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# IMPROVING THE QUALITY OF LIFE FOR INMATES WITH MENTAL HEALTH CONDITIONS

Lassiter, Alfonso A.

Monterey, CA; Naval Postgraduate School


# NAVAL POSTGRADUATE SCHOOL

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# THESIS

**IMPROVING THE QUALITY OF LIFE FOR INMATES WITH MENTAL HEALTH CONDITIONS**

by

Alfonso A. Lassiter

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Co-Advisors: Cristiana Matei
Nadav Morag (contractor)

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This thesis explores what can be done to improve the quality of life of U.S. inmates who suffer from mental health conditions (MHCs). To that end, this thesis uses a comparative analysis of correctional methods applied in the United States and Norway. These two case studies were selected because Norwegian prisons have spectacularly low recidivism rates compared to the American correctional system. The analysis shows that American prisons focus on punitive corrections while Norwegian prisons focus on rehabilitation. American inmates with MHCs could benefit from some of Norway's penal philosophies such as decreasing the ratio of inmates to corrections officers, building smaller prisons designed for rehabilitation and mental health therapy, and federalizing all prisons. Federalizing all prisons would help mitigate the challenges corrections officials face when trying to secure appropriate levels of funding, which directly impact the quality of programming, staffing, and training. Moreover, providing mental health, employment, and educational opportunities to inmates with MHCs while they are incarcerated contributes to improving their quality of life once they are released.

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# IMPROVING THE QUALITY OF LIFE FOR INMATES WITH MENTAL HEALTH CONDITIONS

Alfonso A. Lassiter
Special Agent, United States Secret Service, Department of Homeland Security
BS, Chestnut Hill College, 1999
MBA, Rosemont College, 2002

Submitted in partial fulfillment of the
requirements for the degree of

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from the

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March 2023**

Approved by: Cristiana Matei
Co-Advisor

Nadav Morag
Co-Advisor

Erik J. Dahl
Associate Professor, Department of National Security Affairs

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# ABSTRACT

This thesis explores what can be done to improve the quality of life of U.S. inmates who suffer from mental health conditions (MHCs). To that end, this thesis uses a comparative analysis of correctional methods applied in the United States and Norway. These two case studies were selected because Norwegian prisons have spectacularly low recidivism rates compared to the American correctional system. The analysis shows that American prisons focus on punitive corrections while Norwegian prisons focus on rehabilitation. American inmates with MHCs could benefit from some of Norway's penal philosophies such as decreasing the ratio of inmates to corrections officers, building smaller prisons designed for rehabilitation and mental health therapy, and federalizing all prisons. Federalizing all prisons would help mitigate the challenges corrections officials face when trying to secure appropriate levels of funding, which directly impact the quality of programming, staffing, and training. Moreover, providing mental health, employment, and educational opportunities to inmates with MHCs while they are incarcerated contributes to improving their quality of life once they are released.

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# LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| CBT | cognitive behavioral therapy |
| CO | corrections officer |
| DBT | dialectical behavior therapy |
| GLM | good lives model |
| HRW | Human Rights Watch |
| IMR | illness management and recovery |
| MHC | mental health condition |
| NCS | Norwegian Correctional Service |
| PHS | Psychiatric Health Services |
| RNR | risk-need-responsivity (model) |

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# EXECUTIVE SUMMARY

More people are incarcerated in the United States than in any other Western nation, with 2.2 million inmates across the country.[1] The significant number of people suffering from mental health conditions (MHCs) and confined in American prisons raises concerns among many communities. A 2006 study by the Department of Justice revealed that about 50 percent of inmates suffer from at least one MHC, compared to 11 percent of the American public.[2] More people with MHCs are in prison than in all of the mental health hospitals still operating in the United States, but they do not receive adequate medical care.[3] Furthermore, recidivism rates for inmates with MHCs are 50–230 percent higher than those of the general prison population.[4]

Subject-matter experts across the country are coming together to develop strategies to focus the efforts of prison officials, defense attorneys, prosecutors, judges, probation and corrections officers (COs), and members of the mental health treatment community to improve the outcomes for inmates and former inmates who suffer from MHCs.[5] In this context, this thesis explores what, if anything, can be done to improve the quality of life of inmates who suffer from MHCs. To this end, this thesis uses a comparative analysis of correctional methods applied in the United States and Norway. These two case studies were selected because Norwegian prisons have spectacularly low recidivism rates compared to

[1] Anasseril E. Daniel, "Care of the Mentally Ill in Prisons: Challenges and Solutions," *Journal of the American Academy of Psychiatry and the Law Online* 35, no. 4 (December 2007): 406–10, http://jaapl.org/content/35/4/406.

[2] Daniel, 406.

[3] Daniel.

[4] Jennifer M. Reingle Gonzalez and Nadine M. Connell, "Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity," *American Journal of Public Health* 104, no. 12 (December 2014): 2328–33, https://doi.org/10.2105/AJPH.2014.302043.

[5] Allison Frankel, *Revoked: How Probation and Parole Feed Mass Incarceration in the United States* (New York: Human Rights Watch, 2020), https://www.hrw.org/report/2020/07/31/revoked/how-probation-and-parole-feed-mass-incarceration-united-states; Seth Jacob Prins and Laura Draper, *Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice* (New York: Council of State Governments Justice Center, 2009), https://csgjusticecenter.org/wp-content/uploads/2020/02/Community-Corrections-Research-Guide.pdf.

the American correctional system.[6] Notably, American prisons focus on punitive corrections while Norwegian prisons focus on rehabilitation.[7] American inmates with MHCs could benefit from some of Norway's penal philosophies such as decreasing the ratio of inmates to COs, building smaller prisons designed for rehabilitation and mental health therapy, and federalizing all prisons. Federalizing all prisons would help mitigate the challenges corrections officials face when trying to secure the appropriate levels of funding, which directly impact the quality of programming, staffing, and training.

In the 19th century, the country transitioned from well-run mental health asylums to poorly managed and overcrowded institutions, where very little mental health treatment was provided.[8] When the responsibilities of funding and maintaining mental health hospitals shifted from the federal government to individual state governments, many state hospitals were closed due to the states' inability to maintain funding.[9] This lack of funding became a common problem for all correctional systems throughout the country as housing inmates in a forensic setting such as a psychiatric hospital, where there was an abundance of qualified medical clinicians, was much more expensive than housing them in the medical wing of a prison, where few medical personnel were legally required or available for inmates.

The U.S. correctional system was never designed to warehouse large numbers of inmates with MHCs. However, corrections officials acknowledge that, by default, their prisons have become the largest mental health hospitals in the country and are constitutionally mandated to provide mental health treatment to all inmates who need it.[10] Due to overcrowding and limited resources, most correctional systems around the country are struggling to provide dedicated space inside their facilities for mental health

[6] Maurice Chammah, "I Did It Norway," Marshall Project, November 1, 2017, https://www.themarshallproject.org/2017/10/31/i-did-it-norway.

[7] Chammah.

[8] "Module 2: A Brief History of Mental Illness and the U.S. Mental Health Care System," Unite for Sight, accessed January 27, 2022, https://www.uniteforsight.org/mental-health/module2.

[9] Daniel, "Care of the Mentally Ill in Prisons."

[10] Gonzalez and Connell, "Mental Health of Prisoners."

treatment.[11] Mental health clinicians need to have as much access to their patients as possible; however, the security needs of the facilities where the inmates are housed often conflict with mental health best practices.[12] Most correctional systems have limited resources and few options beyond psychotropic drugs and overworked medical staff.[13] When inmates who have MHCs are not properly treated for their conditions in prison, it is difficult for them to receive follow-up outpatient treatment once they have been released into the community.[14] This connection between insufficient treatment in prison and few community-based outpatient centers contributes to higher recidivism rates among former inmates who have MHCs.[15]

Another assimilation barrier for inmates with MHCs has been the pervasive stereotyping of people with mental disorders as "monsters," which causes other inmates to harm those with MHCs because the latter cannot easily navigate the sub-culture—the unspoken code of conduct among inmates.[16] Inmates with MHCs are often targeted because of the stigma of having an MHC and because other inmates perpetuate the stereotyping and target these vulnerable inmates for abuse. This stigma permeates every aspect of the corrections system, including judges, lawyers, and COs.[17] According to a 2006 study by the Bureau of Justice Statistics, inmates who suffer from MHCs are "three times more likely to be written up for physical or verbal assault of COs, staff, or other

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[11] John S. Shaffer et al., *Managing the Seriously Mentally Ill in Corrections* (Santa Monica, CA: RAND Corporation, 2019), https://www.rand.org/pubs/research_reports/RR2698.html.

[12] Daniel, "Care of the Mentally Ill in Prisons."

[13] Kent A. Kiehl and Morris B. Hoffman, "The Criminal Psychopath: History, Neuroscience, Treatment, and Economics," *Jurimetrics* 51, no. 4 (Summer 2011): 355–97, ProQuest.

[14] Y. Nina Gao, "The Relationship between Psychiatric Inpatient Beds and Jail Populations in the United States," *Journal of Psychiatric Practice* 27, no. 1 (January 2021): 33–42, https://doi.org/10.1097/PRA.0000000000000524.

[15] H. Richard Lamb and Leona L. Bachrach, "Some Perspectives on Deinstitutionalization," *Psychiatric Services* 52, no. 8 (August 2001): 1039–45, https://doi.org/10.1176/appi.ps.52.8.1039.

[16] Michael L. Perlin, "Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence," *Case Western Reserve Law Review* 40, no. 3 (1989): 724, https://scholarlycommons.law.case.edu/caselrev/vol40/iss3/4.

[17] Evelyn Lundberg Stratton, "How a Missionary Kid Ended up Working on Mental Health Prison Reforms: A Speech to a Symposium," *Ohio Northern University Law Review* 41, no. 3 (2015): 799–815, https://digitalcommons.onu.edu/cgi/viewcontent.cgi?article=1224&context=onu_law_review.

incarcerated people" compared to other inmates.[18] In sum, as Jamie Fellner, an advisor for Human Rights Watch, states, "Most jails and prisons are bleak and stressful places in which few prisoners are able to engage in productive, meaningful activities."[19]

By contrast, the Norwegian prison system has enjoyed great success because it uses all elements of the Norwegian welfare state to create synergy by integrating former inmates into the labor markets by encouraging them to take advantage of job training programs and discouraging crime.[20] These rehabilitative programs offered by the Norwegian Correctional Service (NCS) and other elements of the Norwegian welfare state have positively affected the criminogenic conditions for inmates who were unemployed at the time of incarceration.[21] Francis Pakes and Katrine Holt write that "prison policy in Norway has historically been informed by the normalization thesis…[which] informs policy-making throughout, including prison design, staff training, staff–prisoner relations, opportunities for prisoners and an emphasis on prisoner agency."[22] Normalization can be described as the methods by which the NCS manages everyday life for inmates while they are incarcerated, and rehabilitation is the result of improvements in the inmates before they have been reintegrated into society. The Norwegian penal philosophy can thus be described as "small scale, positive and truly focused on rehabilitation."[23] Normalization is used to achieve the desired change in an inmate's criminogenic patterns and behaviors. If the normalization process is successful, then the inmate will be rehabilitated. To that end, NCS

[18] Wendy Sawyer, "New Government Report Points to Continuing Mental Health Crisis in Prisons and Jails," *Prison Policy Initiative* (blog), June 22, 2017, https://www.prisonpolicy.org/blog/2017/06/22/mental_health/.

[19] Human Rights Watch, "Summary: Mental Disability and Misconduct," in *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in U.S. Jails and Prisons* (New York: Human Rights Watch, 2015), para. 9, https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and.

[20] Gordon B. Dahl and Magne Mogstad, "The Benefits of Rehabilitative Incarceration," *NBER Reporter*, no. 1 (March 2020), http://www.nber.org/reporter/2020number1/benefits-rehabilitative-incarceration.

[21] Dahl and Mogstad.

[22] Francis Pakes and Katrine Holt, "Crimmigration and the Prison: Comparing Trends in Prison Policy and Practice in England & Wales and Norway," *European Journal of Criminology* 14, no. 1 (2017): 66, https://doi.org/10.1177/1477370816636905.

[23] Pakes and Holt, 65.

"officers are trained to play an active role in residents' rehabilitation by using positive incentives and motivational interviewing, engaging residents in health-focused programming, and providing intensive mentorship and positive socialization."[24]

The results of Norwegian penal philosophies offer some evidence that raising the quality of life of inmates with MHCs in America is possible. If American prisons improve the quality of life of inmates with MHCs, in theory, more inmates will have the root cause of their criminal behavior addressed, and hopefully, this diminished desire to engage in criminal behavior will yield a reduction in recidivism rates, and the quality of life of society will likewise improve.

This thesis research suggests that providing mental health care, employment, and educational opportunities to inmates with MHCs while they are incarcerated can contribute to improving their quality of life once they are released. This thesis recommends that corrections officials avoid releasing inmates with MHCs from prison just to placate public opinion but instead build more prisons and extend prison sentences so that people incarcerated for longer periods will have at least some rehabilitation and educational opportunities. Another recommendation is to increase the ratio of staff to inmates. This recommendation is an essential step for a safer, more productive management of any correctional facility. Insufficient staffing remains a major barrier to improving the quality of life of inmates with MHCs. Nevertheless, no rehabilitation can start without some level of control, some level of security, and the federalization of all prisons and operations.

Early versions of American psychiatric prisons and insane asylums were well administered and featured many of the most successful characteristics of the NCS, such as purpose-driven workdays, a humane living and working environment, and a religious foundation. The word *asylum* means an institution that offers protection for people who are mentally ill. American culture was built on Judeo-Christian beliefs, which instilled being our brothers' keepers. Allowing inmates with MHCs to be victimized by healthy inmates in jails and prisons is inconsistent with our American values.

[24] Cyrus Ahalt et al., "Role of a US–Norway Exchange in Placing Health and Well-Being at the Center of U.S. Prison Reform," *American Journal of Public Health* 110 (January 2020): S27, http://doi.org/10.2105/AJPH.2019.305444.

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> Remember those in prison as if you were their fellow prisoners, and those who are mistreated as if you yourselves were suffering.
>
> —Hebrews 13:3

> The King will reply, "I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me."
>
> —Matthew 25:40

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# I. INTRODUCTION

The significant number of people suffering from mental health conditions (MHCs) and confined in American prisons raises concerns among many communities. A 2006 study by the Department of Justice revealed that about 50 percent of inmates suffer from at least one MHC, compared to 11 percent of the American public.[1] More people are incarcerated in the United States than in any other Western nation, with 2.2 million inmates across the country.[2] According to the Bureau of Justice Statistics and the Prison Policy Initiative, approximately 228,000 women are incarcerated—101,000 in local jails, 99,000 in state prisons, 16,000 in federal prisons, 7,700 in immigration jails, and 6,600 in youth detention centers.[3] According to 2015 testimony before the Senate Committee on Homeland Security and Governmental Affairs, among the women in prison, 63 percent have been sentenced for a non-violent offense, and "many are incarcerated due to substance abuse and mental health issues."[4] In this connection, Piper Kerman, author of the book *Orange Is the New Black: My Year in a Women's Prison*, testified that she "saw women with mental health issues wait for months to see the one psychiatrist who was available for 1,400 women."[5] Kerman's testimony revealed that nearly two-thirds of incarcerated women "experience some kind of mental illness."[6] Such high incarceration is both the source and result of several problems.

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[1] Anasseril E. Daniel, "Care of the Mentally Ill in Prisons: Challenges and Solutions," *Journal of the American Academy of Psychiatry and the Law Online* 35, no. 4 (December 2007): 406, http://jaapl.org/content/35/4/406.

[2] Daniel.

[3] Wendy Sawyer, "New Government Report Points to Continuing Mental Health Crisis in Prisons and Jails," *Prison Policy Initiative* (blog), June 22, 2017, https://www.prisonpolicy.org/blog/2017/06/22/mental_health/.

[4] *Oversight of the Bureau of Prisons: First-Hand Accounts of Challenges Facing the Federal Prison System: Hearing before the Committee on Homeland Security and Governmental Affairs*, *United States Senate*, 114th Cong. (2015), 7, https://www.govinfo.gov/content/pkg/CHRG-114shrg22227/pdf/CHRG-114shrg22227.pdf.

[5] S., 8.

[6] S., 6.

When the responsibilities of funding and maintaining mental health hospitals shifted from the federal government to individual state governments, many state hospitals were closed due to the states' inability to maintain the same levels of funding.[7] According to Anasseril E. Daniel, clinical professor of psychiatry at the University of Missouri's School of Medicine, "Those with mental disorders have been increasingly incarcerated during the past three decades, probably as a result of the deinstitutionalization of the state mental health system."[8] Daniel maintains that prisons and jails filled the void when most states closed their mental health hospitals.[9] Daniel adds that more people who suffer from MHCs are in prison than in all of the mental health hospitals still operating in the United States, but they do not receive adequate medical help.[10] The screening process in many prisons is not effective at identifying people who suffer from MHCs. According to Jennifer Gonzalez and Nadine Connell, who published a study in the *American Journal of Public Health*, a lack of funding in correctional facilities has reduced the availability of proper screening and treatment of inmates.[11] Their work reveals that the recidivism rates for inmates with an MHC are 50–230 percent higher than those of other inmates.[12]

Another issue for inmates with MHCs has been the pervasive stereotyping of people with mental disorders as "monsters," leading other inmates to harm them.[13] Perlin describes "sanism" as the act of discriminating against people with MHCs and the "irrational prejudice and biases" that exist in American culture, including laws that affect

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[7] Daniel, "Care of the Mentally Ill in Prisons."

[8] Daniel, 406.

[9] Daniel.

[10] Daniel.

[11] Jennifer M. Reingle Gonzalez and Nadine M. Connell, "Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity," *American Journal of Public Health* 104, no. 12 (December 2014): 2328–33, https://doi.org/10.2105/AJPH.2014.302043.

[12] Gonzalez and Connell, 2328.

[13] Michael L. Perlin, "Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence," *Case Western Reserve Law Review* 40, no. 3 (1989): 599–731, https://scholarlycommons.law.case.edu/caselrev/vol40/iss3/4.

people with MHCs.[14] The prevalence of sanism in American culture suggests that people who work at prisons retain some of these same prejudices. This stigma permeates every aspect of society, including judges, lawyers, and corrections officers (COs).[15] According to a 2006 study by the Bureau of Justice Statistics, inmates who suffer from MHCs "are three times more likely to be written up for physical or verbal assault of correctional officers, staff, or other incarcerated people, compared to those without any mental health problems."[16] When prison staff attempt to discipline or protect inmates with MHCs, such as paranoid schizophrenics, solitary confinement could further damage their mental health instead of correcting the offending behavior.[17] In sum, as Jamie Fellner, advisor for Human Rights Watch, states, "Most jails and prisons are bleak and stressful places in which few prisoners are able to engage in productive, meaningful activities."[18] Fellner clearly advocates an alternative to mass incarceration for people who have MHCs because these inmates suffer intended and unintended consequences during their incarceration.

Subject-matter experts across the country are coming together to develop strategies to focus the efforts of prison officials, defense attorneys, prosecutors, judges, probation COs, and members of the mental health treatment community to improve the outcomes for

[14] Michael L. Perlin, "On Sanism," *SMU Law Review* 46, no. 2 (January 1992): 374, https://scholar.smu.edu/cgi/viewcontent.cgi?article=2269&context=smulr; Deborah A. Dorfman, "Doing Time in 'the Devil's Chair': Evaluating Nonjudicial Administrative Decisions to Isolate and Restrain Prisoners and Detainees with Mental Health Disabilities in Jails and Prisons," *American Behavioral Scientist* 64, no. 12 (2020): 1703–4, https://doi.org/10.1177/0002764220956695.

[15] Evelyn Lundberg Stratton, "How a Missionary Kid Ended up Working on Mental Health Prison Reforms: A Speech to a Symposium," *Ohio Northern University Law Review* 41, no. 3 (2015): 799–815, https://digitalcommons.onu.edu/cgi/viewcontent.cgi?article=1224&context=onu_law_review.

[16] Sawyer, "New Government Report."

[17] Dorfman, "Doing Time in 'the Devil's Chair.'"

[18] Human Rights Watch, "Summary: Mental Disability and Misconduct," in *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in U.S. Jails and Prisons* (New York: Human Rights Watch, 2015), para. 9, https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and.

inmates and former inmates who suffer from MHCs.[19] In this context, this thesis explores what, if anything, can be done to improve the quality of life of inmates who suffer from MHCs.

## A. RESEARCH QUESTION

What can be done to help improve the quality of life of inmates who suffer from mental health issues?

## B. LITERATURE REVIEW

Although human beings share many of the same basic characteristics, people react differently to the prison setting, both physically and emotionally. The rigid, everyday life of jails and prisons is difficult for inmates suffering from mental illness. Most correctional facilities—jails and prisons—are set up to manage inmates for punitive and rehabilitative purposes but not necessarily inmates with MHCs.[20] This literature review explores some of the academic and expert analyses related to drivers and risks—to the prison personnel and inmates—of the criminalization and mass incarceration of those who suffer from MHCs. In summary, the next few sections discuss the massive challenge faced by Norwegian and U.S. corrections officials, such as underfunded facilities and insufficiently trained employees, in caring for a subset of the population without advocates or in denial of the help it needs.

### 1. Perspectives on the Challenges for Personnel Who Manage Inmates with MHCs

Prison officials face an overwhelming number of inmates with mental illness but lack the capacity to treat them properly. According to research by Rich Ruddell in 2006,

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[19] Allison Frankel, *Revoked: How Probation and Parole Feed Mass Incarceration in the United States* (New York: Human Rights Watch, 2020), https://www.hrw.org/report/2020/07/31/revoked/how-probation-and-parole-feed-mass-incarceration-united-states; Seth Jacob Prins and Laura Draper, *Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice* (New York: Council of State Governments Justice Center, 2009), https://csgjusticecenter.org/wp-content/uploads/2020/02/Community-Corrections-Research-Guide.pdf.

[20] Maureen L. O'Keefe and Marissa J. Schnell, "Offenders with Mental Illness in the Correctional System," *Journal of Offender Rehabilitation* 45, no. 1/2 (March 2007): 81–104, https://doi.org/10.1300/J076v45n01_08.

inmates often lack access to mental health services because fewer than half of the jails surveyed have the appropriate mental health units.[21] Konrad and Opitz-Welke contend that, in the past, personnel wrongly assessed "deviant behaviors" of inmates who suffered from MHCs as disciplinary problems.[22] The researchers acknowledge that even in the best-managed prison systems, the limited resources allocated to screen and identify inmates who exhibit symptoms of MHCs make mistakes by staff inevitable. According to a Human Rights Watch (HRW) report released in 2003, correctional facilities in the United States hold three times more inmates who suffer from MHCs than do all the mental health hospitals in the country.[23] The report also finds that 70,000 inmates a day and approximately 11 million inmates a year are arrested, processed, and screened for mental illnesses.[24] The report estimates a population of 200,000–300,000 inmates who suffer from major MHCs such as schizophrenia, bipolar disorder, antisocial personality disorder, and major depression.[25] These figures suggest an overwhelmed correctional system regarding mentally ill inmates.

Inmates who suffer from MHCs may try to manipulate the system to their advantage. Patient choices affect prison and jail operations in several ways. According to HRW researchers, many inmates who suffer from MHCs purposefully become non-compliant with their medications to participate in more-desirable activities at the prison, such as work furlough programs.[26] In their view, most prison systems have regulations restricting inmates with MHCs from participating in such sought-after programs.[27] An

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[21] Rick Ruddell, "Jail Interventions for Inmates with Mental Illnesses," *Journal of Correctional Health Care* 12, no. 2 (April 2006): 118–31, https://doi.org/10.1177/1078345806288957.

[22] Norbert Konrad and Annette Opitz-Welke, "The Challenges of Treating the Mentally Ill in a Prison Setting: The European Perspective," *Clinical Practice* 11, no. 5 (September 2014): 519, https://doi.org/10.2217/cpr.14.44.

[23] William Kanapaux, "Guilty of Mental Illness," *Psychiatric Times* 21, no. 1 (January 2004): 1, 4–5, ProQuest.

[24] Kanapaux.

[25] Kanapaux.

[26] Sasha Abramsky and Jamie Fellner, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* (New York: Human Rights Watch, 2003), https://www.hrw.org/report/2003/10/21/ill-equipped/us-prisons-and-offenders-mental-illness.

[27] Abramsky and Fellner.

interview of social worker Marilyn Montenegro confirms that some mentally ill women transitioning out of prison have stopped taking their medication "because [work furlough] is a very desirable program."[28] Discontinuing medication regimens in hopes of getting into such programs contributes to high recidivism rates among this demographic.

Financial constraints within prisons can hamper every aspect of mental health programming, from budget allocations for hiring to therapy services.[29] Reduced funding forces corrections officials to limit the number of COs and clinicians hired to facilitate training and therapy for inmates with MHCs.[30] According to a 2012 report, the law requires the Bureau of Prisons to first "feed, clothe, and provide medical care for inmates."[31] Once prison officials have met these primary directives, they can determine which programs—including mental health programming—and staffing requirements should be funded.[32] Along the same line, Andrea Segal, Rosemary Frasso, and Dominic Sisti assert that inadequately funded correctional facilities force corrections administrators to make tough financial choices.[33] These choices include determining the amount of resources the facility can afford, such as the number of COs and administrative staff.[34] Thus, a reduction in funding directly affects the facility's ability to screen incoming inmates properly for MHCs, purchase medicines, hire well-qualified medical professionals, provide additional and current training of corrections staff, and fully support therapy programs and

[28] Abramsky and Fellner, *Ill-Equipped*; Katherine M. Auty and Alison Liebling, "Exploring the Relationship between Prison Social Climate and Reoffending," *Justice Quarterly* 37, no. 2 (2020): 358–81, https://doi.org/10.1080/07418825.2018.1538421; Tara Haelle, "How to Treat Antisocial Personality Disorder," Everyday Health, February 28, 2020, https://www.everydayhealth.com/antisocial-personality-disorder/treatment/.

[29] David C. Maurer, *Bureau of Prisons: Growing Inmate Crowding Negatively Affects Inmates, Staff, and Infrastructure*, GAO-12-743 (Washington, DC: Government Accountability Office, 2012).

[30] Maurer.

[31] Maurer, 22.

[32] Maurer.

[33] Andrea G. Segal, Rosemary Frasso, and Dominic A. Sisti, "County Jail or Psychiatric Hospital? Ethical Challenges in Correctional Mental Health Care," *Qualitative Health Research* 28, no. 6 (2018): 963–76, https://doi.org/10.1177/1049732318762370.

[34] Segal, Frasso, and Sisti.

priorities.[35] Thus, scholars agree that a lack of funding can permeate every level of correctional operations, negatively affect a facilities' ability to retain mental health resources, and create a greater burden on existing personnel to deal with issues in the general population.

Doctors and other prison personnel wrestle with the dilemma of ethical treatment of MHCs in the context of prison safety. All doctors take the Hippocratic Oath whereby they swear to "first, do no harm," but medical professionals must make difficult decisions when balancing the need for security and safety with an environment conducive to good therapeutic practices inside prisons.[36] According to Jeffrey Metzner and Jamie Fellner, medical professionals working in a correctional system face significant ethical dilemmas regarding MHCs, especially considering the effects of solitary confinement.[37] Metzner and Fellner contend medical professionals need to mitigate the "tension between reasonable medical practices and the prison rules and culture."[38] When considering a career in corrections, most medical professionals have the prerequisite skills to work in a doctor's office or hospital; however, a person needs to be comfortable performing those same functions in a jail or prison surrounded by potentially dangerous and violent people.[39] Along the same line, Lamb, Weinberger, and Gross contend that "severely mentally ill" persons in the correctional system can be challenging for outpatient clinicians who must ensure both the safety of the community and that of the inmate being treated.[40] Thus,

[35] Maurer, *Bureau of Prisons*.

[36] Peter Tyson, "The Hippocratic Oath Today," NOVA, March 26, 2001, https://www.pbs.org/wgbh/nova/article/hippocratic-oath-today/.

[37] Jeffrey L. Metzner and Jamie Fellner, "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *Journal of the American Academy of Psychiatry and the Law* 38, no. 1 (2010): 104–8, http://jaapl.org/content/38/1/104.

[38] Metzner and Fellner, 104.

[39] Ellen Kjelsberg, Tom Hilding Skoglund, and Aase-Bente Rustad, "Attitudes towards Prisoners, as Reported by Prison Inmates, Prison Employees and College Students," *BMC Public Health* 7, no. 71 (2007): 1–9, https://doi.org/10.1186/1471-2458-7-71.

[40] H. Richard Lamb, Linda E. Weinberger, and Bruce H. Gross, "Community Treatment of Severely Mentally Ill Offenders under the Jurisdiction of the Criminal Justice System: A Review," *Psychiatric Services* 50, no. 7 (July 1999): 907–13, https://doi.org/10.1176/ps.50.7.907.

clinicians' safety concerns about these patients may inhibit the treatment that mentally ill inmates receive.

Furthermore, delivering comparable care also poses challenges. Based on concerns about treating inmates with MHCs with the same level of service as any other inmate, many therapists express strong reservations about their ability to provide treatment.[41] Yet COs and medical staff spend significant time balancing scarce programming resources for inmates with MHCs and healthy inmates.[42] For their study, Segal, Frasso, and Sisti interviewed 24 members of staff working at a prison in Pennsylvania regarding the ethical demands of managing inmates who suffer from MHCs.[43] Study respondents revealed that providing treatment to inmates with MHCs strains capacity because most prisons are not designed to be therapeutic places.[44] Likewise, COs cite limited space and overcrowding inside prisons as crippling to ongoing treatment.[45] Without the appropriate space for therapy and housing, many inmates exhibit more severe symptoms and pose greater challenges for medical staff to provide them with quality care.[46] Overcrowding inside prisons puts more pressure on existing medical staff, thus leading to more medical staff vacancies.

Most individuals with MHCs are incarcerated because community-based treatment options are not available.[47] Many scholars have made the connection between the prevalence of inmates with MHCs residing in prisons and insufficient investments in community treatment facilities.[48] In this way, staff overwhelmed by MHCs face seriously ill inmates with few resources or little capacity to handle them. Even inmates who receive

41 Thomas Noll et al., "Professionals' Attitudes towards the Importance of Core Principles for the Mental Health Treatment of Offenders in Correctional Facilities," *Prison Journal* 100, no. 5 (2020): 603–16, https://doi.org/10.1177/0032885520956371.

42 Daniel, "Care of the Mentally Ill in Prisons."

43 Segal, Frasso, and Sisti, "County Jail or Psychiatric Hospital?"

44 Segal, Frasso, and Sisti.

45 Segal, Frasso, and Sisti.

46 Konrad and Opitz-Welke, "Treating the Mentally Ill in a Prison Setting."

47 Kanapaux, "Guilty of Mental Illness."

48 Segal, Frasso, and Sisti, "County Jail or Psychiatric Hospital?"

treatment may not see change. Respondents, including COs, nurses, administrators, and clinicians, opine that effective therapy requires people to use their time in prison as a "learning experience."[49] In a contradictory fashion, these respondents add that inmates with serious MHCs "lack insight" and cannot connect their behavior to their incarceration, leaving the reader to wonder how such learning could happen.[50] In this way, prison personnel face a population that is quite challenging.

Officials also face a variety of risks related to the involuntary medication and forced treatment of inmates. According to Bruce Arrigo and Stacey Shipley, one challenge of managing inmates who suffer from MHCs includes exercising the right of the state to medicate an inmate against his will to prepare him to stand trial.[51] When inmates take medications involuntarily and negative side effects follow, correctional facilities could face lawsuits.[52] Arrigo and Shipley note that some inmates try to game the system by faking an illness, by being segregated from the general prison population, or by gaining access to medications that can be sold in the correctional facilities' black market.[53] In all of these ways, inmates with MHCs challenge those who must manage them.

### 2. Perspectives on MHC Patients' Risk to Themselves

A body of literature discusses the causes of incarceration for MHCs. Research conducted by Mowbray, Grazier, and Holter reveals that inmates enter the correctional system after they have been released from mental health hospitals and placed into community treatment centers, a process otherwise known as being deinstitutionalized.[54] Once under the care of poorly funded community treatment centers, many inmates with MHCs enter the correctional system because they disturb their communities by "loitering,

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[49] Segal, Frasso, and Sisti.

[50] Segal, Frasso, and Sisti.

[51] Bruce A. Arrigo and Stacey L. Shipley, *Introduction to Forensic Psychology: Issues and Controversies in Crime and Justice*, 2nd ed. (Burlington, MA: Elsevier, 2004), ProQuest Ebook Central.

[52] Arrigo and Shipley.

[53] Arrigo and Shipley.

[54] Carol T. Mowbray, Kyle L. Grazier, and Mark Holter, "Managed Behavioral Health Care in the Public Sector: Will It Become the Third Shame of the States?," *Psychiatric Services* 53, no. 2 (2002): 157–70, https://doi.org/10.1176/appi.ps.53.2.157.

stealing food, and breaking and entering to obtain shelter."[55] Mowbray, Grazier, and Holter conclude that the "criminalization of the mentally ill" happens when mental health treatments are unavailable and sufferers self-medicate as a way of managing their illness.[56] Researchers with the RAND Corporation acknowledge that prisons and jails may have inadequate resources for the treatment of MHCs, but incarceration might be the only opportunity for inmates with MHCs ever to receive mental health services.[57] In sum, scholars agree that a basic level of care is better than no care at all.[58] Thus, those with MHCs enter the system by accident and sometimes by choice.

Prison conditions worsen the MHCs of inmates and pose a threat to all prisoners and prison staff. Goldman and Ray write that many inmates who suffer from MHCs "have other risk factors associated with a higher incidence of violent behavior (e.g., substance abuse, neurological impairment, poor impulse control) that is often exacerbated by psychotic symptoms."[59] Ray and Goldman warn that inmates with MHCs behave in such unpredictable and unusual behaviors that they make themselves targets of victimization or victimize others.[60] Their research reveals that jails with inappropriate living conditions for MHCs permit "disruptive and dangerous behaviors."[61] Based on Ray and Goldman's research, prisons may need to find dedicated space for inmates with MHCs to reduce the potential for victimization.

Scholars and experts agree that prisons and jail cultures torment inmates with mental health needs. According to Daniel Semenza and Jessica Grosholz, studies show many factors influence inmates' behavior, and "mental disorder is one of the most

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[55] Mowbray, Grazier, and Holter, 162.

[56] Mowbray, Grazier, and Holter, 161–62.

[57] John S. Shaffer et al., *Managing the Seriously Mentally Ill in Corrections* (Santa Monica, CA: RAND Corporation, 2019), https://www.rand.org/pubs/research_reports/RR2698.html.

[58] Shaffer et al.

[59] Kenneth A. Ray and Mark Goldman, *Jail Mental Health Design and Programming: "Options & Opportunities"* (Washington, DC: National Institute of Corrections, 2013), 11, https://www.hsdl.org/?abstract&did=753003.

[60] Ray and Goldman.

[61] Ray and Goldman, 11.

consistent and significant predictors of institutional misconduct," such as perpetrating violence or becoming the victim of violence from fighting.[62] Craig Haney suggests that healthy inmates often target inmates with MHCs because the latter display unusual and irritating behaviors.[63] These behaviors could manifest in talking too much or too little or a lack of hygiene (refusal to take showers or groom themselves).[64] Haney argues that most prison cultures do not value close relationships with prison staff because inmates may view them as a form of dependency and weakness.[65] His research indicates that the prison environment is not a safe place for a person labeled mentally ill because most inmates consider such a moniker a vulnerability that "diminishes prisoners in the eyes of their fellow inmates."[66] In this way, their presence in prison sets up mentally ill inmates as targets.[67]

Inmates might not recognize their mental illnesses and their need for medications but face limited therapeutic or rehabilitative options. Convincing healthy people to take their medicine can be difficult, but persuading a person suffering from an MHC to take his medicine may be even more challenging. An HRW report explains that some inmates who suffer from MHCs believe they have an illness while others do not.[68] Nevertheless, inmates who recognize they suffer from an MHC may develop paranoia that the mental health professionals helping them are involved in a conspiracy against them.[69] For those grounded in reality, researchers at HRW report that many inmates stop taking their medications because of an aversion to their side effects.[70] Even though prisons have

[62] Daniel C. Semenza and Jessica M. Grosholz, "Mental and Physical Health in Prison: How Co-occurring Conditions Influence Inmate Misconduct," *Health & Justice* 7, no. 1 (December 2019): 2, https://doi.org/10.1186/s40352-018-0082-5.

[63] Craig Haney, "'Madness' and Penal Confinement: Some Observations on Mental Illness and Prison Pain," *Punishment & Society* 19, no. 3 (2017): 310–26, https://doi.org/10.1177/1462474517705389.

[64] Haney.

[65] Haney.

[66] Haney, 319.

[67] Haney.

[68] Abramsky and Fellner, *Ill-Equipped*.

[69] Abramsky and Fellner.

[70] Abramsky and Fellner.

resources to provide some level of service for inmates with MHCs, it is insufficient to provide in-depth therapy for every inmate.[71] Long waiting lists accompany very limited resources such as therapies, meaningful prison jobs, and individual counseling.[72] Most mental health treatment offered by prisons is limited to the distribution of medication, and few facilities offer individual therapy.[73] Thus, inmates with MHCs have more access to medication than therapy but may refuse medications and lack other options.

Refusing medications can bring about cascading negative consequences for inmates with MHCs. First, researchers claim that prisoners who discontinue their medications worsen their MHCs, posing a greater danger to themselves or others.[74] By the same token, those who are non-compliant with their medications may have a difficult time understanding the directions of COs or institutional rules, so they may be punished with solitary confinement, restraints, or involuntary medication—which pose a risk to the inmates themselves.[75] In this way, refusing medication can be the first step toward greater punishments within the prison setting, and more fragile mental health.

## C. RESEARCH DESIGN

This thesis explores the issues inside prisons and jails that negatively affect the quality of life of inmates who suffer from MHCs. It also seeks to ascertain how to improve their quality of life. To this end, this thesis employs a comparative analysis of correctional methods applied in the United States and Norway. I selected these two case studies because they showed a certain degree of success in combating some of the challenges associated with MHC inmates and improving their lives. Norwegian prisons have spectacularly low recidivism rates compared to the American correctional system.[76] Notably, American

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[71] Shaffer et al., *Managing the Seriously Mentally Ill in Corrections*.

[72] Leah A. Jacobs and Sequoia N. J. Giordano, "'It's Not Like Therapy': Patient-Inmate Perspectives on Jail Psychiatric Services," *Administration and Policy in Mental Health* 45, no. 2 (March 2018): 265–75, https://doi.org/10.1007/s10488-017-0821-2.

[73] Shaffer et al., *Managing the Seriously Mentally Ill in Corrections*.

[74] Abramsky and Fellner, *Ill-Equipped*.

[75] Abramsky and Fellner.

[76] Maurice Chammah, "I Did It Norway," Marshall Project, November 1, 2017, https://www.themarshallproject.org/2017/10/31/i-did-it-norway.

prisons focus on punitive corrections while Norway and European countries have focused on rehabilitation.[77]

After providing an overview of the challenges associated with practitioners and the inmates who suffer from MHCs in U.S. prisons, this thesis analyzes the types of treatment programs that have proven effective in Norway and the United States. The framework of analysis involves the voluntarily or involuntarily treatment of MHC prisoners in the United States and Norway. Further analysis examines how mental health care is administered to inmates with MHCs in custody in psychiatric hospitals, prisons, and jails. Additional criteria considered in the case studies include the rate of recidivism, the quality of mental health care, the ratio of inmates to clinicians, and the attitude of all stakeholders—COs, medical personnel, and inmates—regarding their experiences. Finally, this thesis compares the cultural and political forces' impact on types of correctional methods—including rehabilitating the inmates, providing access to high levels of mental health care, and providing jobs while inside prison that pay a living wage.

Correctional officials in Norway face the same challenges that U.S. COs face when managing inmates with MHCs. Housing inmates with MHCs has always been more expensive and received less funding than housing other inmates. This thesis identifies and discusses barriers to improving the quality of life of inmates who have MHCs and determines which methods are potentially adoptable in the United States. Many scholars write that the chief feature of U.S. prisons seems to be command, control and punishment, as contrasted with the Norwegian themes of rehabilitation and normalization, through an inmate's time incarcerated.

In conducting this research, I consulted primary sources, including policy papers, legislation, surveys, and official documents; and secondary sources, including Bureau of Justice Statistics studies, Department of Justice archives, and peer-reviewed journals and articles. A review of several bodies of research revealed that perfect knowledge is not attainable in examining why inmates with MHCs recidivate at a higher rate than healthy inmates. The reason or inspiration behind the behavior that led to these inmates'

[77] Chammah.

committing crimes can only be knowable if each inmate is interviewed. However, the U.S. correctional system does not have the infrastructure to conduct mass interviews and fact-finding studies on such a granular level. Norwegian NCS officials do not have perfect knowledge either; however, they do have more data, which draw them closer to understanding such problems. By leveraging all that the Norwegian welfare state offers to citizens in a coordinated multi-agency effort, the NCS gains a more holistic view of each inmate's criminogenic circumstances—a stark contrast with the status quo for inmates with MHCs in the United States. Based on the findings of this research, this thesis offers recommendations for improving the prison conditions of inmates with MHCs.

## D. CHAPTER OVERVIEW

Chapter II presents an overview of and research on the treatment of inmates with MHCs, examining why inmates with MHCs are housed primarily in prisons instead of psychiatric hospitals. Chapter III comprises case studies and a comparative analysis of the Norwegian and American correctional systems, exploring the methods and techniques used by Norwegian prison officials to achieve a low recidivism rate relative to other Western countries. Chapter IV offers findings, recommendations, and areas for future research, particularly regarding some of the Norwegian penal practices that could be adopted in the United States.

# II. INSTITUTIONALIZATION OF MENTALLY ILL INMATES IN THE UNITED STATES

This chapter provides an overview of current U.S. correctional practices being used to care for inmates with MHCs—including the institutionalization of inmates with MHCs in prisons—the increasing population of inmates with MHCs, rising recidivism rates, the cost of caring for inmates with MHCs, the unintended consequences of institutionalizing inmates with MHCs, and the types of therapies available to prisons in the United States. This chapter examines how people with MHCs end up in the correctional system, why they have historically needed special housing separate from other inmate housing, and how the needs of inmates with MHCs have changed over political and cultural shifts in the American correctional system, resulting in both negative and positive impacts for these inmates.[78]

Many of the earliest mental health facilities had good intentions and attempted to provide treatment for individuals with MHCs.[79] A common characteristic among these early institutions was their small inmate population and focus on "individualized care."[80] In the 19th century, the country transitioned from well-run mental health asylums into poorly managed and overcrowded institutions where very little mental health treatment was provided.[81] In the 20th century, the American correctional system began moving away

[78] Martin Knapp et al., "The Economic Consequences of Deinstitutionalisation of Mental Health Services: Lessons from a Systematic Review of European Experience," *Health & Social Care in the Community* 19, no. 2 (2011): 113–25, https://doi.org/10.1111/j.1365-2524.2010.00969.x; Pål Hartvig and Ellen Kjelsberg, "Penrose's Law Revisited: The Relationship between Mental Institution Beds, Prison Population and Crime Rate," *Nordic Journal of Psychiatry* 63, no. 1 (2009): 51–56, https://doi.org/10.1080/08039480802298697.

[79] "Deinstitutionalization: A Psychiatric 'Titanic,'" Frontline, May 10, 2005, https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

[80] Frontline.

[81] "Module 2: A Brief History of Mental Illness and the U.S. Mental Health Care System," Unite for Sight, accessed January 27, 2022, https://www.uniteforsight.org/mental-health/module2.

from the total institutionalization framework of inmates with MHCs to a minimalist community outpatient framework, which some scholars refer to as deinstitutionalization.[82]

Deinstitutionalization occurs when inmates are released from one type of institution, such as a psychiatric hospital, and receive treatment in community-based outpatient settings.[83] Trans-institutionalization occurs when inmates are released from one type of institution, such as a psychiatric hospital, and eventually end up in prisons or jails.[84] This outcome is increasingly common because housing inmates in a forensic setting such as a psychiatric hospital is much more expensive than housing them in the medical wing of a prison. When inmates who have MHCs are not properly treated for their conditions in prison, it is difficult for this population to receive follow-up outpatient treatment once they have been released into the community.[85] This connection between insufficient treatment in prison and few community-based outpatient centers contributes to higher recidivism rates among former inmates who have MHCs.[86]

## A. FROM INSTITUTIONALIZATION TO INCARCERATION

How the correctional system manages inmates with MHCs has improved greatly since the 19th century. It was once thought that the best way to treat people with mental illnesses was to segregate them from society and provide them with full-time inpatient care, referred to as the total institutional mental health framework.[87] This framework of institutionalization began in the mid-1800s, during the early American mental health reform movement. In the 1840s, one of the most successful psychiatric reformers in

[82] Isabel M. Perera and Dominic A. Sisti, "Mass Shootings and Psychiatric Deinstitutionalization, Here and Abroad," *American Journal of Public Health* 109, no. S3 (2019): S176–77, https://doi.org/10.2105/AJPH.2018.304764.

[83] Unite for Sight, "A Brief History of Mental Illness."

[84] Unite for Sight.

[85] Y. Nina Gao, "The Relationship between Psychiatric Inpatient Beds and Jail Populations in the United States," *Journal of Psychiatric Practice* 27, no. 1 (January 2021): 33–42, https://doi.org/10.1097/PRA.0000000000000524.

[86] H. Richard Lamb and Leona L. Bachrach, "Some Perspectives on Deinstitutionalization," *Psychiatric Services* 52, no. 8 (August 2001): 1039–45, https://doi.org/10.1176/appi.ps.52.8.1039.

[87] Fred E. Markowitz, "Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates," *Criminology* 44, no. 1 (February 2006), 45–72, https://doi.org/10.1111/j.1745-9125.2006.00042.x.

American history, Dorothea Dix, was so appalled by the poor conditions in prisons endured by inmates who suffered from MHCs that she convinced state legislatures to build more than 30 psychiatric hospitals across the country. This framework, initiated by Dix, resulted in the creation of mental health hospitals, asylums, and other facilities designed specifically for incarcerated people with MHCs.[88]

Since the early 19th century, the training and professionalism of corrections officials have helped to further reform how inmates with MHCs are housed. According to a Frontline documentary, the 1880 census conducted "a canvassing of all hospitals, jails, and almshouses…[for] 'insane persons,'" revealing only "75 public psychiatric hospitals in the United States for the total population of 50 million people."[89] The census also recorded "a total of 91,959 insane persons, of which 41,083 were living at home, 40,942 were in hospitals and asylums for the insane, 9,302 were in almshouses, and only 397 were in jails" and prisons.[90] Based on these census figures, only .4 percent of inmates with MHCs were housed in jails. Further analysis of the census revealed that the "total number of prisoners in all jails and prisons was 58,609, so that severely mentally ill inmates constituted only 0.7 percent of the population of jails and prisons."[91]

Indeed, many scholars hypothesize there is a correlation between the number of MHC-designated hospital beds and the number of people incarcerated in prisons, a relationship known as Penrose's law, first demonstrated by Lionel Penrose in 1939.[92] Penrose had attempted to prove that many of the people who resided in psychiatric hospitals eventually ended up in other institutions, such as prisons and jails. Penrose further demonstrated a connection between the number of mental health hospital beds and the

[88] Markowitz.

[89] Frontline, "Deinstitutionalization."

[90] Frontline.

[91] Frontline.

[92] Hartvig and Kjelsberg, "Penrose's Law Revisited"; Markowitz, "Psychiatric Hospital Capacity."

number of murders.[93] Penrose's research revealed that a reduction in major crimes would result in providing more MHC-designated hospital beds.[94]

However, according to Fred Markowitz, "as a result of developments in pharmacology, stricter standards for involuntary commitment, and changes in public expenditures, there has been a dramatic decline in the capacity of public psychiatric hospitals to maintain America's most severely mentally ill" inmates.[95] Markowitz writes, "Until the 1960s, substantial numbers of persons with mental illness could be treated in large, publicly funded hospitals."[96] According to Markowitz's research, "in 1960, about 563,000 beds were available in U.S. state and county psychiatric hospitals (314 beds per 100,000 persons), with about 535,400 resident patients. By 1990, the number of beds declined to about 98,800 (40 per 100,000) and the number of residents to 92,059."[97] Markowitz also observes that inpatient units in private psychiatric and general hospitals have somewhat made up for the reduced capacity of public psychiatric hospitals.[98] In particular, acute treatment for those with MHCs is usually provided by emergency rooms and psychiatric units at general hospitals, with the ability to bill their stay to Medicaid.[99] However, Markowitz's research reveals that because the treatment is billable, there is a financial incentive to provide care for people with MHCs but not enough resources for those who need long-term inpatient care.[100] Researchers estimate that, today, the United States needs between 40 and 60 psychiatric beds for every 100,000 Americans.[101]

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93 Markowitz, "Psychiatric Hospital Capacity."

94 Markowitz.

95 Markowitz, 45.

96 Markowitz, 46.

97 Markowitz, 46.

98 Markowitz.

99 Markowitz.

100 Markowitz.

101 Ryan K. McBain, Jonathan H. Cantor, and Nicole K. Eberhart, "Estimating Psychiatric Bed Shortages in the US," *JAMA Psychiatry* 79, no. 4 (2022): 279–80, https://doi.org/10.1001/jamapsychiatry.2021.4462.

## B. A SPIKE IN INMATES WITH MHCS

Over the last seven decades, funding for state psychiatric hospitals has decreased, and incarceration rates of people with MHCs have increased in many jurisdictions around the country. As the overall prison population has grown, so has the population of inmates with MHCs. People with MHCs who do not get a bed in a mental health facility could end up in a prison instead.[102] Without strong community outpatient mental health care options or access to psychiatric hospitals, people with MHCs often find their way into the correctional system.

When people with MHCs are free and interacting with society, they typically come to law enforcement's attention due to their MHC symptoms manifesting in unusual or threatening behavior. Occasionally, trained law enforcement officials properly assess the individuals' disorders, resulting in an attempt to provide some form of mental health treatment. However, even when individuals taken into custody by the police are placed in mental health hospitals and are seen by mental health professionals, there are typically not enough dedicated resources to provide better outcomes for them.[103] According to Daniel Yohanna, about "50 beds per 100,000 people would meet needs for acute and long-term care, but in some states the number of available beds is as low as 5 per 100,000 people."[104] Based on these numbers, Yohanna opines that a significant number of people who need treatment will not receive it, as there are not enough beds available to them.[105]

In many instances, however, MHC-induced behavior coupled with the individuals' inability to understand their situation results in their being taken into custody.[106] These encounters normally result in criminal arrests and placement in correctional facilities. An inmate's first few moments entering a jail or prison during the screening and initial intake

[102] Daniel Yohanna, "Deinstitutionalization of People with Mental Illness: Causes and Consequences," *AMA Journal of Ethics* 15, no. 10 (2013): 886–91, https://doi.org/10.1001/virtualmentor.2013.15.10.mhst1-1310.

[103] Abramsky and Fellner, *Ill-Equipped*.

[104] Yohanna, "Deinstitutionalization of People with Mental Illness."

[105] Yohanna.

[106] Wendy Sawyer and Peter Wagner, "Mass Incarceration: The Whole Pie 2020," Prison Policy Initiative, March 24, 2020, https://www.prisonpolicy.org/reports/pie2020.html.

phase of processing into a correctional facility, especially the screening for MHCs, are crucial. COs who process inmates during their initial entry into a jail or prison play a vital role in ensuring those with MHCs are properly screened and identified.[107] When inmates are properly screened, they have a better chance of receiving treatment for their illnesses and experiencing better outcomes while they are incarcerated.[108] Well-run jails and prisons use a variety of tools to screen inmates for MHCs.[109] Often, however, inmates with MHCs are quickly screened and issued some sort of stabilizing drug to aid in their competence to stand before a judge or compliance so as not to threaten themselves or others.[110]

As a result of improved mental health screening, the use of trained staff, more tools used to detect MHCs, and shrinking budgets available for psychiatric hospital beds, Y. Nina Gao writes that the American correctional system has experienced exponential growth in its MHC population.[111] HRW reports that there are "no national statistics in historical rates of mental illness among [the] prison population."[112] Nevertheless, many prison systems report rising numbers of inmates with MHCs within the prison population.[113] Some scholars estimate that 20–25 percent of the overall incarcerated prison population suffers from MHCs.[114] Christine Herman's research reveals that approximately 40 percent of federal inmates have learned of their MHC status while only half have received any mental health treatment for their illness.[115] A study by the Department of Justice has revealed that about 50 percent of inmates suffer from at least one MHC, compared to just

107 Haney, "'Madness' and Penal Confinement."

108 Haney.

109 Haney.

110 Abramsky and Fellner, *Ill-Equipped*.

111 Gao, "Psychiatric Inpatient Beds and Jail Populations," 33–42.

112 Abramsky and Fellner, *Ill-Equipped*.

113 Abramsky and Fellner.

114 Segal, Frasso, and Sisti, "County Jail or Psychiatric Hospital?"

115 Christine Herman, "Most Inmates with Mental Illness Still Wait for Decent Care," NPR, February 3, 2019, https://www.npr.org/sections/health-shots/2019/02/03/690872394/most-inmates-with-mental-illness-still-wait-for-decent-care.

11 percent of the American public.[116] Anasseril Daniel concurs that approximately half of prison inmates have MHCs.[117]

Considering that some scholars estimate that at least 20–25 percent of the American prison population suffers from some form of MHC, the approximate number of people incarcerated with an MHC exceeds 250,000.[118] Based on Sawyer and Wagner's research, the total number of inmates suffering from MHCs in the correctional system exceeds 300,000.[119] Inmates who have MHCs are so common in the criminal justice system that they outnumber patients who reside in psychiatric hospitals around the nation. Sawyer and Wagner's research has revealed that only "22,000 people are involuntarily detained or committed to state psychiatric hospitals and civil commitment centers."[120] As of 2014, a major shortage of psychiatric beds contributed to an environment where "10 times more individuals with serious mental illness [were] in jails and state prisons than in the remaining state mental hospitals."[121] According to Daniel, "Correctional institutions have become the de facto state hospitals, and there are more seriously and persistently mentally ill in prisons than in all state hospitals in the United States."[122] As a result of this trans-institutionalization, criminal justice officials face an overwhelming number of inmates with mental illness but lack the capacity to treat them properly.

Trans-institutionalization could be contributing to the number of inmates with MHCs in the correctional system. Gao's research reveals that "decreases in local psychiatric bed capacity appear to be associated with subsequent increases in local jail populations."[123] Gao observes that "a consequence of reducing psychiatric inpatient bed

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116 Daniel, "Care of the Mentally Ill in Prisons," 406.

117 Daniel.

118 Segal, Frasso, and Sisti, "County Jail or Psychiatric Hospital?"

119 Daniel, "Care of the Mentally Ill in Prisons," 406.

120 Sawyer and Wagner, "Mass Incarceration."

121 "Serious Mental Illness Prevalence in Jails and Prisons," Treatment Advocacy Center, September 2016, https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695.

122 Daniel, "Care of the Mentally Ill in Prisons," 406.

123 Gao, "Psychiatric Inpatient Beds and Jail Populations," 1.

capacity is an increase in the jail population due to more psychiatrically ill inmates, aggravating the challenge of psychiatric treatment delivery within the U.S. criminal justice system."[124] The mental health care system is a combination of poorly coordinated entities unprepared to provide care for inmates with MHCs; likewise, state correctional systems are poorly coordinated and not designed to provide mental health care inside jails and prisons.

## C. RECIDIVISM OF INMATES WITH MHCS

One body of literature indicates that many inmates with MHCs experience a high rate of recidivism. The Bureau of Justice Statistics (BJS) corroborates this finding.[125] According to the Northwestern Prison Education Program, in a study that tracked the activities of 404,638 former prisoners in 30 states, the BJS found that more than two-thirds returned to prison within three years and three-quarters within five.[126] Stringer writes that the recidivism rates for inmates with MHCs are as high as 80 percent.[127] Most of these rearrests occurred during the first 12 months after they were released from jail or prison. One reason for this high recidivism rate, according to Gonzalez and Connell, involved many inmates with MHCs not receiving treatment while they were incarcerated.[128] Of the inmates with MHCs who are initially compliant with their prescribed medications in prison, only half remain compliant.[129] Gonzalez and Connell write, "This treatment discontinuity has the potential to affect both recidivism and health care costs on release from prison."[130] When inmates with MHCs are not properly screened, identified, and provided appropriate

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[124] Gao, 1.

[125] Doris James and Lauren Glaze, *Mental Health Problems of Prison and Jail Inmates*, NCJ 213600 (Washington, DC: Bureau of Justice Statistics, 2006), https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf.

[126] "Benefits of Prison Education," Northwestern Prison Education Program, accessed October 10, 2021, https://sites.northwestern.edu/npep/benefits-of-prison-education/.

[127] Heather Stringer, "Improving Mental Health for Inmates," *Monitor on Psychology* 50, no. 3 (March 2019), para. 9, https://www.apa.org/monitor/2019/03/mental-heath-inmates.

[128] Gonzalez and Connell, "Mental Health of Prisoners."

[129] Gonzalez and Connell.

[130] Gonzalez and Connell, 2328.

treatment, they can further decompensate or receive the wrong therapies.[131] As a result, they are likely to recidivate due to their unmanaged MHCs.[132]

For inmates with severe MHCs, such as schizophrenia, bipolar disorder, antisocial personality disorder or sociopathy, and psychopathy, not receiving appropriate mental health treatment while they incarcerated could play a role in their recidivism. According to Kent Kiehl and Morris Hoffman, psychopaths are overrepresented in prisons.[133] They write that psychopaths represent about "1% of the general male adult population,…make up between 15% and 25% of the males incarcerated in North American prison systems…[and] are 15 to 25 times more likely to commit crimes that land them in prison than non-psychopaths."[134] Kiehl and Hoffman maintain that being a psychopath is the primary characteristic of those incarcerated.[135] According to the researchers, psychopaths commit additional crimes at much higher rates than do other subsets of inmates without MHCs, even though psychopaths make up a quarter of the overall prison population.[136] Their research reveals that the recidivism rate for psychopaths is as high as 80 percent.[137]

### 1. The Cost of Caring for Inmates with MHCs

Managing inmates with MHCs can be challenging and expensive for both prisons and jails. For inmates with MHCs, correctional systems incur the same expenses as those for healthy inmates in addition to the cost of special housing, mental health therapies, and dedicated space inside the facility for mental health treatment.[138] Facilities that house inmates with MHCs must also hire psychologists, psychiatrists, nurses, therapists, and

131 Kent A. Kiehl and Morris B. Hoffman, "The Criminal Psychopath: History, Neuroscience, Treatment, and Economics," *Jurimetrics* 51, no. 4 (Summer 2011): 355–97, ProQuest.

132 Gonzalez and Connell, "Mental Health of Prisoners."

133 Kiehl and Hoffman, "The Criminal Psychopath."

134 Kiehl and Hoffman, 14.

135 Kiehl and Hoffman.

136 Kiehl and Hoffman.

137 Kiehl and Hoffman.

138 Daniel, "Care of the Mentally Ill in Prisons."

other clinicians to provide therapy and prescribe and dispense pharmaceuticals.[139] According to the Treatment Advocacy Center, "It costs $80 a day to house a regular inmate but $130 a day for an inmate with mental illness."[140] One 2003 study revealed that "the average prisoner costs the state about $22,000 a year, but prisoners with mental illness range from $30,000 to $50,000 a year."[141] According to Kiehl and Hoffman, psychopathic inmates "are responsible for approximately $460 billion per year in criminal social costs" of the estimated $2.3 trillion burden nationally—including the cost of prosecutors, judges, COs, and prison and jail housing—from all crime.[142] For some perspective, obesity costs $200 billion, smoking $172 billion, and alcoholism $329 billion.[143] Given the staggering financial toll, corrections officials who allocate funding for mental health treatment may decide to withhold treatment from some inmates with MHCs such as psychopathy because psychopaths can be resistant to some forms of mental health therapy.

Another cost of incarcerating inmates with MHCs, particularly psychopaths, is incurred by taking special precautions to manage this population across the entire correctional system. According to Harris and Rice, "No clinical intervention will ever be helpful," and "no effective interventions yet exist for psychopaths."[144] Many scholars agree that psychopaths consume an enormous amount of resources when they are introduced to the correctional system and that limited rehabilitation resources, such as therapy, should be used for other MHC populations that might be more responsive to it.[145]

Given the monetary and other costs of treating inmates with MHCs, HRW maintains that it may be fiscally prudent for state correctional systems to send inmates with MHCs to prisons at a cost of $35,000 per year instead of sending them to state hospitals,

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139 Daniel.

140 Treatment Advocacy Center, "Serious Mental Illness Prevalence in Jails and Prisons."

141 Treatment Advocacy Center.

142 Kiehl and Hoffman, "The Criminal Psychopath."

143 David A. Anderson, "The Aggregate Burden of Crime," *Journal of Law & Economics* 42, no. 2 (1999): 611–42, https://doi.org/10.1086/467436.

144 Grant T. Harris and Marnie E. Rice, "Treatment of Psychopathy: A Review of Empirical Findings," in *Handbook of Psychopathy* (New York: Guilford Press, 2006), 563.

145 Kiehl and Hoffman, "The Criminal Psychopath."

which can cost as much as $90,000–$100,000 per year.[146] There is a body of literature indicating that some correctional systems around the country have realized the financial incentives of managing inmates with MHCs in prisons instead of more expensive environments, such as nursing homes or psychiatric hospitals.[147] One reason for this development is that inmates are not eligible for Medicare while they are incarcerated, and their benefits can only be restored if they re-apply upon their release from prison.[148]

In comparing the costs of incarcerating healthy inmates to the cost of incarcerating inmates with MHCs in jails and prisons, it is clear the most cost-effective way to manage jails and prisons is to divert inmates with MHCs to more appropriate facilities that are equipped to address their needs.[149] It is an observable fact that once individuals are introduced to the correctional system, it is difficult to stay out of the system, especially for people who have MHCs.[150]

### 2. The Unintended Consequences of Institutionalization for Inmates with MHCs

Living in a regimented environment like a prison is challenging for many inmates who suffer from MHCs and can produce numerous unintended consequences for them. For one, inmates with MHCs often struggle with institutional rules and the unspoken code of conduct among healthy inmates, which often leads to violent outcomes. Correctional facilities were not designed to be safe places for inmates with MHCs—they were designed for healthy inmates who can navigate complex, strict rules and directions provided by COs. Inmates must navigate an incredibly hostile and unforgiving place full of violent gangs in which anyone who stands out for acting oddly or not quickly understanding the hierarchy

146 Abramsky and Fellner, *Ill-Equipped*.

147 Abramsky and Fellner.

148 Edward P. Mulvey and Carol A. Schubert, "Mentally Ill Individuals in Jails and Prisons," *Crime & Justice* 46, no. 1 (January 2017): 231–77, https://doi.org/10.1086/688461.

149 Mulvey and Schubert.

150 Mulvey and Schubert.

of the facility will likely face some type of penalty.[151] Managing inmates with MHCs requires well-trained COs who can distinguish between inmates who are violating prison rules of their own volition and inmates who are merely experiencing some psychotic episodes they cannot control. However, many American prisons and jails are plagued with unprofessional COs and understaffed mental health facilities.[152] When inmates with MHCs are not properly screened and identified, their MHCs could manifest as behaviors easily misinterpreted by other inmates and COs as acts of aggression. When COs mistake inmates' psychotic behavior as a challenge to authority, the inmates are often punished, and their mental health may further decline or decompensate.[153] Prisons and jails can, therefore, be some of the most dangerous settings in the world for inmates who have MHCs, who are frequently the targets of abuse by other inmates and punished more often by COs due to their inability to navigate the rules and regulations of the facilities.[154]

In addition to physical harm, another unintended consequence of institutionalizing inmates with MHCs is the worsening of their psychological conditions—making them more likely to be institutionalized again and, thus, creating a vicious cycle. Many are placed in solitary confinement, which can have negative psychological effects. According to Craig Haney, "Large numbers of seriously mentally ill prisoners continue [to] languish for very long periods of time in prisons that are unsuited to house and treat them, including extremely harsh segregation units that expose them to significant risk of serious psychological harm."[155] Haney adds that inmates with MHCs "endure significant psychological stress and pain, and are placed in jeopardy of further deterioration and decompensation."[156] Haney writes, "The adverse psychological consequences of prison

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[151] E. Lea Johnston, "Vulnerability and Just Desert: A Theory of Sentencing and Mental Illness," *Journal of Criminal Law & Criminology* 103, no. 1 (Winter 2013): 147–83, https://scholarship.law.ufl.edu/facultypub/354/.

[152] Johnston.

[153] Jerry McKee, Joseph V. Penn, and Angela Koranek, "Psychoactive Medication Misadventuring in Correctional Health Care," *Journal of Correctional Health Care* 20, no. 3 (July 2014): 249–60, https://doi.org/10.1177/1078345814532419.

[154] McKee, Penn, and Koranek.

[155] Haney, "'Madness' and Penal Confinement," 323.

[156] Haney, 323.

confinement can be severe, long lasting, even permanent and, in the case of the many mentally ill prisoners for whom the risk of suicide is intensified in isolation, fatal."[157]

A final important unintended consequence of incarcerating inmates with MHCs is that because psychopaths are resistant to therapy, they may further decompensate if they receive the wrong treatment. As Kiehl and Hoffman point out, "The law attributes all antisocial acts, psychopathic or no, to the same forces it attributes all acts of people whose reason is sufficiently intact to be presumed to have free will: a conscious judgment to violate social norms, usually for personal gain, and for which, once caught, they must be held responsible."[158] They ask, "How can the system morally punish those of us who on occasion breach the social contract, sometimes for our own gain and sometimes not, but forgive a whole category of criminals who breach it all the time for their own gain?"[159] Finally, as Kiehl and Hoffman state, "Psychopaths seem perfectly capable of resisting self-harming actions that do not require an understanding of the social network. That is, they can resist sticking their hands in a bees nest to get honey, they just cannot resist reaching into another person's pocket to take money."[160] Scholars such as Haney and Kiehl and Hoffman agree that while prisons and jails are not the ideal setting to care for inmates with MHCs, they also agree that it is the duty of the correctional system to distinguish between the good that occasionally does bad, the bad, and the mad so that the drug dealer who occasionally sells drugs is sentenced but so is the criminal psychopath who commits crimes at a higher rate than non-psychopaths.[161]

### 3. Therapies for Inmates with MHCs

There are many forms of therapies available to inmates with MHCs; however, the problem for most prisons and jails is that there are not enough resources for all of the

[157] Haney, 323.

[158] Kiehl and Hoffman, "The Criminal Psychopath," 8.

[159] Kiehl and Hoffman, 11.

[160] Kiehl and Hoffman, 12.

[161] Kiehl and Hoffman.

inmates who suffer from mental illness.[162] The correctional system lacks the resources to hire enough nurses, psychiatrists, and psychologists to provide space for the inmates with MHCs.[163] In addition, many prisons and jails lack the dedicated space needed to house and treat inmates with MHCs.[164]

However, some scholars have observed that inmates with MHCs can play a major role in their own mental health therapy. Many scholars have learned that if mental health professionals teach inmates "illness management skills," they might identify the root cause of these incarcerations and thereby reduce the rate of recidivism of those inmates.[165] Illness management skills require that inmates recognize their illnesses and be taught relapse and coping skills to help prevent future mental health episodes.[166] According to Texas Tech psychologist Robert Morgan, who has created a new therapy program called Changing Lives and Changing Outcomes, inmates with MHCs can be taught to avoid situations that lead to criminal behavior.[167] Morgan's six-week program includes "155 hours of group and individual therapy sessions in which clinicians [teach] participants about healthy ways of dealing with anger and fear, how to interpret situations, medication adherence and other skills."[168] Morgan argues that inmates with MHCs need not only mental health treatment but also treatment for criminal thinking. Morgan's research indicates that if inmates could learn what triggers their MHCs, they might avoid such "antisocial thought patterns."[169] Morgan has also observed that inmates with MHCs

[162] H. Richard Lamb and Linda E. Weinberger, "Persons with Severe Mental Illness in Jails and Prisons: A Review," *Psychiatric Services* 49, no. 4 (April 1998): 483–92, https://doi.org/10.1176/ps.49.4.483.

[163] Daniel, "Care of the Mentally Ill in Prisons."

[164] Lamb and Weinberger, "Persons with Severe Mental Illness in Jails and Prisons."

[165] Kim T. Mueser et al., "Illness Management and Recovery: A Review of the Research," *Psychiatric Services* 53, no. 10 (October 2002): 1272–84, https://doi.org/10.1176/appi.ps.53.10.1272.

[166] Mueser et al.

[167] Stringer, "Improving Mental Health for Inmates."

[168] Stringer, para. 9.

[169] Stringer, "Improving Mental Health for Inmates," para. 6. See also Robert D. Morgan et al., "Prevalence of Criminal Thinking among State Prison Inmates with Serious Mental Illness," *Law and Human Behavior* 34, no. 4 (August 2010): 324–36, https://doi.org/10.1007/s10979-009-9182-z.

participating in his program experience a reduction in "depression, anxiety, hostility, paranoid ideation, psychoticism and reactive criminal thinking."[170]

Many other mental health frameworks are potentially useful in treating inmates with MHCs such as the illness management and recovery model (IMR), the good lives model (GLM), and the risk-need-responsivity (RNR) model of rehabilitation.[171] According to Kim Mueser et al., the IMR framework "was developed in order to help clients with schizophrenia or major mood disorders learn how to manage their illnesses more effectively in the context of pursuing their personal goals."[172] IMR is an evidenced-based practice for individuals to learn new techniques to mitigate their MHCs. IMR can be taught by a medical professional or in a peer group, which is especially useful in a prison setting as other inmates could assist in the role of peers. GLM is based on the idea that "all humans fashion their lives around their core values and follow some sort of (often implicit) good life plan, however rudimentary."[173] According to Ward, Yates, and Willis, GLM maintains that "offending results from flaws in an individual's life plan and relates either directly and/or indirectly to the pursuit of primary goods."[174] Ward and his colleagues argue that an inmate's pursuit of items of value, such as material goods, and the priorities placed on those items could be indicative of one's life priorities.[175] The RNR model is one of the most commonly used rehabilitation frameworks for treating inmates with MHCs.[176]

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[170] Stringer, "Improving Mental Health for Inmates," para. 9.

[171] D. A. Andrews, James Bonta, and J. Stephen Wormith, "The Risk-Need-Responsivity (RNR) Model: Does Adding the Good Lives Model Contribute to Effective Crime Prevention?," *Criminal Justice and Behavior* 38, no. 7 (2011): 735–55, https://doi.org/10.1177/0093854811406356.

[172] Kim T. Mueser et al., "The Illness Management and Recovery Program: Rationale, Development, and Preliminary Findings," *Schizophrenia Bulletin* 32, no. S1 (October 2006): S33, https://doi.org/10.1093/schbul/sbl022.

[173] Tony Ward, Pamela Yates, and Gwenda Willis, "The Good Lives Model and the Risk Need Responsivity Model: A Critical Response to Andrews, Bonta, and Wormith (2011)," *Criminal Justice and Behavior* 39, no. 1 (January 2012): 96, https://doi.org/10.1177/0093854811426085.

[174] Ward, Yates, and Willis, 96.

[175] Ward, Yates, and Willis.

[176] J. Stephen Wormith and Alexandra M. Zidenberg, "The Historical Roots, Current Status, and Future Applications of the Risk-Need-Responsivity Model (RNR)," in *New Frontiers in Offender Treatment: The Translation of Evidence-Based Practices to Correctional Settings*, ed. Elizabeth L. Jeglic and Cynthia Calkins (Cham: Springer International, 2018), 11–41, https://doi.org/10.1007/978-3-030-01030-0_2.

According to Andrews, Bonta, and Wormith, the RNR model is used to help determine which inmates are treated and what they have been treated for based on their criminal risk and needs.[177] Criminogenic risks include low engagement with employment or education, substance abuse, and pro-criminal attitudes.[178] The theory is that most inmates have unmet criminogenic needs, but if those needs are met, it is possible to reduce future recidivism events.[179]

Other examples of mental health treatment for inmates with MHCs include cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT). According to Isabel Yoon, Karen Slade, and Seena Fazel, these "psychological therapies for mental health outcomes in prisoners were modestly effective," so additional research should be conducted to determine the impact of psychological therapy in prisons.[180] According to Kelly Moore et al., "Learning to regulate and tolerate emotions, refrain from maladaptive behaviors such as substance use or aggression and communicate effectively with others are considered primary treatment needs among general population jail inmates."[181] Moore et al. write that DBT is an "evidence-based intervention that addresses these very skills deficits."[182] Normally, DBT is used for inmates who have severe personality disorders both inside and outside prisons and has shown evidence of improvements to impulsivity and "emotion dysregulation."[183] CBT focuses on the inmates' negative thoughts and attempts to make positive corrections to their thinking processes.

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177 Andrews, Bonta, and Wormith, "The Risk-Need-Responsivity Model."

178 "Criminogenic Theories," Forensic Fundamentals, accessed January 22, 2022, https://forensicfundamentals.com.au/articles/criminogenic-theories/.

179 Andrews, Bonta, and Wormith, "The Risk-Need-Responsivity Model."

180 Isabel A. Yoon, Karen Slade, and Seena Fazel, "Outcomes of Psychological Therapies for Prisoners with Mental Health Problems: A Systematic Review and Meta-Analysis," *Journal of Consulting and Clinical Psychology* 85, no. 8 (August 2017): 792, https://doi.org/10.1037/ccp0000214.

181 Kelly E. Moore et al., "Pilot Study of a Brief Dialectical Behavior Therapy Skills Group for Jail Inmates," *Psychological Services* 15, no. 1 (February 2018): 2, https://doi.org/10.1037/ser0000105.

182 Moore et al., 2.

183 Moore et al.

## D. CONCLUSION

The purpose of his chapter was to provide readers with some background on the institutionalization of inmates who have MHCs and explain why many of them are housed within the correctional system. The correctional system was never designed to warehouse large numbers of inmates with MHCs. However, American correctional systems acknowledge that, by default, they have become the largest mental health hospitals in the country and that they are constitutionally mandated to provide mental health treatment to all inmates who need it. Due to overcrowding and limited resources, most correctional facilities around the country are having a difficult time providing dedicated spaces for mental health treatment.[184] Mental health clinicians need as much access to their patients as possible; however, the security needs of the facility where the inmates are housed often conflict with mental health best practices.[185] Finally, screening procedures play a significant role in assessing inmates for placement in the appropriate therapy.[186] Thus, screening is a critical step in processing inmates, considering that most correctional systems have limited resources and few options beyond psychotropic drugs and overworked medical staff.[187]

[184] Shaffer et al., *Managing the Seriously Mentally Ill in Corrections*.

[185] Daniel, "Care of the Mentally Ill in Prisons."

[186] Markowitz, "Psychiatric Hospital Capacity."

[187] Kiehl and Hoffman, "The Criminal Psychopath."

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# III. COMPARATIVE ANALYSIS OF U.S. AND NORWEGIAN PENAL PHILOSOPHIES

Chapter II detailed how U.S. penal philosophies have evolved beyond housing inmates who suffer from MHCs without any meaningful mental health treatment, as well as the challenges that arise today in incarcerating and caring for inmates with MHCs. The lack of adequate mental health care for these inmates suggests that this evolution has come full circle and raises the question of how we can once again improve the quality of life of inmates with MHCs. To investigate this issue, this chapter examines the Norwegian correctional system—specifically the philosophical and practical differences between the methods that Norwegian and American corrections systems use to manage inmates with MHCs. This chapter first explores Norway's cultural attitudes toward inmates and their impact on the country's penal philosophy. Then, it investigates the costs to Norway of incarcerating inmates who have MHCs, training for Norwegian prison employees who manage inmates with MHCs, and the contributions of well-trained employees and properly funded facilities to Norway's exceptionally low recidivism rates. Finally, it presents a comparative analysis of the Norwegian and American correctional systems to craft recommendations for improvements in the United States, for the benefit of inmates with MHCs.

This chapter finds that the American correctional system generally focuses on a security-, control-, and punitive-oriented prison experience while the Norwegian correctional system centers on a penal philosophy of rehabilitation and normalization. The principle of normalization describes the concept of making life for those who are incarcerated as close as possible to life upon release.[188] For example, many Norwegian inmates have their sentences structured so they may keep their jobs while incarcerated.[189]

[188] Jill van de Rijt, Esther van Ginneken, and Miranda Boone, "Lost in Translation: The Principle of Normalisation in Prison Policy in Norway and the Netherlands," *Punishment & Society* (2022), https://doi.org/10.1177/14624745221103823.

[189] Gordon B. Dahl and Magne Mogstad, "The Benefits of Rehabilitative Incarceration," *NBER Reporter*, no. 1 (March 2020), http://www.nber.org/reporter/2020number1/benefits-rehabilitative-incarceration.

Pratt's analysis further suggests that when a government has a robust welfare state and all the social controls that come with it, the government has more than just penal controls to manage inmates with MHCs who have criminogenic needs—it can also leverage rehabilitation programs, mental health therapy, and employment programs.[190] Norway's welfare state provides the economic umbrella that helps the Norwegian correctional system provide inmates with uninterrupted medical and mental health care, and it proves all inmates with assistance in finding employment during their incarceration and post-incarceration.[191] This structure assists inmates with MHCs—who might not be high functioning and who might struggle with tasks such as participating in job interviews, selecting housing, and scheduling and keeping medical appointments—in their transition back into society. The totality of this structure reinforces the rehabilitation of inmates with MHCs and, therefore, gives them a chance at better quality of life, which will improve their chances of a successful reentry into society.

## A. INFLUENCE OF CULTURE ON NORWAY'S PENAL PHILOSOPHY

Many scholars have described the Norwegian penal philosophy as exceptional and worthy of study. Norwegian penal philosophy is not just a collection of laws regulating the treatment of inmates but rather a manifestation of cultural morals and mores. According to John Pratt, "The roots of Scandinavian exceptionalism are to be found in the highly egalitarian cultural values and social structures of these societies."[192] Pratt's research into Norwegian history has revealed that "social conditions [provide] for little class distinction and high levels of egalitarianism…[so] there is no nobility with political or economic privileges, no large estates, no capitalist class."[193] Pratt argues that "very strong religious homogeneity, with almost universal membership of the Lutheran church," is made manifest

190 John Pratt, "Scandinavian Exceptionalism in an Era of Penal Excess: Part I: The Nature and Roots of Scandinavian Exceptionalism," *British Journal of Criminology* 48, no. 2 (March 2008): 119–37, https://doi.org/10.1093/bjc/azm072.

191 "About the Norwegian Correctional Service," Norwegian Correctional Service, accessed March 3, 2022, https://www.kriminalomsorgen.no/informasjon-paa-engelsk.536003.no.html.

192 Pratt, "The Nature and Roots of Scandinavian Exceptionalism," 120.

193 Pratt, 124.

in Norwegian culture.[194] He opines that this "sameness" among Norwegians has helped to strengthen communal bonds and focus on the "collective rather than individual interests."[195] Pratt adds that "egalitarianism [has been]…institutionalized and embedded in [Norwegian] social fabrics through the development of the Scandinavian welfare state."[196] In sum, Norwegian penal practices are based on more than laws and regulations—they are heavily influenced by Norwegian norms and morals, which find their origin in Norwegians' interpretation of their religion.

Norwegians' religion, education, and customs have thus greatly influenced the way their government-run institutions, including the correctional system, operate. Pratt writes, "This framework…began to sharply diverge from those in the Anglo-American world."[197] In particular, Scandinavian norms and religious foundations have helped to insulate Norway from the law-and-order politics that have inspired harsher punitive sentencing in places like America.[198] Pratt posits that Norwegian exceptionalism encompasses the way in which people are incarcerated such as by making prison as similar to life outside as possible.[199] Pratt's research reveals that in Norwegian culture, imprisonment itself is the punishment, so conditions inside prison should not be punishing; prison conditions "can then approximate to life outside as far as possible, rather than being allowed to degrade and debase all within."[200] Likewise, according to Cyrus Ahalt et al., "the Norwegian Correctional Service…believes that people go to court to get punished and go to prison to become better neighbors."[201] Thus, NCS officials focus their efforts on rehabilitation instead of punishment when administering an inmates time served during their incarnation.

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194 Pratt, 124.

195 Pratt, 125.

196 Pratt, 120.

197 Pratt, 120.

198 Pratt.

199 Pratt.

200 Pratt, 119.

201 Cyrus Ahalt et al., "Role of a US–Norway Exchange in Placing Health and Well-Being at the Center of U.S. Prison Reform," *American Journal of Public Health* 110 (January 2020): S27, http://doi.org/10.2105/AJPH.2019.305444.

The Norwegian penal philosophy can therefore be described as "small scale, positive and truly focused on rehabilitation."[202] To that end, "NCS officers are trained to play an active role in residents' rehabilitation by using positive incentives and motivational interviewing, engaging residents in health-focused programming, and providing intensive mentorship and positive socialization."[203] In addition, Francis Pakes and Katrine Holt explain that "prison policy in Norway has historically been informed by the normalization thesis…[which] informs policy-making throughout, including prison design, staff training, staff–prisoner relations, opportunities for prisoners and an emphasis on prisoner agency."[204] Normalization can be described as the methods by which the NCS manages everyday life for inmates while they are incarcerated, and rehabilitation is the result of improvements in the inmate before they have been reintegrated into society. Normalization is used to achieve the desired change in an inmate's criminogenic patterns and behaviors.[205] If the normalization process is successful, then the inmate will be rehabilitated. Jill van de Rijt, Esther van Ginneken, and Miranda Boone describe the normalization thesis using these three points: "apart from the restriction of freedom, prisoners keep the same rights as every other citizen," normality requires that "no more security and safety measures be instated than necessary, and all aspects of life in prison should be shaped as much as possible to the equivalent of life in free society."[206] According to the researchers, "The principle of normality has many practical consequences. Inmates should plan their own finances, do their own shopping and cooking, wash their own clothes and keep their cell clean, [and] search for work or school."[207] Van de Rijt, van Ginneken, and Boone add that "the prison should be an arena for practicing

[202] Francis Pakes and Katrine Holt, "Crimmigration and the Prison: Comparing Trends in Prison Policy and Practice in England & Wales and Norway," *European Journal of Criminology* 14, no. 1 (2017): 65, https://doi.org/10.1177/1477370816636905.

[203] Ahalt et al., "US–Norway Exchange," S27.

[204] Pakes and Holt, "Crimmigration and the Prison," 66.

[205] van de Rijt, van Ginneken, and Boone, "Lost in Translation."

[206] van de Rijt, van Ginneken, and Boone, 9.

[207] van de Rijt, van Ginneken, and Boone, 12.

daily activities and taking responsibility for one's own life," and this responsibility is a key factor in avoiding future incarceration.[208]

Norwegians thus apply the principles of normalization to create environments in prisons that are conducive to inmates' rehabilitation and, ultimately, reintegration into their original communities. Moreover, most Norwegian prisons are very small, the largest having approximately 400 beds. In Norway, the number of inmates has been kept low by design because Norwegian penal philosophies call for smaller, more intimate prison settings that facilitate a normalizing and rehabilitative environment; thus, Norway has a waiting list of approximately 3,000 people to get into prison.[209] Some Norwegian politicians have attempted to resolve this problem by proposing that corrections officials expand the size of prisons; however, these efforts have been met with public backlash because Norwegian penal philosophies call for smaller facilities to better manage them.[210]

In addition, corrections officials apply the normalization theory by placing inmates as close to home as possible to allow the inmates to maintain regular relationships with family and employers. Prisons are located throughout the country to allow inmates' family and friends to visit them while they are serving their sentences.[211] The Norwegian penal philosophy also takes advantage of the Norwegian welfare state and utilizes other elements of state government to help find employment for inmates. Inmates earn competitive wages while incarcerated, which helps with their reintegration by allowing them to build up financial resources for when they are released. In fact, "local [Scandinavian] communities compete with each other for the location of new prisons, recognizing their economic and social benefits."[212]

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[208] van de Rijt, van Ginneken, and Boone, 12.

[209] Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

[210] Berit Johnsen, Per Kristian Granheim, and Janne Helgesen, "Exceptional Prison Conditions and the Quality of Prison Life: Prison Size and Prison Culture in Norwegian Closed Prisons," *European Journal of Criminology* 8, no. 6 (2011): 515–29, https://doi.org/10.1177/1477370811413819.

[211] Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

[212] Pratt, 121.

This philosophy of normalization also requires that core prison services such as health care and mental health care be provided by community medical professionals so that this relationship can continue once the inmates have been released from prison. Pratt explains that the Norwegian correctional system has a policy of using community mental health resources so that the inmates have the option of continuing with the same mental health professionals when they are released.[213] The Norwegian correctional system also helps inmates with housing and health care to aid their reintegration. These policies help inmates maintain continuity in taking their medications and seeing the same doctors.[214]

One of the additional benefits of Norway's penal philosophy is that corrections officials use open and closed prisons as a carrot-and-stick reward system. According to Pratt, there are "major distinctions between Scandinavian closed and open prisons, with the latter holding between 20 and 30 per cent of the respective prison populations."[215] Closed prisons resemble most American prisons with their traditional high security walls and strict security measures.[216] Some minimum-security prisons in the United States share some of the same features of Norwegian open prisons, but they are exceptions and do not represent the American prison template. Open prisons provide many freedoms and privileges that closed prisons do not. Some have compared open prisons in Norway to college campuses—comprising single-cell units or even apartments with private showers, kitchens, and TVs—or camp sites.[217] One of the most recognized open prisons in Norway offering many of these amenities is Bastoy Prison, located in the Oslo Fjord.[218] However, many Norwegian prisons of both types share some of the same monitoring features as American prisons such as frequent screenings for illegal narcotics.[219] Many prisoners

213 John Pratt, "Scandinavian Exceptionalism in an Era of Penal Excess: Part II: Does Scandinavian Exceptionalism Have a Future?," *British Journal of Criminology* 48, no. 3 (May 2008): 275–92, https://doi.org/10.1093/bjc/azm073.

214 Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

215 Pratt, 121.

216 Pratt.

217 Pratt.

218 Pakes and Holt, "Crimmigration and the Prison."

219 Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

convicted of less serious crimes, such as drunk driving, may be placed in an open prison while more serious offenders go directly to a closed prison. According to Pratt, inmates convicted of major crimes spend more time in closed prisons than do inmates convicted of lesser crimes.[220] However, many inmates are presented an opportunity to apply for assignment to an open prison near their homes in preparation for reintegration toward the end of their incarceration.[221] Pratt argues that fewer than "20 percent of referrals to open prisons are recalled to closed institutions for breaches of the rules each year."[222] As such, the NCS practice of using open and closed facilities as a reward and penalty tool appears to be effective when used to rehabilitate inmates' behavior.

Finally, another feature of Norwegian culture that influences Norwegian penal philosophy is a strong trust in subject-matter expert policy decisions, which help to limit political interference in the administration of sentencing. According to Lappi-Seppälä, Norwegian law is structured so that "the legislator decides only in broad terms on the [penal] latitudes, and the rest is at the discretion of independent judges," an approach which "seems to be less vulnerable to short-sighted and ill-founded political interventions, compared with politically elected bodies with the powers to give detailed instructions on sentencing."[223] Norwegians' trust in subject-matter experts offsets and limits the influence of mass media, which nevertheless provide "its already well informed public with objective rather than sensationalized crime knowledge; traditions of social welfarism which reduced criminogenic tendencies and led to a less severe punishment mentality; high levels of social capital; [and] the power and influence of expertise."[224] Pratt argues that "when these [characteristics], or some combination of them, are present in a given society, the less likelihood there will be of that society marching down the route towards penal excess."[225]

220 Pratt, 121.

221 Pratt, 121.

222 Pratt.

223 Tapio Lappi-Seppälä, "Explaining Imprisonment in Europe," *European Journal of Criminology* 8, no. 4 (2011): 322, https://doi.org/10.1177/1477370811411459.

224 Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

225 Pratt, 135.

Still, Norwegian media reports have little impact on NCS policies, which are administered by subject-matter experts instead of politicians.

## B. HOW NCS CARES FOR INMATES WITH MHCS

Given Norway's penal philosophies, improving the quality of life of inmates with MHCs is consistent with the NCS's chief goal of rehabilitating all inmates and returning them to the community. To accomplish these goals, the NCS uses myriad tools, including basic education for inmates, integrated multi-agency training sessions for COs, stakeholder (NCS staff and inmate) input into the rehabilitation programming at the beginning of the inmate's sentencing, and external mental health counseling for inmates. The secondary benefits of these approaches include providing housing assistance for inmates, fostering an environment where inmates' dignity is respected and they are valued as human beings, and reinforcing the personal support networks that inmates held before incarceration. The NCS's investments in inmate education and mental health therapies create more employment opportunities and promote better decision making by inmates with MHCs. Overall, the NCS system invests significant time and money in both inmates and employees, which improves the quality of life of inmates with MHCs.

First, by providing basic education for all incarcerated, the NCS improves the employment prospects of inmates with MHCs.[226] According to Sarah Hean, Elisabeth Willumsen, and Ødegård Atle, a considerable number of incarcerated Norwegian adults lack basic education.[227] They highlight that prison education is an essential service and should be a part of all inmates' rehabilitation plans.[228] NCS studies similarly show that most inmates are in need of basic education.[229] According to Norwegian laws, inmates

226 Dahl and Mogstad, "The Benefits of Rehabilitative Incarceration."

227 Sarah Hean, Elisabeth Willumsen, and Ødegård Atle, "Making Sense of Interactions between Mental Health and Criminal Justice Services: The Utility of Cultural Historical Activity Systems Theory," *International Journal of Prisoner Health* 14, no. 2 (2018): 124–41, https://doi.org/10.1108/IJPH-01-2017-0006.

228 Hean, Willumsen, and Atle.

229 Christin Tønseth and Ragnhild Bergsland, "Prison Education in Norway—The Importance for Work and Life after Release," ed. Sammy King Fai Hui, *Cogent Education* 6, no. 1 (2019): 1628408, https://doi.org/10.1080/2331186X.2019.1628408.

with MHCs are entitled to the same level of education as any other Norwegian citizen.[230] Thus, NCS prisons have incorporated the services of local school districts to help provide basic educational instruction for all inmates. The Norwegian penal philosophy of normality calls for the use of local educational resources so that inmates receive the same level of education they would have received had they never been incarcerated. This service further supports the notion of normalization because it educates inmates who have MHCs in basic skills, such as reading and writing, needed to survive unsupervised when they re-enter society.[231]

In addition, NCS officials have an inclusive understanding of their role in rehabilitation because the training they receive is comprehensive and integrated with other professions, which contributes to a more holistic treatment of inmates with MHCs and helps NCS officials foster an atmosphere conducive to rehabilitation and education for inmates with MHCs.[232] Inmates' needs and wants as understood by one agency might not have the same significance to another agency, and absent strong collaboration between these agencies, information that might be used to improve the quality of life of an inmate could be overlooked. Therefore, according to William Dugdale and Sarah Hean, "prisoner rehabilitation and reintegration require careful interprofessional collaborative practice, provided by multiple key workers from different professional backgrounds and organizations."[233] Likewise, Lahtinen et al. argue that collaboration is a much more holistic and effective approach to maximizing the efforts of multiple agencies.[234]

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[230] Beate Roth and Terje Manger, "The Relationship between Prisoners' Educational Motives and Previous Incarceration, Sentence Length, and Sentence Served," *London Review of Education* 12, no. 2 (July 2014), https://doi.org/10.18546/LRE.12.2.06.

[231] Päivikki Lahtinen et al., "Interorganisational Collaboration in a Norwegian Prison—Challenges and Opportunities Arising from Interagency Meetings," in *Improving Interagency Collaboration, Innovation and Learning in Criminal Justice Systems: Supporting Offender Rehabilitation*, ed. Sarah Hean et al. (Cham: Springer International, 2021), 31–57, https://doi.org/10.1007/978-3-030-70661-6_2.

[232] Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

[233] William Dugdale and Sarah Hean, "The Application of Norwegian Humane Ideals by Front-Line Workers When Collaboratively Reintegrating Inmates Back into Society," in *Improving Interagency Collaboration, Innovation and Learning in Criminal Justice Systems: Supporting Offender Rehabilitation*, ed. Sarah Hean et al. (Cham: Springer International, 2021), 112, https://doi.org/10.1007/978-3-030-70661-6_5.

[234] Lahtinen et al., "Interorganisational Collaboration in a Norwegian Prison."

Kjelsberg contends that, ideally, mental health care should consist of teams of "multidisciplinary professionals such as nurses and COs because they bring diverse perspectives when providing care of inmates with [MHCs]."[235] Therefore, a combined joint effort of stakeholders from interested agencies appears to represent one of best options for providing care for inmates with MHCs and improving their quality of life.

Indeed, research has shown that collaboration among professionals has been one of the NCS's most effective tools in helping inmates with reintegration.[236] Pratt reveals that CO training in Norway, for example, "is likely to take place alongside that provided for probation officers—there is no great difference in the academic and professional ethos that separates these two groups of correctional workers."[237] The prerequisites for becoming a CO in Norway are extensive, as nearly all COs possess outside qualifications before they attend two years of paid training with the NCS.[238] By extension, inmates with MHCs are often incarcerated and treated simultaneously, thus justifying the joint agency effort.[239] Lahtinen et al. maintain, however, that "the different legal and regulatory frameworks of [multiple] agencies often complicate coordination of the services and may hinder collaboration."[240] The NCS's emphasis on collaboration between Norwegian prison officials and agencies in other disciplines, such as mental health, housing, and labor, is designed to alleviate these difficulties and assist inmates with MHCs when they are reintegrating into the community.[241] This collaboration represents the intersection or interoperability of the "punishment and rehabilitation paradigms" for the various agencies, a framework proposed by Lahtinen et al.[242]

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235 Ellen Kjelsberg et al., "Mental Health Consultations in a Prison Population: A Descriptive Study," *BMC Psychiatry* 6 (2006): 27, https://doi.org/10.1186/1471-244X-6-27.

236 Dugdale and Hean, "The Application of Norwegian Humane Ideals," 122.

237 Pratt, "The Nature and Roots of Scandinavian Exceptionalism," 121.

238 Pratt, 120.

239 Lahtinen et al., "Interorganisational Collaboration in a Norwegian Prison."

240 Lahtinen et al., 32.

241 Lahtinen et al.

242 Lahtinen et al., 32.

To facilitate this collaboration, since 2016, all Norwegian prisons have used two digital tools—BRIK and KOMPIS—to capture data about inmates.[243] Through BRIK, inmates and their individually assigned officers complete a questionnaire about the inmates' education, health, and social conditions.[244] KOMPIS is an assessment tool used to plan the prison's work services and map inmates' physical and mental health needs, activities, and educational and training resources.[245] Lahtinen et al. assert that the continued and enhanced use of these digital tools could further promote partnerships among all stakeholders, including NCS officials, medical professionals, and inmates.[246] Using both BRIK and KOMPIS, along with many other digital tools, has enhanced the efforts of a broad range of NCS professionals, thus supporting a more holistic approach to meeting the needs of inmates with MHCs and providing resources.

This collaboration between NCS stakeholders helps to prevent gaps in agency services provided to inmates with MHCs, which helps to improve their quality of life.[247] One of the goals of the NCS's penal philosophy is to help incarcerated individuals locate housing and establish relationships with landlords, doctors, and mental health counselors, among others, before their release, so those relationships are easier to maintain upon reintegration.[248] Many ex-convicts struggle with the discrimination of being formerly incarcerated when trying to find housing and employment, and it is even more difficult for former inmates with MHCs.[249] The collaboration of the Norwegian NCS with other government agencies provides inmates with MHCs a helping hand when they are reintegrating into the community.[250] This fusion of services enables inmates with MHCs

[243] Lahtinen et al.

[244] Lahtinen et al.

[245] Lahtinen et al.

[246] Lahtinen et al.

[247] Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

[248] Hannah Dickens, "Theories of Desistance from Crime and the Norwegian Penal System," Classic Journal, accessed April 22, 2022, https://theclassicjournal.uga.edu/index.php/2019/02/06/theories-of-desistance-from-crime-and-the-norwegian-penal-system/.

[249] Dickens.

[250] Lahtinen et al., "Interorganisational Collaboration in a Norwegian Prison."

to obtain additional assistance designed for former inmates when searching for housing and both primary and secondary health care professionals, including mental health counselors.[251] Such collaboration among NCS officials and other professionals improves the quality of life of inmates with MHCs, who are less likely to be sent back to prison when they have a strong support network based on the investments made during their incarceration.[252]

Another important effect of this collaboration is that members of multiple agencies gather once a month to develop a plan for each inmate and decide which administrative tools they will use to help the inmate with rehabilitation and eventual reintegration.[253] These meetings further contribute to the quality of life of inmates with MHCs by educating all stakeholders—inmates with MHCs and NCS officials—on the public resources available to them so that inmates have the dignity of agency in their own rehabilitation.[254] NCS officials use two plans to manage inmates during their incarceration: the sentencing plan and the individual care plan.[255] Sentencing plans are a product of the NCS based on the terms established by the court in its judgment.[256] The NCS's implementation of the sentencing plan informs inmates with MHCs of their expected roles and contributions while incarcerated, so they have some order in their daily lives.[257] The individual care plan is developed for inmates who need more intensive care, such as inmates with MHCs.[258] Both plans are constantly updated and implemented by the inmate, along with NCS, medical, and other government agency stakeholders.[259] The purpose of the plans is to improve the quality of life of inmates with MHCs by creating an environment where they

[251] Lahtinen et al.

[252] Lahtinen et al.

[253] Lahtinen et al.

[254] Lahtinen et al.

[255] Lahtinen et al.

[256] Lahtinen et al.

[257] Lahtinen et al.

[258] Lahtinen et al.

[259] Lahtinen et al.

fully understand what life will be like and what resources they have to help with their rehabilitation.[260]

A central concept in the NCS' approach to inmates with MHCs is that, with some exceptions, medical care is not provided by NCS employees, which helps the NCS avoid potential conflicts of interest when making medical and security decisions about inmates with MHCs, thus maximizing their quality of life. According to Lahtinen et al., since the 1970s, the Norwegian "import model" has made it a legal requirement for external health care and mental health services to provide care to NCS inmates.[261] Thus, the NCS does not have its own medical providers. As with education in the country, under the principles of normalization, the NCS uses the same medical professionals that non-incarcerated Norwegian citizens use because Norwegian law mandates the same level of care for inmates with MHCs as for other citizens. According to studies conducted by Kjelsberg et al., the Psychiatric Health Services (PHS) agency, which provides physical and mental health care for all Norwegian prisons, is an integral element of the country's general health services.[262] The PHS is fully autonomous of the NCS and, thus, should have fewer conflicts of interest that impact the quality of life of inmates with MHCs when providing them care.[263]

This approach to treatment increases the chances that decisions made by medical professionals are in the best interest of the patient, just as those decisions would be for civilians treated outside a prison environment.[264] Kjelsberg et al. explain that "within the first week of incarceration, all new prisoners are screened for possible somatic or psychiatric health problems."[265] Screenings at NCS prisons are conducted by highly trained mental health professionals and other licensed professionals who can properly

[260] Lahtinen et al.

[261] Lahtinen et al.

[262] Kjelsberg et al., "Mental Health Consultations in a Prison Population."

[263] Kjelsberg et al.

[264] Kjelsberg et al.

[265] Kjelsberg et al.

diagnose inmates.[266] According to Kjelsberg et al., among these professionals, 52 percent of diagnosing PHS therapists are psychologists, 24 percent are psychiatric nurses, and a few medical clinicians are social workers.[267] Furthermore, the best practice of psychiatric nurses and COs working collaboratively for the treatment of inmates with MHCs improves the inmates' quality of life because psychiatric nurses can identify behaviors that warrant further treatment but COs might not identify as a symptom.[268] In sum, these NCS policies reflect that incarcerated people have a right to the same standards of health care in prison as they would receive on the outside.

Finally, a crucial characteristic of the import model is that the NCS encourages inmates with MHCs to develop relationships with mental health professionals while they are incarcerated, so that they may continue these relationships on reintegration into society—thus reducing the chances of a gap in mental health care treatment coverage during their initial reentry into society and thereby the probability of reoffending. If inmates with MHCs have a primary mental health provider who is familiar with their needs, they are more likely to obtain follow-up mental health treatment.[269] Acknowledging the connection between serious MHCs and violent acts, Løvgren and Wiig express concern over recent changes to the Norwegian health care system policy—designed to protect a patient from being coerced into involuntary mental health referrals—that could have the unintended consequence of creating benchmarks for involuntary committals that are "too high for the establishment of compulsory care…[such that] patients have to become very ill before they receive adequate treatment."[270] Therefore, according to Løvgren and Wiig, "people who have not yet committed acts of violence can then develop such severe

[266] Kjelsberg et al.

[267] Kjelsberg et al.

[268] Kjelsberg et al.

[269] Dickens, "Theories of Desistance."

[270] Pia Jorde Løvgren and Pia Therese Wiig, "Farlige, Syke Personer—Hjelpetrengende Eller tikkende Bomber?" [Dangerous, sick people—In need of help (or ticking bombs)?], *Tidsskrift for Den Norske Legeforening* [Journal of the Norwegian Medical Association] 13, no. 27 (September 2022), https://doi.org/10.4045/tidsskr.22.0536. This quote and others were derived from an English translation of the online article.

symptoms that they pose a risk to others."[271] The researchers add that "easier access to adequate health services for the sickest patients with mental disorders will…be able to reduce the risk of serious acts of violence perpetrated by mentally ill persons, thus further reducing the chances of these inmates returning to the NCS and thereby improving their quality of life."[272] All in all, a relatively small amount of funds invested in preventive measures could result in tremendous cost savings in the future.

In sum, the collaboration efforts of all NCS stakeholders help fill the gaps in social services sectors, such as housing, health care, and employment, in an environment in which these services are scrutinized by critics of Norwegian penal philosophies for the vast sums of money spent to help improve the quality of life of inmates with MHCs.[273] Though expensive, the NCS penal philosophies reduce recidivism, sometimes to as low as 20 percent, compared to 45 percent in the UK and 76 percent in the United States.[274] Research has shown that when inmates who have MHCs use the resources available in the Norwegian welfare state, they are more likely to be employed and educated, stay compliant with their prescribed medications, and have housing, and as a result, should be able to resist reoffending in the future.[275] Some scholars and researchers opine that educational opportunities have reduced recidivism rates by as much as 43 percent for prisoners who participate in prison education programs.[276] According to Gordon Dahl and Magne Mogstad, NCS penal practices "[place] an emphasis on helping ex-convicts integrate back into society, with access to social-support services and active labor market programs…[and lower] the probability that an individual will reoffend within five years by 27 percentage

271 Løvgren and Wiig.

272 Løvgren and Wiig.

273 Dugdale and Hean, "The Application of Norwegian Humane Ideals."

274 Dugdale and Hean, 112.

275 Line Elisabeth Solbakken and Rolf Wynn, "Barriers and Opportunities to Accessing Social Support in the Transition from Community to Prison: A Qualitative Interview Study with Incarcerated Individuals in Northern Norway," *BMC Psychology* 10, no. 1 (2022), https://doi.org/10.1186/s40359-022-00895-5.

276 Northwestern Prison Education Program, "Benefits of Prison Education."

points."[277] Dahl and Mogstad acknowledge that incarceration reduces crime; however, they argue that the nature of the time spent during incarceration—specifically the type of programming that the inmates receive and how sentencing is applied—impacts the quality of life of inmates with MHCs and contributes to the overall reduction in crime.[278]

## C. COMPARATIVE ANALYSIS

The Norwegian and American approaches to managing inmates with MHCs can be distinguished primarily by the overall goals of each country's correctional system—which influence the motivation and harshness of sentencing, the architectural design of the prisons, the degree of collaboration among corrections professionals and inmates, the levels of training for corrections personnel, and the amount of money invested in prisons—resulting in extreme differences between the two countries' rates of recidivism. Overall, Norway's egalitarian cultural values heavily influence its laws and penal philosophies, and these intersecting influences help to create a better quality of life than in the American correctional system for inmates who have MHCs.

One major difference between the two countries is the American focus on retribution and punitive sentencing versus Norway's focus on rehabilitation and education, the latter of which contributes to a better quality of life of inmates with MHCs. American corrections officials are more concerned with punishing criminals with long and harsh sentences as a form of deterrence and incapacitation. Sentences that do not address the mental health needs of inmates with MHCs could result in their further decompensation. Another effect of this type of sentencing is that, when the root cause of MHC-induced behaviors is not addressed, the behaviors will likely send inmates back through the revolving door of the American correctional system.[279] Research by Allison et al. has revealed that "limited access to inpatient treatment has been associated with higher suicide

[277] Dahl and Mogstad, "The Benefits of Rehabilitative Incarceration," 19–20.

[278] Dahl and Mogstad, 20.

[279] S. Allison et al., "When Should Governments Increase the Supply of Psychiatric Beds?," *Molecular Psychiatry* 23 (April 2018): 796–800, http://dx.doi.org/10.1038/mp.2017.139.

risk, premature mortality, homelessness, violent crime and incarceration."[280] By contrast, NCS focuses on improving inmates and preparing them for their eventual release back into society.[281] Norwegian penal philosophies are thought by many researchers to reduce recidivism rates by attacking the root cause of these inmates' incarceration, which is typically their untreated mental health needs.[282] Norwegian corrections officials structure inmates' sentencing and time spent incarcerated with access to mental health care and an environment that is conducive to providing that treatment, thus improving the quality of life of inmates with MHCs.

Norway's prisons are designed to be smaller and more easily managed, another key difference between Norwegian and American penal philosophies that impacts the quality of life of inmates with MHCs. Norwegian prisons are designed with a one-to-one ratio of COs to inmates, allowing for more personal interactions between inmates and COs and enabling NCS staff to detect mental health behavioral changes and develop stronger rapport among inmates with MHCs.[283] In American prisons, the ratio is typically one CO for every four inmates, but according to news reports, in one Louisiana prison, the ratio is one to 300.[284] Smaller CO-to-inmate ratios are much more challenging to manage because detecting behavioral issues among inmates with MHCs is more difficult, which might have an adverse impact on their quality of life.[285] According to research by Kenneth Ray and Mark Goldman, inmates with MHCs exhibit behaviors that could be described as

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[280] Allison et al., 796.

[281] Bjørn Kjetil Larsen, Sarah Hean, and Atle Ødegård, "A Conceptual Model on Reintegration after Prison in Norway," *International Journal of Prisoner Health* 15, no. 3 (2019), https://doi.org/10.1108/IJPH-06-2018-0032.

[282] Karen Bouffard, "Could Norway's Mental Health Focus Reduce Incarceration in Michigan?," *Detroit News*, October 10, 2019, https://www.detroitnews.com/story/news/special-reports/2019/10/10/norway-prison-model-fixing-mental-illness-problems-michigan-prisons/1504226001/.

[283] Johnsen, Granheim, and Helgesen, "Exceptional Prison Conditions"; Kenneth Adams and Joseph Ferrandino, "Managing Mentally Ill Inmates in Prisons," *Criminal Justice and Behavior* 35, no. 8 (2008): 913–27, https://doi.org/10.1177/0093854808318624.

[284] John Haughey, "Inmate per Diem Cuts, Staff Turnover Muddle Louisiana Corrections Budget Talks," Center Square Louisiana, March 20, 2018, https://www.thecentersquare.com/louisiana/inmate-per-diem-cuts-staff-turnover-muddle-louisiana-corrections-budget-talks/article_55febb48-2c41-11e8-a12d-1fbbdb169175.html.

[285] Johnsen, Granheim, and Helgesen, "Exceptional Prison Conditions."

"idiosyncratic" and "unpredictable" and "may be at higher risk of victimization or harming others in correctional settings and often have their clinical conditions exacerbated by overcrowding, hostility, and loss of basic freedoms."[286] Gonzalez and Connell add that "crowded living quarters…[pose] adaptation challenges for those with mental health conditions in prison settings…[and a] lack of privacy…increase [s] risk of victimization" by other inmates, leaving the most vulnerable inmates open to abuse.[287] Finally, overcrowded facilities further hinder the ability of staff to provide quality programming, including training and mental health treatment, and lack private spaces for mental health treatment.[288] Research has thus shown that crowded facilities negatively affect the quality of life of inmates with MHCs as well as the working environment of corrections personnel.

Another difference between the two countries' systems is that the NCS allows for collaboration with prisoners, some of whom are invited to attend yearly planning meetings with NCS officials, where staff and inmates alike decide policy and resolve other matters.[289] The NCS policy of incorporating the feedback of inmates into their sentence scheduling creates a sense of ownership for the inmates and makes them stakeholders in the outcome of their sentencing. This activity increases the likelihood of improving the quality of life of participating inmates.

A third difference between the American and Norwegian correctional systems is the level of collaboration between prison officials and mental health agencies. A key structural difference is the near seamless collaboration of various Norwegian agencies.[290] This level of collaboration allows for a more holistic approach to helping inmates with MHCs address the underlying cause of the behaviors that brought them to the attention of the NCS. One important practice employed by the NCS is its close coordination with external mental health providers to avoid a gap in coverage for inmates reintegrating into society, thus improving the quality of life of inmates with MHCs by reducing their chances

286 Ray and Goldman, *Jail Mental Health Design and Programming*, 11.

287 Gonzalez and Connell, "Mental Health of Prisoners," 2329.

288 Adams and Ferrandino, "Managing Mentally Ill Inmates in Prisons."

289 Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

290 Lahtinen et al., "Interorganisational Collaboration in a Norwegian Prison."

of unwanted outcomes. By contrast, according to Gonzalez and Connell, in American prisons, "a substantial portion of the prison population is not receiving treatment for mental health conditions."[291] They add that in the United States, limited correctional system resources prohibit the use of external medical facilities and personnel due to the cost of transporting inmates with MHCs.[292] Gonzalez and Connell write that this lack of consistent therapy could have adverse effects on recidivism rates and inmates' mental health and, thus, their quality of life.[293]

Yet another substantial difference between the systems is the level of training and credentials required to become a CO. The training requirements for the American correctional system are much lower than for the NCS, with less training contributing to lower quality of life for inmates with MHCs. As this thesis reveals, the most significant variable in the success of any mental health care treatment program is the level of training and buy-in from its employees.[294] Well-trained COs are likely to fully grasp the NCS's advanced corrections policies. Pratt explains that CO training and qualifications in Norway are rigorous, so correctional work is a highly sought-after career in that country.[295] By comparison, as this thesis reveals, American prisons have a difficult time hiring and retaining qualified candidates for CO positions and often resort to hiring those with minimal qualifications.[296] The qualifications to become a CO in most of the United States are already marginal. In South Carolina, for example, corrections officials recently lowered the minimum age of applicants to just 18 years, with no degree or advanced education required. The initial training academies in most states vary from just a few weeks to a few months.[297] As a result, prisons are not getting the most qualified applicants, which can impact the quality of work of COs and the quality of life of inmates with MHCs.

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[291] Gonzalez and Connell, "Mental Health of Prisoners," 2328.

[292] Gonzalez and Connell.

[293] Gonzalez and Connell.

[294] Noll et al., "Core Principles for the Mental Health Treatment of Offenders."

[295] Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

[296] Joe Russo, "Workforce Issues in Corrections," National Institute of Justice, December 1, 2019, https://nij.ojp.gov/topics/articles/workforce-issues-corrections.

[297] Ahalt et al., "US–Norway Exchange," S27–29.

A final key difference is the long-term financial investment that the Norwegians have made in their prisons compared with the lesser investment made by the American correctional system. The American corrections investment strategy has been described as short-term compared to Norway's investment, which many scholars consider to be a more comprehensive and holistic approach to improving the quality of life for all inmates, including those with MHCs.[298] The cost of incarceration in America is approximately $31,000 per inmate each year as opposed to about $120,000 in Norway, whose costs include funding for inmates needing mental health treatment and other programming—as illustrated by this research.[299] Norway thus spends almost four times the amount that the United States spends on rehabilitation and housing for inmates.[300] However, this thesis has shown that this investment confers the long-term savings realized by the reduction in recidivism rates and accomplished by the NCS.[301] According to Dahl and Mogstad, when former inmates are presented with employment options due to the skills they developed when incarcerated, they are more likely to refrain from committing future crimes, thus saving the Norwegian government significant prosecution-related expenses, including the cost of a trial, police and prosecutors, jails and COs.[302]

The NCS system invests significant time and money up front in both inmates and employees, and this investment has been returned through a 20 percent recidivism rate in Norway. As this research reveals, a low rate of rearrests improves the quality of life of inmates with MHCs and has the ripple effect of improving their communities' and families' quality of life as well. Conversely, prioritizing security, control, and enforcement of the rules in the American correctional system has reduced its focus on rehabilitation and left little funding for resources that could be used for rehabilitation of inmates with MHCs. Overall, funding for rehabilitation in Norway's prisons is much more expensive than correctional system costs in the United States, yet the return on investment reveals that the

298 Larsen, Hean, and Ødegård, "A Conceptual Model on Reintegration."

299 Dahl and Mogstad, "The Benefits of Rehabilitative Incarceration."

300 Dahl and Mogstad.

301 Dahl and Mogstad.

302 Dahl and Mogstad, 20.

focus on rehabilitation vis-à-vis punitive corrections is well worth the upfront investments made by the Norwegians.[303]

The result of the differences between the American correctional system and Norway's NCS prisons is that the U.S. incarceration rate of 693 per 100,000 people is significantly higher than Norway's incarceration rate of 72 per 100,000 people.[304] This research shows that Norway's 20 percent recidivism rate is 55 percentage points lower than that of the United States when calculating the recidivism of inmates released for more than five years.[305] The recidivism rate for inmates in America is 75 percent, compared to Norway's mere 20 percent.[306] Mogstad et al. note that incarceration rates in the United States have accelerated over the last 50 years compared to those in Europe, chiefly Norway, and their research suggests that the difference in incarceration rates could be the product of the planning, collaboration, and funding instituted by the NCS.[307] In the United States, corrections officials lack data to explain why former inmates with MHCs recidivate and commit additional crimes; however, due to the Norwegian welfare state's robust record keeping, researchers in Norway appear to have more data available to determine the recidivism rate and understand the corresponding trends.

All in all, according to Dahl and Mogstad, subject-matter experts are uncertain of the benefits of incarceration and cannot pinpoint which effect incarceration best supports, criminogenic or preventive criminal justice policies.[308] This research demonstrates the viability of rehabilitation-centered sentences and their potential preventive value.[309] The NCS is successful in getting former inmates to participate in job training programs, which

303 Dahl and Mogstad.

304 Manudeep Bhuller et al., "Incarceration, Recidivism, and Employment," *Journal of Political Economy* 128, no. 4 (April 2020): 1286, https://doi.org/10.1086/705330.

305 "Scandinavian Jails: Why Is Their Recidivism Rate So Much Better?," Encartele, April 27, 2018, https://www.encartele.net/2018/04/what-can-us-correctional-facilities-learn-from-scandinavian-jails/.

306 Encartele, "Scandinavian Jails," para. 6. See also Renford Reese, "The Prison Education Project," *International Review of Education* 65 (2019): 688, https://doi.org/10.1007/s11159-017-9695-5.

307 Magne Mogstad et al., "Incarceration Can Be Rehabilitative," Centre for Economic Policy Research, March 24, 2019, https://cepr.org/voxeu/columns/incarceration-can-be-rehabilitative.

308 Dahl and Mogstad, "The Benefits of Rehabilitative Incarceration."

309 Dahl and Mogstad.

encourage future employment and, thus, reduce the appeal of criminal activities.[310] These changes occur for rehabilitated individuals who were unemployed before incarceration.[311] The Norwegian penal philosophies offer some evidence that raising the quality of life of inmates with MHCs in America is possible. If American prisons improve the quality of life of inmates with MHCs, in theory, more inmates will have the root cause of their criminal behavior addressed, thus reducing recidivism rates and improving the quality of life for society.

## D. CONCLUSION

This chapter examined the Norwegian correctional system—specifically the philosophical and practical differences between the methods that Norwegian and American corrections officials use to manage inmates who have MHCs. This chapter first explored Norway's cultural attitudes toward inmates and how those attitudes impact the country's penal philosophy. Then, it investigated the costs to Norway of incarcerating inmates who have MHCs, training Norwegian prison employees who work with inmates with MHCs, and properly funding facilities, all of which contribute to Norway's exceptionally low recidivism rates. Finally, this chapter compared key aspects of the American and Norwegian correctional systems—the motivation and harshness of sentencing, the architectural design of the prisons, the degree of collaboration among corrections professionals and inmates, the levels of training for corrections personnel, and the amount of money invested in prisons.

In sum, Norway's religion, education, and customs have greatly influenced the way its government-run agencies collaborate and create a fusion of efforts, which improve the quality of life of inmates who have MHCs. By contrast the American correctional system's fixation with long and harsh sentences rather than rehabilitation; insufficient CO-to-inmate ratios; lack of feedback from stakeholders, including inmates; and minimal CO training, professional requirements, and investments in mental health care for inmates all factor into the staggering rate of incarceration and recidivism in the United States. The next chapter

[310] Dahl and Mogstad.

[311] Dahl and Mogstad.

offers findings and policy recommendations, gleaned from NCS best practices, to address the challenges of housing and caring for inmates with MHCs in American prisons.

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# IV. FINDINGS, RECOMMENDATIONS, AND CONCLUSION

This thesis has explored the issues inside prisons and jails that negatively affect the quality of life of U.S. inmates who suffer from MHCs. It has also sought to ascertain how to improve their quality of life. To that end, this thesis has conducted a comparative analysis of correctional methods in the United States and Norway. Norway is a useful case study because it, like the United States, has struggled with the special provisions of incarcerating inmates with MHCs; however, Norwegian penal policies show a certain degree of success in combating some of the challenges associated with MHC inmates and improving their quality of life. As a result, Norwegian prisons have spectacularly low recidivism rates compared to the American correctional system.[312]

This chapter offers policy recommendations and areas for future research that could reveal solutions to many of the main barriers to improving the quality of life of inmates with MHCs in the United States. Based on research in this thesis, it is recommended that American corrections officials make every attempt to secure additional funding for a significant increase in critical infrastructure and resources such as staffing and redesigned facilities. More funding is needed to adopt staffing like Norway's one-to-one inmate-to-CO ratio and to build more prisons that are smaller and easier to manage for quality control and that promote therapeutic environments.

## A. FINDINGS

First, this thesis finds that many inmates with MHCs enter the American correctional system because they come to the attention of law enforcement after committing a crime or exhibiting some sort of abnormal behavior that was likely caused by their illness. From the 19th century to the mid-20th century, most inmates with MHCs were housed and treated at psychiatric hospitals, formerly known as insane asylums. Many of these earliest mental health facilities had good intentions in that they attempted to provide treatment to individuals with MHCs. Historical accounts reveal that those early

312 Chammah, "I Did It Norway."

institutions were not overcrowded and were focused on "individualized care."[313] By the mid-20th century, the country had transitioned from these well-run mental health asylums into poorly managed and overcrowded institutions where very little mental health treatment was provided. Within decades, the American correctional system began moving away from this total institutionalization framework of inmates with MHCs to a minimalist community outpatient framework, which some scholars refer to as deinstitutionalization.

During deinstitutionalization, inmates were released from institutions such as psychiatric hospitals and began to receive treatment in community-based outpatient settings.[314] However, deinstitutionalization often resulted in trans-institutionalization, occurring when inmates released from one type of institution, such as a psychiatric hospital, eventually end up in prisons or jails.[315] This outcome has become increasingly common because housing inmates with MHCs in a forensic setting such as a psychiatric hospital is much more expensive than housing them in the medical wing of a prison.[316] Even though inmates with MHCs have a constitutional right to health care and, by law, prisons are mandated to provide care for inmates, adequate mental health care is not always available for every inmate. Frequently, American jails and prisons lack the funding to provide qualified clinical personnel and dedicated spaces inside prisons to conduct therapy. In many American jails, mental health therapy has been reduced to simply providing pharmaceuticals.[317] When inmates who have MHCs are not properly treated for their conditions in prison, it is difficult for them to receive follow-up outpatient treatment once they have been released back into the community.

The second finding from this research is that prisons and jails were never designed as substitutes for psychiatric hospitals; however, they have by default become some of the largest mental health providers in America because most states have severely reduced the number of dedicated psychiatric beds available to the public. When people do not have

313 Frontline, "Deinstitutionalization."

314 Unite for Sight, "A Brief History of Mental Illness."

315 Lamb and Bachrach, "Some Perspectives on Deinstitutionalization."

316 Lamb and Bachrach.

317 Jacobs and Giordano, "It's Not Like Therapy."

access to mental health beds and treatment, they further decompensate and can eventually come to the attention of law enforcement and enter the correctional system. While many inmates see a mental health professional for the first time in their lives while incarcerated, prison is not an optimal place for improving the quality of life of inmates who suffer from MHCs. This pattern of a lack of quality treatment in the correctional system and of availability and funding for community-based outpatient centers contributes to higher recidivism rates for U.S. inmates who have MHCs.

By contrast, many Norwegian penal practices help improve the quality of life of inmates with MHCs. The NCS and American corrections officials face many of the same challenges when developing a strategy to manage inmates with MHCs. Norway has not reduced the number of available public psychiatric beds as much as America has, and as a result, the American correctional system has a much higher percentage of this subset of inmates in its prisons than do the Norwegians.[318] Still, more than two-thirds of Norwegian inmates suffer from mental health issues or learning disabilities.[319]

The NCS works closely with elements of the Norwegian welfare state to help mitigate the challenges that inmates with MHCs face in accessing needs and wants. Norwegians' religion, education, and customs have greatly influenced the way their government-run institutions operate, including the NCS. Many of the NCS's management practices and theories have been built on these core cultural beliefs. Scandinavian norms and religious foundations have, thus, helped to insulate Norway from the politically motivated law-and-order policies that have inspired some of the harsher punitive sentencing in America. Research in this thesis has shown that in Norwegian culture, the sentence of imprisonment is the punishment, so the conditions inside prison can be a positive, rehabilitative environment—rather than devolving into the degrading and inhumane space that the correctional system in the United States has become. Earlier versions of American prisons and psychiatric hospitals were managed similarly to their

[318] Lamb and Bachrach, "Some Perspectives on Deinstitutionalization."

[319] Hartvig and Kjelsberg, "Penrose's Law Revisited."

Norwegian counterparts; however, due to overcrowding, the lack of funding, and an underinformed public, those facilities fell into decline and mismanagement.

Third, American prisons focus on punitive corrections while the NCS focuses on rehabilitation—in Norway, inmates with MHCs have a better quality of life in a rehabilitative environment.[320] In the 1990s, Norway experienced a period of significant prison reform and changed its focus from a punitive to a rehabilitative philosophy.[321] "Norwegian exceptionalism" is a phrase commonly used in the realm of corrections to describe the high standards of incarceration in Norway, such as making prison as similar as possible to life outside of prison. This philosophy of normalization furthers the goal of reintegrating inmates back into society. The Norwegians have, therefore, applied evidence-based rehabilitation methods as part of their penal philosophy, which includes educational programs and workshops. NCS officials believe that a focus on humane treatment leads to rehabilitation for many inmates and that communicating to the inmates with emotional intelligence and compassion and keeping them in a constant state of purpose-driven work allow them to refocus their energy in a much more positive manner than the destructive behaviors they exhibited before incarceration.[322] NCS officials think that this type of therapy reduces aggression, thus improving inmates' mental and physical health, which improves the quality of life of inmates with MHCs. Indeed, there is convincing evidence that all inmates who participate in prison-based education and vocational training programs have lower recidivism rates.

Also in the 1990s, in response to increased violent crime associated with the drug trade, the American correctional system continued down the path of punitive penal philosophies and a continued reduction in prison-based educational and rehabilitative policies. Most scholars reluctantly acknowledge that the incapacitation effect—the period when inmates serve their sentences in prisons or jails—is effective at preventing inmates

320 Karen Bouffard, "Why Psychotic Killers Get Care, Not Prison Time in Norway," *Detroit News*, October 10, 2019, https://www.detroitnews.com/story/news/special-reports/2019/10/10/why-psychotic-killers-get-care-not-prison-time-norway/1636366001/.

321 Dahl and Mogstad, "The Benefits of Rehabilitative Incarceration."

322 Bouffard, "Could Norway's Mental Health Focus Reduce Incarceration in Michigan?"

from committing more crimes simply because they are locked up. In addition, as this research has shown, harsh jail experiences further deter criminals from committing additional crimes because they never want to return to prison. One problem with this line of thinking is that a certain subset of criminals, specifically inmates with MHCs, usually does not have the mental capacity to appreciate the deterrence effect. Another problem with that limited focus on crime prevention is that incapacitation is very expensive, and there is little consideration for what happens upon an inmate's release from jail, including appropriate funding for corrections staff to provide post-incarceration follow-up assistance. Many inmates with MHCs face challenges and need additional assistance with securing housing, employment, and outpatient services for mental health care.

Fourth, a crucial difference lies in the resources offered by Norway's robust welfare state vis-à-vis the limited resources available to inmates with MHCs from the American welfare state. NCS officials have major advantages over their American counterparts in the correctional system because of all the social controls that come with Norway's welfare state. The Norwegian welfare state is one national program designed for cradle-to-grave social support in contrast to America's 50 individually managed state welfare systems.[323] The Norwegian government supports the NCS with more than just penal controls to manage inmates with MHCs who have criminogenic needs; the NCS leverages the rehabilitation programs, mental health therapy, and employment programs available to all Norwegians. These programs help the NCS coordinate opportunities for inmates with MHCs with uninterrupted medical and mental health care, and it provides all inmates with assistance in finding employment during their incarceration and post-incarceration. For their transition back into society, this structure assists inmates with MHCs who may not be high functioning and who might struggle with tasks such as participating in job interviews, selecting housing, and scheduling and keeping medical appointments. The totality of this structure reinforces the rehabilitation of inmates with MHCs and, therefore, gives them a greater chance of a better quality of life, which will improve their chances of a successful reentry into society. Norwegian inmates with MHCs fare much better than their

[323] Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

counterparts in the American correctional system because American inmates with MHCs are not afforded the abundance of resources provided by the Norwegians.

The fifth key difference between the two systems is the quality of applicants for CO positions in Norway versus the limited pool of talented people interested in the CO position in America. The analysis of the quality of NCS employees revealed that the credentials required to become a CO are significantly more stringent for the NCS than for the American correctional system. Norwegian COs earn much higher wages, and employment opportunities are much more selective and competitive. Most American CO positions require only a high school diploma.[324] Another difference between the correctional systems is that most American COs receive approximately three to six months of training and are not incentivized to pursue additional education or training; Norwegian COs, on the other hand, are required to train for a minimum of two years at the NCS national training academy, the Correctional Service of Norway Staff Academy, where they learn psychology and conflict resolution.[325]

The NCS, therefore, on average has a more highly trained and better educated workforce and, as a result, can fully embrace more sophisticated penal philosophies such as normalization and inmate agency. Norwegian COs understand that their jobs are to help rehabilitate inmates by normalizing their time spent in prison and teaching the inmates life skills so that they can be successfully reintegrated into society. Inmates who have been mentored by NCS COs have their criminogenic needs met by building rapport with COs and, thus, are less likely to recidivate and more likely to improve the quality of their lives. When the NCS embraced the idea of prison guards acting as "role models, coaches and mentors," recidivism was reduced to less than 20 percent, while the American recidivism rate has increased to over 76 percent in certain categories, including the subset of inmates who have MHCs.[326] Rehabilitating with education and mentorship has helped to improve the quality of life of Norwegian inmates with MHCs during incarceration and upon release.

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[324] Russo, "Workforce Issues in Corrections."

[325] Lahtinen et al., "Interorganisational Collaboration in a Norwegian Prison."

[326] "How Norway Turns Criminals into Good Neighbours," BBC News, July 7, 2019, https://www.bbc.com/news/stories-48885846; Ahalt et al., "US–Norway Exchange."

The sixth major difference between the U.S. and Norwegian penal philosophies is that the Norwegian policies are much more personable, positive, and passionately focused on rehabilitation and improving people. NCS operations are informed by the normalization thesis, which heavily influences all NCS policy-making, "including prison design, staff training, staff–prisoner relations, opportunities for prisoners and an emphasis on prisoner agency."[327] The American correctional system can be described as the impersonal warehousing of bodies, with a central focus on punishment, security, and control. American prisons were built with this focus while Norwegian prison facilities were designed to create an environment that promotes rehabilitation and normality, providing each inmate with an opportunity to model life inside prison as if they had not been incarcerated. Norwegian NCS officials and inmates benefit from significant investments in critical infrastructure such as smaller and redesigned facilities that promote rehabilitation. Norway's prisons are smaller and easier to manage for quality control and promote therapeutic environments. Many open Norwegian prisons are designed to have a private cell and bathroom for each inmate. This feature alone is exceptional compared to American prisons, where two to three inmates are assigned to a single six-by-ten-foot cell with a shared toilet. American prison cells create a challenging situation for anyone—given the inordinate time spent in extreme proximity with other inmates—let alone inmates with MHCs, whose quality of life has suffered severely.

## B. POLICY RECOMMENDATIONS

Based on these six findings, most of Norway's penal philosophies and practices are worthy of consideration; however, as illustrated later in this chapter, many of the NCS's polices are not economically feasible in American prisons as of this writing.

Nevertheless, the first recommendation is to avoid releasing inmates with MHCs from prison just to placate public opinion. Instead, an alternative would be to go against conventional thinking—start building more prisons, and extend prison sentences so that people incarcerated for longer periods will have at least some rehabilitative and educational

[327] Pakes and Holt, "Crimmigration and the Prison," 66.

opportunities. When inmates are arrested and sent to prison, many of them are mandated by the court to get mental health therapy. Some of the research in this thesis has revealed that some inmates with MHCs are diagnosed by a mental health professional and are medicated for the first time in their lives while in prison, thus providing them with tools to improve their quality of life and avoid becoming a recidivism statistic. Prisons are not ideal places to seek mental health therapy for the first time, but they are far superior to self-medicating in a drug den or a dumpster on the streets.

Second, another Norwegian practice that American corrections officials should consider is to make every attempt to secure additional funding for a significant increase in critical infrastructure and resources such as redesigned facilities and staffing. More funding is needed to build more prisons that are smaller and easier to manage for quality control and that promote therapeutic environments. Inmates who deviate from normal behavioral patterns in prison, whether from antisocial personalities or mental health challenges, are likely difficult to detect when housed and hiding in plain sight in a massive prison. The Norwegian policy of maintaining smaller, more easily managed prisons would be an excellent antidote to the prevalence of bad actors inside prisons, whether they be the inmates themselves or COs abusing their authority.

Third, increasing the ratio of staff to inmates is an essential step for safer and more productive management of any correctional facility. The lack of sufficient staffing remains a major barrier to improving the quality of life of inmates with MHCs; no rehabilitation can begin without some level of control and security. However, as detailed in Chapter III, increasing funding for more prison personnel faces a tremendous barrier in the United States and is unlikely to happen absent some sort of catastrophic event inside a prison due to overcrowding and understaffing. Based on the current political climate in the United States, the correctional system should adopt the Norwegian style of one-to-one CO-to-inmate ratios on a selective basis, such as in a minimum-security facility housing inmates who express a desire to be rehabilitated. If these selective increases in staffing at correctional facilities prove successful, then support for increased funding for staffing might achieved in the future.

Fourth, another recommendation is that the United States adopt a policy of federalizing all prisons and psychiatric hospitals because this would mitigate some of the challenges that corrections officials experience when they do not receive adequate funding and training. Currently, each state funds its own correctional system and sets its own priorities for programming, staffing, and other standards, which creates inconsistent standards of treatment for inmates and training for COs. The only way to accomplish uniform levels of funding and programming would be for all prisons to become federalized. Funding through the federal government would ensure that funding for correctional facilities is consistent throughout the country, as the funding would be based on national standards such as those of the Bureau of Prisons. With federal funding for all prisons, local resistance to higher taxes for public projects that benefit a small subset of inmates should ease, as it would become a national concern. Federalism will also ensure that training is consistent and elevated for all CO positions, which should improve the quality of life of inmates with MHCs.

In sum, federalization is achievable, and corrections officials in all 50 states should work to secure an increase in funding for all prisons in their jurisdictions. One of the uses of this funding should be more consistent and uniform mental health care programming, which would empower corrections officials to hire the best clinicians and COs and practice the most effective programming for inmates with MHCs in every state. Moreover, the federal government should provide financial incentives for the creation of reintegration programs in every state's correctional system. These reintegration programs would help bridge the housing, employment, and health care gaps for inmates with MHCs before their release back into society, and afterward. When inmates with MHCs are incarcerated, they should receive the same level and quality of treatment regardless of the facility's location; however, each state may present different challenges for inmates once they have been released. Housing may be more challenging for those reintegrating in California compared to Alabama, for example, and providing quality mental health care may be more challenging in Alabama than in California. Therefore, the recommendation is that these programs be locally or state-managed programs but financed by federal grants because local officials are in a position to better understand the needs and wants of former inmates

with MHCs. These programs should be designed for implementation during inmates' time in prison and post-incarceration to help ensure that former inmates with MHCs are receiving follow-up appointments for housing, employment, and mental health care needs. These programs are necessary because without additional help with these challenges, many of these inmates with MHCs will further decompensate and likely return to prison. Research shows that most inmates will be released from prison and, after experiencing a major life-changing event, will eventually phase out or age out of criminogenic thinking, but until inmates experience such an epiphany, this recommendation could be the bridge between inmates' criminal past and an improvement in their quality of life.

## C. BARRIERS TO ADOPTING NORWEGIAN PENAL PHILOSOPHIES

While the NCS implements some of the best penal philosophies and practices in the world for inmates with MHCs, a number of barriers make it unlikely that some of these NCS features will be adopted in the American correctional system. First of all, the amount of collaboration between COs and prisoners in Norway is not likely to be adopted in the United States because the American correctional system has had consistently undertrained, less-educated COs who are not likely to embrace Norwegian penal theories. Thus, adopting Norwegian corrections practices would require a significant ideological change among senior corrections officials. However, security and control have historically been the primary objectives of American corrections officials. According to Liebling and Arnold, American prisons have always been organized and managed from a top-down mindset, with strong paramilitary overtones among the rank-and-file COs.[328] This type of leadership style means an internal cultural change that rewards an upward flow of innovation from frontline employees is sorely needed, so adopting Norwegian-style inmate collaboration is not likely.

The adoption of the Norwegian-style one-to-one CO-to-inmate ratio is also unlikely in the United States due to the limited resources available to corrections officials. The

[328] Alison Liebling and Helen Arnold, "Social Relationships between Prisoners in a Maximum Security Prison: Violence, Faith, and the Declining Nature of Trust," *Journal of Criminal Justice* 40, no. 5 (September–October 2012): 413–24, https://doi.org/10.1016/j.jcrimjus.2012.06.003.

American correctional system maintains comparable CO-to-inmate ratios in a small number of minimum-security prisons and juvenile facilities. However, according to data published by the Department of Justice in 2022, there were approximately 42,000 COs in the United States guarding 1.2 million inmates, which represented a 28-to-one average.[329] If the United States adopted the Norwegian policy of a one-to-one ratio, the correctional system would need to expand its workforce by another 1.85 million COs. This requirement is another major barrier when considering which Norwegian penal practices American prisons could adopt.

Finally, limited favorable public sentiment among American taxpayers toward inmates with MHCs represents another major barrier to Norwegian levels of funding for American prisons because Americans prefer politicians who support legislation that is tough on crime.[330] It is expensive to incarcerate large numbers of people for lengthy prison sentences, and most Americans agree that much of those funds should be redirected to other areas of need.[331] By contrast, NCS officials enjoy major financial support from the Norwegian people and their government because they are more educated than Americans in the challenges faced by inmates with MHCs and effective evidence-based penal practices—most Americans are not interested in raising taxes for projects when they do not understand how the funds will be invested and how those projects directly impact their communities.[332] According to recent polling in California, a majority of participants favored increased funding for incarceration alternatives to help reduce the excessive cost of housing large numbers of people in prisons.[333] Overall, according to Pratt, most Norwegians have a high level of trust in their NCS's policy-making decisions regarding

329 E. May, "Prison Guards in America—The Inside Story," *Corrections Magazine* 11, no. 6 (December 1976): 3–5, https://www.ojp.gov/ncjrs/virtual-library/abstracts/prison-guards-america-inside-story.

330 Bouffard, "Could Norway's Mental Health Focus Reduce Incarceration in Michigan?"

331 "91 Percent of Americans Support Criminal Justice Reform, ACLU Polling Finds," American Civil Liberties Union, November 16, 2017, https://www.aclu.org/press-releases/91-percent-americans-support-criminal-justice-reform-aclu-polling-finds.

332 Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

333 Brian Heller de Leon, "Pew Study: Strong Majority of Voters Favor Alternatives to Incarceration," *Center on Juvenile and Criminal Justice* (blog), April 5, 2012, https://www.cjcj.org/news/blog/pew-study-strong-majority-of-voters-favor-alternatives-to-incarceration.

evidence-based rehabilitation philosophies.[334] By contrast, research conducted by Pratt revealed that Americans are more reactive to sensational news stories about crime and, thus, tend to support more punitive, harsher prison sentences.[335] These differences in American and Norwegian public opinions make it highly unlikely that most of the barriers to adopting Norwegian penal philosophies can be overcome in the United States. The chief barrier is convincing the American public that making improvements to the quality of life of inmates with MHCs by making a large financial investment in corrections would directly benefit the American public.

In sum, there are many barriers to adopting most of Norway's penal practices; however, a few Norwegian practices—such as redesigning prisons, increasing the level of training of COs, and improving the quality of mental health programming for inmates with MHCs—are feasible and could be adopted in the United States.

## D. FUTURE RESEARCH

Subject-matter experts across the country are coming together to develop strategies to focus the efforts of prison officials, defense attorneys, prosecutors, judges, probation COs, and members of the mental health treatment community to improve outcomes for inmates and former inmates who suffer from MHCs. Most individuals with MHCs are incarcerated because community-based treatment options are not available. Many scholars have made the connection between the prevalence of inmates with MHCs in prisons and insufficient investments in community treatment facilities. However, what remains unclear is whether communities will support penal philosophies that work best for improving the quality of life of inmates with MHCs such as Norwegian-style evidence-based programming. Detailed, direct evidence connecting rehabilitation with a reduction in crime on individual and macro levels is scarce, so future research should investigate methods and tools that track each individual inmate with an MHC and the outcomes after receiving treatment so that the correctional system can pinpoint what programming is effective and worthy of further investment.

[334] Pratt, "The Nature and Roots of Scandinavian Exceptionalism."

[335] Pratt, 135.

## E. CONCLUSION

In summary, the conditions in which inmates with MHCs have been incarcerated, dating back to the 1880 census, have improved; however, the quality of care could be enhanced even further.[336] There are many moral and economic incentives to accomplish this task. The current trend of releasing people with MHCs from prison is not an effective long-term solution; it only temporarily appeases members of the public who are concerned about large numbers of inmates being incarcerated.

Most people who have been incarcerated exercised their free will and violated a law, which resulted in temporary suspension of their liberty, not their civil rights. This thesis has revealed that corrections programming can be effective in improving the quality of life of inmates with MHCs. The NCS in Norway has demonstrated that cognitive desistence, a process that happens whenever a person's behavior and beliefs, such as attitudes toward crime, contradict each other, is possible after people have been exposed to life-changing opportunities such as health care, employment, marriage, and having children.[337] Most criminals stop offending as they age, and 95 percent of criminals are eventually released back into society.[338] Research in this thesis suggests that providing mental health care, employment, and educational opportunities to inmates with MHCs while they are incarcerated should contribute to improving their quality of life once they are released.

Early versions of American psychiatric prisons and insane asylums were well run and featured many of the most successful characteristics of the NCS such as the purpose-driven workday, a humane living and working environment, and a religious foundation. The word *asylum* means an institution that offers protection for people who are mentally ill, its synonyms including safe harbor, shelter, den, hideaway, refuge, sanctuary, and haven. American culture was built on Judeo-Christian beliefs, which instilled being our

336 Carla Yanni, "Housing Lunatics and Students: Nineteenth-Century Asylums and Dormitories," *Change over Time* 6, no. 2 (Fall 2016): 154–72, https://doi.org/10.1353/cot.2016.0011.

337 Dickens, "Theories of Desistance."

338 Dickens.

brothers' keepers. Allowing inmates with MHCs to be victimized by healthy inmates in jails and prisons is inconsistent with our American values.

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