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# The Structure of Correctional Mental Health Services

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While estimates vary, the high prevalence of serious mental illness in American jails and prisons is clear. Steadman and his colleagues (1987) demonstrated that the prevalence of severe or significant psychiatric disability among sentenced felons is at least 15 percent; when coupled with mental retardation or brain damage, at least 25 percent of the inmate population in the New York State Department of Correctional Services was found to have at least a significant psychiatric or functional disability. Teplin and Swartz (1989) demonstrated that the prevalence rates of schizophrenia and major affective disorder are two to three times higher in jails than in the general population, even after adjusting for demographic differences.

Axelson (1987) found significant discrimination against psychotic detainees charged with only misdemeanors in accessing various types of pretrial release. Similarly, Valdiserri, Carroll, and Hartl (1986) found that psychotic inmates were four times more likely than nonpsychotic inmates to have been incarcerated for less serious charges such as disorderly conduct and threats.

There are a number of reasons why people with mental illness find their way into correctional settings despite efforts (e.g., insanity defenses, alternatives to incarceration programs) to divert them to alternative dispositions. For some, the offense will be severe and unrelated to their mental illness,[1] thus ruling out the dropping of nuisance charges or negotiated insanity pleas. For others, the stress of the correctional environment will bring about psychiatric crises in people who were mentally intact in the community (Gibbs 1987). Finally, with the meteoric rise in illegal drug use and its well-documented relationship to criminal behavior (see, e.g., O'Neil and Wish 1990; Mirsky 1988; Petrich 1976), urban jails especially are facing large increases in the numbers of newly admitted inmates who are suffering from drug-induced psychosis upon arrest.

In correctional institutions, those inmates with severe mental illness or in psychiatric crisis present a host of problems to correctional administrators. Foremost among these is the possibility of serious injury to staff and other inmates posed by some mentally ill inmates whose behavior is both uncontrolled and violent. Mentally ill inmates may be terrified of hallucinations and may stay up all night screaming, keeping other inmates awake, causing them to become angry or even violent in response. Housing assignments must take into account the mutual fears of inmates with and without mental illness.

A second set of problems posed by the occurrence of psychiatric crises and severe mental illness in correctional facilities is related to liability. Tragedies such as suicides and restraint-related deaths may have dire legal consequences. Legal fees can be very expensive, even in the absence of adverse judgments or settlements. Public opinion, so seldom sympathetic to inmates, nevertheless solidly expects correctional officials, at the very least, to keep their inmates alive.

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1. Virkkunen (1974), for example, reported that only about one third of violent offenses committed by schizophrenics occurred during psychotic episodes.

Finally, despite the general stereotype of "guards" as tough and unfeeling, a successful suicide is often devastating to staff, who feel responsible for keeping inmates safe.

The diversity of American correctional facilities is astonishing. Local corrections range from one-person police lockups to urban jails, such as New York City's Riker's Island, which may house more than 20,000 inmates. Similarly, state prisons vary from very small field camps to walled prisons of more than 5,000 inmates.

Jails and prisons are alike in many ways. Both are viewed as correctional settings, with uniformed staff, secure perimeters (depending on custody level), and usually stark accommodations. Both jails and prisons can also be very stressful environments, due to forced association, segregation by gender, extremes of noise and temperature, and so on. Finally, the most important similarity between jails and prisons is the challenge of keeping them safe.

There are also important differences between the two settings. While prisons are self-contained environments that tend to house inmates for long periods of time, jails often hold detainees for only a matter of hours; thus, jails need to be treated as part of the larger communities in which they exist (Steadman, McCarty, and Morrissey 1989).

The goals of the two settings also differ. For pretrial detainees, jails exist predominantly to hold and process people until their case is resolved by the courts. Often, jail detention depends solely on external factors such as the ability of the defendant's family to raise money so as to post bond. For sentenced misdemeanants, jails serve as short-term punishment, with or without an effort at rehabilitation. Prisons, on the other hand, serve to punish the most serious offenders, and to prepare them through various prison programs for their eventual return to society.

## THE LEGAL REQUIREMENTS FOR CORRECTIONAL MENTAL HEALTH SERVICES

Singer (1982), and more recently, Cohen (1988), Cohen and Dvoskin (1992), and O'Leary (1989) have written extensively about the legal bases for requiring mental health services in jails and prisons, and about the required components and standards that various courts have established for such services.

A convicted inmate's right to medical and psychiatric treatment in prison is guaranteed by the Eighth Amendment's prohibition against cruel and unusual punishment and stems from the state's role as incarcerator. The Supreme Court has interpreted this responsibility as the duty to avoid "deliberate indifference" to the serious medical needs of inmates (*Estelle v. Gamble* 1976). Later, other federal and state courts specifically included psychiatric needs within the standard (e.g., *Bowring v. Godwin* 1977). To incarcerate someone with deliberate indifference to their significant psychiatric needs is thus viewed as cruel and unusual punishment and may be remedied, often through class action lawsuits, by injunctive relief and/or monetary damages, compensatory and/or punitive. The recent conservative turn in the federal judiciary, however, has made it far more difficult for plaintiffs to succeed (e.g., *Hudson v. McMillian* 1992).

For pretrial detainees, the right to treatment stems from the due process rights guaranteed by the Fourteenth Amendment. Nevertheless, "Detainees are entitled to at least the same level of care as the convicted" (Cohen 1988). Cohen lists six essential elements, taken from a prison class action suit in Texas (*Ruiz v. Estelle* 1980), as providing a useful framework for planning mental health services (see also American Psychiatric Association 1989):

1. Systematic screening and evaluation
2. Treatment that is more than mere seclusion or close supervision
3. Participation by trained mental health professionals
4. Accurate, complete, and confidential records
5. Safeguards against psychotropic medication prescribed in dangerous amounts, without adequate supervision, or otherwise inappropriately administered
6. A suicide prevention program

In addition to constitutional litigation, correctional administrators who ignore the mental health needs of inmates may also be vulnerable to tort liability, such as wrongful death actions, in the case of inmates who receive no treatment for severe depression and subsequently commit suicide (O'Leary 1989). Injuries to staff and other inmates resulting from inadequate mental health services can lead to tort liability (*Mental and Physical Disability Law Reporter* 1986), as well as great expense due to occupational injury leave and disability retirements. Inadequate medical or psychiatric services can result in malpractice claims against both medical and mental health providers in the jail.

Finally, while the services described in this chapter need to be available to inmates, they do not have to be provided by or within the jail or prison itself. The diversity of opinion on the appropriate auspices and location of correctional mental health services rivals that of the services themselves. It is not often especially important who provides the services, or whether the services are brought to the inmates or the inmates are brought to the services.

Thus, there is a clear constitutional requirement that correctional administrators provide for the serious psychiatric needs of those they incarcerate. Deliberate indifference—the constitutional standard—is not a very demanding one and it should be clear that legal considerations alone will not necessarily lead to ideal or even adequate services. Good public policy will necessitate a balancing of various public policy considerations that include reducing liability, providing humane treatment for prisoners, and maintaining the safety of staff and other inmates, all within a framework of cost effectiveness in an increasingly conservative fiscal environment.

## SERVICE COMPONENTS

Due to the many differences between jails and prisons, some of which are discussed in this chapter, the priorities for mental health services are somewhat different in each setting. For example, Steadman (1990) and his colleagues have discussed their findings that, for jails, the priority services are screening, crisis intervention, and discharge-oriented case management. Prison environments, on the other hand, due to their typically longer lengths of stay, lend themselves to the possibility of longer-term psychotherapy and psychiatric rehabilitation that are rarely seen in jails. Despite these differences, however, the services themselves fall into generic categories that hold up rather well between the two settings. But bear in mind that there will be differences, subtle or obvious, between the implementation of each service as it is adapted to each specific correctional environment.[2]

### Screening

Screening must be regarded as the most important service element in correctional mental health (Pogrebin 1985; Teplin and Swartz 1989). Screening is not only a specifically required legal obligation (Cohen 1988) but is clinically and programmatically essential as well. It is impossible to appropriately treat serious mental illnesses or psychiatric crises without identifying the specific individuals affected. There are a number of acceptable ways to provide this screening, but several elements must be present:

- *Trained staff.* Standardized screening tools can be successfully administered by line staff, provided that they are adequately trained in the administration of each screening instrument and know where to refer inmates identified as being in need of services.
- *Documentation.* The results of the screening must be clearly and legibly documented and available to those responsible for medical care, housing assignment, and follow-up services. Records must also be maintained in a manner that assures the privacy and confidentiality of each inmate, while facilitating communication between different mental health and medical providers.
- *Low threshold.* The screening must have a low threshold for referral to more extensive evaluation. That is, any indication of either a history or current evidence of mental illness or psychiatric crisis must result in referral for a follow-up evaluation. Likewise, any unusual or eccentric mannerisms or behaviors observed must be specifically documented and referred for further evaluation.
- *Standardization.* By routinely conducting the screening during booking, and by training staff in the screening procedure, one avoids an idiosyncratic process where a mentally ill inmate's chances of being identified depend on who happens to be on duty when the inmate arrives.

### Follow-up Evaluations

No matter who provides screening for mental health service needs, it will be necessary to provide more extensive and detailed evaluations for those inmates initially identified during the screening process as likely to require mental health services. These exams must be timely and responsive to specific issues raised during the screening, and they must result in treatment recommendations that are practical within the correctional setting.

Since psychiatrists are difficult to recruit, and a great deal more expensive than other mental health providers, it makes sense to have these "second-level" follow-up evaluations routinely conducted by psychologists, social workers, or psychiatric nurses with advanced degrees. Finally, since the evaluations will be diagnostic in nature, they should generally be done by at least master's-level staff with training in psychopathology (Dvoskin 1989).

It is important to limit these evaluations to issues that have immediate treatment implications. Given the generally limited treatment resources in correctional settings, full-scale psychological test batteries should be limited to inmates whose symptoms raise diagnostic questions that can only be answered by psychological testing (Dvoskin 1989).[3]

For inmates who appear to require psychiatric services such as psychotropic medication, a referral to the psychiatrist will then be in order. It is important to have some capacity for the emergency administration of medication during weekends and nights. On-call psychiatrists may provide telephone consultations with on-site nonpsychiatric physicians

2. Inmates in psychiatric crisis or those with severe mental illnesses are also defendants whose competency to proceed is likely to be questioned. However, it is not necessary that jails or their mental health programs actually provide competency assessments. Such assessments by jail staff could well drain needed clinical resources away from treatment within the institution. For a more complete discussion of this topic, see Chapter 27, "Criminal Competence."

3. There are of course other appropriate uses of routine psychological testing. Standardized tests have been used as part of the classification process. Various systems have been developed (see, e.g., Megargee 1976; Edinger, Reuterfors, and Logue 1982) that utilize computer-scored psychological tests such as the Minnesota Multiphasic Personality Inventory (MMPI) to make security and program classification decisions. Standardized testing may also prove useful in furthering research on the mental health needs of inmates and detainees. It is not suggested that the use of psychological test batteries as part of a competent psychological assessment has no value. However, in the real world of inadequate resources, it is most unlikely that any jail would have enough psychologists to provide time-consuming clinically administered batteries to more than a small fraction of patients needing follow-up evaluation.

or registered nurses. Twenty-four-hour on-site psychiatrist availability is a luxury likely to be found only in a few very large and well-funded settings. In smaller jurisdictions, mobile crisis teams from the local community mental health provider or nearby general hospital emergency rooms may be able to serve the jail.

### Crisis Intervention

Even where the very best screening and evaluation services are present, it will still be impossible to identify upon admission all of the inmates who will require psychiatric services during their incarceration or detention. No screen is perfect, and even "cutting-edge" instruments will have some false negatives. Further, certain kinds of psychoses may allow the inmate to appear, at least temporarily, quite unimpaired even under stress. It is important to note, however, that there are a number of reasons why inmates will either be, or appear to be, psychologically intact upon intake, and later experience a psychiatric crisis within the jail setting.

Jails and prisons can be extraordinarily stressful environments. Overcrowding, extremes of cold or heat, noise, filth, and the fear of assault may all contribute to the psychological deterioration of even the most "mentally healthy" inmate. Jails may be even more distressing than prisons, since most jail inmates have recently arrived and have a great deal of uncertainty as to their legal and penal futures. For first-time offenders especially, their expectations are likely to be colored by television or movie dramatizations stressing the violence in jails. Perhaps most upsetting to first-time offenders is the simple truth that jail inmates are not always very nice to one another. Together, these various stressors can lead to psychiatric crises at any time during the course of incarceration.

Another risk factor is any preexisting psychological condition that makes a person vulnerable to psychiatric crisis or mental illness. Family histories of affective disorder appear to increase the risk of severe depression, which could be triggered by the stresses discussed here. Certain personality disorders, especially borderline personality disorder, create a variety of risks for psychiatric crises, including suicidal gestures, emotional hyperreactivity, and acute psychoses (especially in response to being locked up).

Thus, correctional facilities, as a matter of law and sensible policy, must have some sort of ready access to crisis services. These services include psychotropic medication, special watch procedures, psychological or counseling services, detoxification (since drugs may be available inside the jail), information (such as when the inmate will get to see a lawyer or receive visits), and consultation with correctional staff about how to handle problematic inmates.

Administration of psychotropic medications in emergency situations can be dangerous, especially with newly admitted inmates whose blood toxicity has not been determined. As the incidence of illegal drug abuse has increased, the likelihood of a psychiatric crisis being due to toxicity has also increased. The safe prescription of medications in emergencies involving newly admitted inmates would thus include a physical examination. Since the time of day will often preclude such safeguards, many physicians will elect such nonpharmacological treatment interventions as seclusion or constant observation to resolve the immediate crisis and keep the inmate safe until services can be obtained. Other facilities will elect to utilize local general hospital emergency rooms.

Special management precautions in response to psychiatric emergencies include moving the inmate to a different bed location, thereby separating violent inmates from others, possibly allowing for easier and more frequent observation or closer proximity to nursing or other services. Often inmates will be put on "special watches" such as constant observation or one-to-one, especially where suicidal intent is suspected.

The special management precautions are required for two reasons. Each facility has an overriding obligation to protect inmates or detainees from foreseeable and preventable harm. They may also follow from the duty to provide medical or psychiatric treatment, although the two considerations will often overlap. In either case, the most important job in any psychiatric crisis in jail is to ensure the safety of all of the people who live and work there. Thus, crisis response is as much the responsibility of correctional staff as it is the mental health staff, even where twenty-four-hour mental health staff is available.

Verbal counseling in crises is not only the least intrusive intervention available but often it is the most effective, especially where the crisis is in response to a specific event or the novelty of the incarceration itself. For any inmate, with or without longstanding mental illnesses, these crises are often a response to fear. Inmates fear many things, some real and some imagined. Often, simply providing information, spiking rumors, or offering support can significantly improve an inmate's response to his situation.

Every jail and police lockup that receives direct admissions from the street must have access to medically supervised alcohol and drug detoxification services. However, it is important to note that this service is primarily medical in nature and is not a mental health service.[4] Consultation services, when provided by mental health staff to the correctional staff, can be sophisticated suggestions for handling difficult inmates or can be as simple as suggesting a cell change. The mental health staff must be viewed as supportive of the correctional staff's mission to make the jail safe for everyone.

4. Obviously, once detoxification is safely accomplished, assessment should be made of any need for subsequent mental health service, but it is worth reiterating that the act of detoxification is a medical function.

As with nearly all jail-based mental health services, it is imperative that adequate documentation and communication of crisis responses be maintained. Where off-hour providers are contractors or are from other agencies, it is imperative that essential aspects of the crisis and actions taken in response to it be communicated to the mental health and correctional staff.

Finally, the competent resolution of any crisis must include some reasonable effort to prevent its recurrence. While the provision of information itself can be effective, other steps may include supporting a psychologically fragile inmate through a crisis, or other preventive steps such as ongoing supportive therapy, skill building (e.g., how to safely "do time"), or building social supports, such as helping the inmate to contact family or friends.

### *Suicide Prevention*

Especially in local correctional facilities, suicide prevention has recently received a great deal of attention (Cox and Landsberg 1989; Hayes 1989; O'Leary 1989; Haycock 1989; Cox, Landsberg, and Paravotti 1989; Sherman and Morschauser 1989; Rakis and Monroe 1989; Atlas 1989). In brief, research has shown that the period of greatest vulnerability is during the first eight hours of incarceration, which may well occur during the evenings or weekends when no clinical professionals are present. Despite a dramatic increase in jail suicides across the nation during the past few years, a comprehensive statewide program in New York seems to have enabled sheriff and police departments to actually reduce suicides (Cox, Landsberg, and Paravotti 1989). This state-funded program is a simple and locally implemented program of staff training and procedure development for identifying and managing inmates at high risk of suicide. It is described in greater detail in Chapter 53, "Issues in the Prevention and Detection of Suicide Potential in Correctional Facilities."

The results of the New York program have been impressive. In upstate counties, for example, despite increasing admissions, censuses, and overcrowding, jail and lockup suicides have dropped since the program's inception from a high of thirty in 1985 to successive years of twenty-five, sixteen, eight, and only five in 1989 (New York State Commission of Correction 1989).

### *Use of Psychotropic Medications*

Psychiatrists who work in correctional settings must be aware of all of the usual issues surrounding emergency psychiatry (see, e.g., Anderson, Kuehnle, and Catanzano 1976; Dubin 1988; Saltzman et al. 1986). There are several other considerations that are especially or even uniquely important in dealing with local correctional patients.

People who are put in jail are rarely especially compliant. It should therefore not be surprising that inmates may be unwilling to take their medication exactly as ordered by physicians (Smith 1989). Inmates who feel oppressed by the criminal justice system often view psychotropic medication ordered by an institutional physician as an instrument of that oppression. Busy physicians may spend an inadequate amount of time explaining the need for medication, its value to the patients, or what to do about side effects. If dosages are not carefully monitored and adjusted, the patient may experience a variety of unsettling, uncomfortable, and even dangerous side effects. As a result, correctional nurses need to take special care when administering medications in the jail to ensure that the patients are not "cheeking" medications so they appear compliant or to save for later sale. Minor tranquilizers are especially prone to abuse and black market sale within the jail, and therefore are often not included in correctional formularies.

Finally, at least some time should be devoted to explaining to patients the need for psychotropic medication, beyond what may be typically provided for "informed consent." More formal prison-based patient education programs, while still comparatively new, have shown an ability to significantly increase patients' knowledge of the symptoms and treatments of schizophrenia (Melville and Brown 1987).

### *Substance Abuse Counseling*

Many severely mentally ill persons also abuse illegal substances and alcohol (Carey 1989). Indeed, the mentally ill chemical abuser (MICA) is a growing concern among virtually all segments of the mental health system. For these MICA patients, abuse of alcohol and other drugs can exacerbate psychiatric symptoms and even bring about psychotic episodes that may persist after the intoxication subsides. For these patients, upon discharge from jail, referral should be made to substance abuse treatment programs.

Abrams (1990) demonstrated the high prevalence of inmates with multiple occurring disorders, including substance abuse and depression, most often with antisocial personality disorder being the primary syndrome. Thus, she concludes, "Intervention programs aimed at substance abusers or depressives which do not address the elements necessary for treating co-occurring character disorders may have a minimal impact on either the detainee or the crime rates" (see also Mirsky 1988).

## Psychological Therapies

For inmates who are confused and anxious, frequent and surprisingly brief visits can provide reassurance that the inmate has not been psychologically abandoned. Often, the simple provision of accurate information about the criminal justice process can relieve a tremendous amount of anxiety and need not always be supplied by mental health professionals. Experienced correctional officers, paralegals, and even volunteers can often be quite helpful in this regard.

For more extreme psychiatric crises, intervention might consist of longer sessions. These sessions should focus on identifying personal strengths, which will help the inmate

overcome the experience. Often, providing an understanding that others have gone through similar crises and survived can be reassuring.

During periods of extreme psychological stress, a *real* part of the value of a therapist or counselor is to be a nonthreatening source of company. It is comforting simply to be listened to, especially when in the middle of what may be perceived as an abusive experience. Inmates who experienced physical or sexual abuse or torture as children may experience incarceration as a reenactment of this trauma, and may be especially responsive to such support.

The type of "therapy" most valuable to jail inmates is often provided by staff who lack formal training but who have a natural ability simply to treat others with dignity and humanity. Often, jail and prison inmates report that they were most helped through a crisis by a particular correctional officer or nurse.

For those inmates suffering from severe mental illnesses, the immediate focus of therapy is to protect the inmate from deteriorating in response to the correctional environment. People with schizophrenia especially seem to have trouble adapting to environmental change and require a great deal of support. The focus of psychotherapy is to provide the seriously mentally ill inmate with a touchstone to aid in reality testing, to avoid withdrawal into psychosis in response to fear of staff or other inmates.

Finally, for short-stay inmates, tenure in jail may be an important opportunity for referral to the social service or mental health service delivery system in the community.

### Case Management

Case management can be of use to inmates during their period of incarceration, as well as being an essential part of the discharge planning process. Within the correctional setting, during periods where they are lost to service, stressors may of course continue to build up in the absence of supportive services. It therefore is important to periodically "check in" with identified psychologically vulnerable and mentally ill inmates even during periods of apparently good adjustment. These very brief sessions can prove an effective investment if they prevent more serious exacerbations that require more extensive and costly services. Of course, case management is even more effective in linking inmates to appropriate mental health services upon their release (Griffin 1990).

### External Hospitalization

Although access to hospitalization for emergency psychiatric treatment is essential, it is often unavailable, especially to smaller jails. The ability to obtain brief psychiatric inpatient care when it is necessary is of tremendous importance not only to the inmate requiring the transfer but to the other inmates and staff as well. Emergency hospitalizations have only one goal—to stabilize the patient by reducing severe psychiatric symptoms. Follow-up treatment should continue either in the correctional facility or in the community if pretrial release can be obtained.

Inpatient hospitalization is often accomplished via transfer to an outside psychiatric hospital or ward. However, some jurisdictions such as San Diego, California (Meloy 1985), and Westchester County, New York, provide inpatient treatment within the local jail itself.

## CONSULTATION AND STAFF TRAINING

While screening is essential to identify inmates and detainees in need of clinical attention upon arrival, their subsequent mental health depends in large part on the ability of correctional officers to identify inmates in psychiatric distress and make appropriate referrals. It is therefore important to provide officers with basic training in some of the signs of emotional disturbances, and how to inform clinicians in a behaviorally specific manner what exactly led the officer to suspect mental illness.

This training is certainly not meant to create diagnosticians of correctional officers, although correctional officers can supplement the efforts of clinicians by learning to assist inmates in coping with the everyday stresses of incarceration (Lombardo 1985). Perhaps the most important component of the training is how to access the resources available. As noted above, the curriculum should include basic suicide prevention training as well.

Consultations will often revolve around the correctional management of inmates or detainees (Brodsky and Epstein 1982). A simple decision to separate two inmates can often prevent a dangerous assault or a psychiatric crisis, and administrators who learn to trust their clinical staff come to value advice in such decisions. Finally, in addition to positively affecting the mental health of the inmates, mental health professionals can also reduce job-related stress among correctional line staff (Dembo, Williams, and Stafford 1986–87).

## SPECIAL HOUSING AND MANAGEMENT OPTIONS

The most common reason for referral of an inmate to mental health services is disruptive or violent behavior, either toward self or others. Frequently, mental health staff will be asked to make a judgment about the level of supervision required to keep the inmate and others safe. Alternatives include one-to-one or constant observation status, movement to a safer or more isolated cell, or movement to a cell nearer to the observation post maintained by staff.

Other creative approaches include the use of multibed dormitories. Company can help alleviate depression, and inmates who are ambivalent about their own suicidality may watch each other far more diligently than staff. Also, it is easier to watch a group of people in one room than in individual rooms.

It is important to be realistic. It is unfair and clinically inappropriate to order a five-minute watch when the clinician knows there are inadequate staff to perform it. These orders are perceived by staff as an attempt by clinicians to shift responsibility to less well-paid correctional staff. By working together, it is usually possible to work out an arrangement that is both reasonable and clinically appropriate. For example, an order for constant observation will require three staff to observe three inmates in adjoining cells. An order worded "observe every minute," on the other hand, would allow one officer to walk back and forth, and observe all three inmates quite frequently.

## SPECIAL-NEEDS INMATES

For some ethnic minorities and non-English-speaking inmates, jails can be frightening and oppressive places. Foster (1988) reports that traditional psychiatric approaches may not work well with Native Americans in the federal prison system. Black and Hispanic people in jail are typically less often served by the mental health system (Steadman, Holohean, and Dvoskin 1991). This phenomenon may reflect an unwillingness to seek help from predominantly white providers, but may also reflect subtle and even unintentional racism among those same providers. Toch, Adams, and Greene (1987) found a number of ethnic differences in prison infractions, and concluded that subcultural and psychological predispositions may converge to produce prison adjustment problems.

As noted in this chapter, victims of child sexual or physical abuse, as well as other crime victims and combat veterans, may well encounter symptoms of posttraumatic stress disorder while in jail. The phenomenon of being locked up in a very small space by intimidating male authority figures can be frighteningly reminiscent of childhood experiences. For female inmates, especially those who have survived such abuse, the entire process can seem abusive, including strip searches and showering under observation. In our work with incarcerated females in New York, inmates frequently report long histories of sexual violence at the hands of fathers, husbands, boyfriends, and strangers (Browne 1987, 23). This abuse is often directly linked to the instant offense, as in the case of women who kill abusive spouses to protect themselves or their children.

Female detainees may have a variety of other special problems in adapting to correctional settings (Sobel 1980). These include the possibility of preexisting pregnancies, which require prenatal medical care, as well as recent mothers whose forced separation from their infant children can contribute to severe postpartum depression or even psychosis (see, e.g., McGaha 1986).

## SUMMARY AND CONCLUSIONS

Jails and prisons can seem like virtual seas of human service need, and the resources will never be adequate. Thus, administrators must take into account which services are most costly and sparse and use these resources judiciously. Social workers and psychiatric nurses are less expensive than psychiatrists and psychologists, are more available, and are more likely to be more culturally and ethnically similar to the inmates they will serve.

While prisons require a broad array of "community" mental health services, in jails and lockups resources must be focused on short-term crisis services designed to identify, protect, and treat those inmates who are most vulnerable to suicide, injury, or severe psychological distress. Each setting must focus on the mental health services that relate to its population and mission.

This chapter outlines the basic legal requirements for correctional mental health and proposes a structure for meeting those requirements in a cost-effective manner. Above all, resources must be used efficiently, so that each inmate has timely access to the essential services that the law and human decency require.

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