an individual probably must be treated if his illness is so severe that he is unable to comply with the demands of day-to-day life in prison. This criterion, based on practical considerations, was studied by Ernst and Keating [*24*] in the California prison system. They found that 10% of felons were "suffering from emotional illness of such degree as to preclude their adequately adapting to normal institutional regime" and that they required special observations or containment. This criterion seems to comply with the standards for classification and segregation of inmates set by the court in *Pugh* [*21*]. Second, a mentally ill inmate probably must be treated if his illness precludes possible rehabilitation. If an inmate became so incapacitated that he could not participate in rehabilitation, educational, vocational, or other programs, his illness probably would be preventing any attempt at rehabilitation. Such programs per se are not a constitutional right of the incarcerated. If an individual were incapable of participating in these programs solely because of mental illness, however, failure to treat the illness might constitute the impedance of rehabilitation proscribed by *Pugh*.

Conclusions

By creating a more humane environment for incarceration, the state would begin to fulfill its responsibility for the prevention of mental deterioration. Imprisonment cannot be a completely humane punishment, however, and no amount of prison reform would be adequate to eliminate all conditions that foster mental deterioration. Meaningful attempts at prophylaxis would require special programs and facilities better to enable inmates to deal with the stresses that are an inevitable consequence of confinement. The mental hygiene work of Allerton and Peterson [*25*] and the crisis intervention work of Querido [*36*] have demonstrated the effectiveness of supportive therapy at times of great stress. Such therapy, directly related to situational difficulties, has been shown to reduce the incidence or mental illness and to increase the capacity of individuals to cope with the demands of day-to-day life. A program to facilitate the adjustment of inmates to their incarceration should be part of an effective psychiatric treatment program, directed at the full spectrum of mental illness extant in the prison population. The discussion of the structure of such a program is beyond the scope of this paper.

The court decisions cited here list many instances in which the state has lost sight of its responsibilities for mental health care of prisoners. In discussing the state's shortcomings, however, it is important to consider the goals of incarceration. The failure of rehabilitation programs has forced the state to rank punishment as the primary goal of imprisonment. Some argue that the harsh conditions in many prisons legitimately further the goal of punishment and serve to deter some criminals. The lack of mental health services for prisoners contributes to the harshness of the prison environment. In punishing prisoners, however, the court and prison systems "must weigh the competing interests" [*21*] of the state and the prisoner. The state is obligated to provide some mental health care for prisoners; it is not obligated, however, to invest unlimited resources in the penal system. The state is entitled to punish severely those guilty of crimes; it is not entitled, however, to impede the rehabilitation and encourage the dehabilitation of prisoners. Much research is needed to determine what type of psychiatric therapy is most appropriate to treat mental illness among prisoners and how such therapy can be delivered on a cost-effective basis.

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Address requests for reprints or additional information to
Andrew F. Leuchter, M.D.
UCLA Neuropsychiatric Institute
760 Westwood Plaza
Los Angeles, Calif. 90024