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**CORRECTIONAL PHILOSOPHIES' ROLE IN THE SUPERVISION,
MANAGEMENT AND TREATMENT OF PERSONS WITH
MENTAL ILLNESSES IN A U.S. AND A FINNISH PRISON**

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ABSTRACT

Correctional Philosophies' Role in the Supervision, Management and
Treatment of Persons with Mental Illness in a U.S. and a Finnish Prison.

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This dissertation research study is the first step in developing a comparative understanding of the role of correctional philosophies in the treatment and supervision of persons with mental illness inside the prisons of Finland and the United States. A large body of international empirical research exists regarding persons with mental illness in prisons, but responses by individual countries vary greatly. Furthermore, the large body of international empirical research on persons with mental illness in prisons indicates that individual countries vary greatly in their treatment, management, and supervision of this population. In order to understand this variance, this study employs a qualitative cross-national data collection strategy to investigate the role of *correctional philosophies* in the treatment, management, and supervision of persons with mental illness in prisons in Finland and the United States. Of particular interest is how such people obtain and receive treatment, in addition to their levels of satisfaction with that treatment, in each national context. In adopting a comparative approach, this qualitative research attempts to discern common trends in mental health treatment, identify the most effective, proficient, and results-oriented of these treatments, and set a cross-national agenda for future collaboration on similar projects with prisons in different parts of the world.

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CHAPTER 1

Introduction

American and European prison systems face large numbers of prisoners with mental illnesses. Correctional facilities in the United States house an estimated twice as many persons with serious mental illness as do psychiatric hospitals (Torrey, 1995). Torrey acknowledges “application of these typical prevalence rates to the prison population of the U.S. suggests that a few hundred thousand prisoners might have psychotic illness, major depression, or both” (p. 1611). Europe is also facing an increase in the population of prisoners with mental health problems, and recent reviews involving 23,000 prisoners from twelve countries confirms that the mental health of prisoners is an international problem of increasing proportions (Blaauw et al., 2000; Joukamaa, 1995; Rasmussen et al., 1999). These findings have several implications that transcend national borders and institutions. First, they indicate that rates of serious psychiatric disorders are substantially higher in prisons than in the general population throughout Europe and the United States. Second, the findings suggest that the burden of treatable serious mental disorders in prisoners is substantial (Torrey, 1995; Fazel and Danesh, 2002). And third, this population is increasingly becoming the responsibility of correctional facilities.

The United States and Finland have different correctional philosophies toward prisoners in general and toward the management, supervision, and treatment of prisoners with mental illnesses. A humanitarian, rehabilitative approach prevails in most Western European prisons compared to a more retributive model found in contemporary U.S. prisons. According to Cullen et al. (2000), “get tough” crime control policies in the United States are often portrayed as a reflection of the public's will; some Americans tend to be punitive and want offenders’ incarcerated (p. 1). Research from the past decade

both reinforces and challenges this public sentiment. The U.S. public tends to accept, if not prefer, a range of punitive policies (e.g., capital punishment, three-strikes-and-you're-out laws, incapacitation, etc.). Despite years of disapproval and condemnation, however, rehabilitation, particularly for young people, remains an essential part of American correctional philosophy. There is also widespread, continued support for early intervention programs (e.g., Head Start, Boys and Girls Clubs, etc.). In the end, the public shows a tendency to be punitive and progressive, wishing the correctional system to achieve the diverse missions of doing justice while protecting public safety (Cullen, Fisher, & Applegate, 2000).

Conversely, the primary task of the Finnish Prison Administration is to enforce sentences passed by the courts. General public opinion, as expressed by Parliament and carried out by government agencies, requires sentences to be humane and effective in character, meaning they must be based on law, provide adequate security for the prison community, and manifest respect for the integrity of all inmates. Finnish criminal justice policy is based on the premise that the punishment of criminal acts resides in the denial of liberty only (include source).

SPECIFIC PURPOSE OF STUDY

An in-depth study of psychiatric practices in prisons is necessary to provide a sense of how persons with mental illness are managed, treated, and supervised and would allow prison officials to make more informed decisions about how to develop effective ways to manage prisoners with psychiatric diagnoses. The purpose of this dissertation research is to improve our understanding of U.S. and Finnish approaches to prisoners with mental illness. Finnish prisons tend to treat inmates with psychiatric illnesses in a

more humanitarian manner than U.S. prisons with their more punitive approach. These two approaches, humanistic and punitive, represent a polar stance toward the same population. The Vantaa Prison in Finland is one prison with a humanitarian stance. Northern State Prison, located in the United States, represents a more retributive approach. It is the assertion of this researcher that these differences in stance should lead to observed differences in operational procedures and individual level outcomes.

This study reviews policies and practices affecting prisons that house inmates with mental illnesses in two different countries. The two prisons diverge in practices and types of inmate populations. Northern State Prison in New Jersey is presently under a federal consent decree stipulated by *C.F. v. Terhune* decision that it must provide mental health treatment to all prisoners in need. Vantaa Prison in Vantaa, Finland, in contrast, has a specialized housing unit within the prison that provides voluntary mental health treatment to prison inmates from a pre-assigned geographical region covering seven prisons.

This study used four different data collection methodologies to gather information from two different sites – Vantaa Prison in Finland and Northern State Prison in New Jersey – with the goal of comparing prison practices toward inmates with mental illness. The four-pronged data collection strategy was comprised of site visits, inmate interviews, staff interviews, and document reviews.

METHODOLOGY OVERVIEW

This research study investigates Finnish and U.S. mental health services and the perceptions of those practices by inmates with mental illness. More specifically, it examines treatment, management, and supervision policies of persons with mental illness

in Finnish and U.S. prisons through interviews with inmates and staff, and extensive site visits. In addition, a document review contrasts the official stance toward treatment and supervision. The study notes differences and similarities in policies in the two countries and highlights what may be typical experiences for psychiatric inmates in their respective prison systems.

This study is purposely narrow in scope because it seeks to answer specific questions about the interaction between prisoners with mental illness and treatment professionals in Finnish and U.S. prisons. In particular, this study shows how correctional philosophies are related to and shape prison based mental health practices and outcomes. This comparative method allows the researcher to gain access to information needed to explore specific research questions. Additionally, since this research was not based on a large random sample, the results are not generalizable to other New Jersey or U.S. prisons or Finnish prisons.

This study is qualitative in nature. The strength of the qualitative methodology, especially those involving in-depth analysis of small groups or a small number of contexts (i.e., ethnographies or case studies), is that it provides rich detail about the “goings on” in the lives of informants. That is, the strength of qualitative methods is that they provide deep, realistic insight into a relatively small number of organizations and persons affected by those institutions. Lastly, qualitative studies, although limited by small samples and specific locations, are well-suited to studying processes and uncovering local causation, which though limited, add to the international prison and mental health literature that scholars acknowledge is lacking. Small-scale qualitative

research can add to understanding how country specific criminal justice policies affect prisoners with mental illness (Williams, 1983).

SITES

Vantaa Prison

Vantaa Prison is a maximum-security facility thirty minutes outside of Helsinki. The prison currently houses approximately 210 inmates, including 19 female offenders, and pre-trial detainees. The pre-trial detainees are part of the 210 inmates. It has an inpatient specialized housing unit with 14 beds for male inmates with a range of mental illnesses. Inmates in need of psychiatric intervention are referred from seven area prisons and from within the general population Vantaa Prison. The specialized housing unit does not provide 24 hour coverage; inmates who need involuntary treatment are sent to an off-site psychiatric hospital for treatment.

Northern State Prison

Northern State Prison is a medium security facility located in Newark, New Jersey housing 2,700 male offenders. Within the institution there are three separate specialized housing areas for inmates with mental illnesses. Prisoners exhibiting mental illness are placed in one of these three areas. The most acutely ill inmates are housed in the Crisis Stabilization Unit (CSU). From there inmates are moved to the Residential Treatment Unit (RTU) where they participated in daily rehabilitation programming, receive psychiatric medications and counseling. Once further psychiatric stabilization is achieved, inmates are transferred to the Transitional Care Unit (TCU), which prepares them for the general population or to return to home prisons. The Psychology department authorizes all transfers that involve inmates who are mentally ill. As of mid-year 2004,

there were 445 inmates on the mental health roster (i.e., inmates with Axis I diagnoses) at Northern State Prison, or sixteen percent of the total prison inmate population. It should be noted that the New Jersey Department of Corrections (NJ DOC) mental health roster is updated daily.

DATA COLLECTION

1. INTERVIEWS WITH INMATES DIAGNOSED WITH MENTAL ILLNESSES

In-depth interviews with inmates with mental illness at Northern State and Vantaa focused on gathering information about specialized housing units, their perceptions and opinions of prison staff and treatment within the specialized housing units. A standardized open-ended interview schedule (see Appendix A) was used to interview inmate subjects while they were incarcerated. This type of interview allowed respondents to provide their own answers to questions. The exact wording and sequence of questions was predetermined. The inmate subjects in both countries were asked questions in the same order although their content changed reflecting different correctional and treatment practices, types of housing areas and security levels, and previous prison mental health treatment experiences, including psychotropic medications and group participation experiences.

The interview focused on inmate adaptation and coping skills in prison, the benefits, or lack thereof, of psychiatric medications, experiences in specialized housing, and opinions of staff. During the interviews, it was also possible for this writer to make observations, clarify questions, or correct misunderstandings. This writer also took notes on the environment in which interviews took place. This methodology gathers information on inmates' motives and expectations in seeking mental health treatment,

types of psychiatric practices that inmates found effective or not, opinions about treatment providers, experiences with psychiatric medications, their participation in treatment planning (i.e., right to self-determination), and negative aspects of treatment.

2. INTERVIEWS WITH MENTAL HEALTH STAFF

To learn about their individual observations and interactions with prisoners with mental illnesses, this research included interviews with Northern State Prison mental health staff (n=4) and Vantaa Prison mental health staff (n=6). The interviews were comprised of semi-structured open-ended questions (see Appendix B), which permitted staff to reflect on the services they provided and, more broadly, on their role within prison mental health services. The purpose of these interviews was to ascertain how different correctional philosophies affected the prisons' goals and how those philosophies were manifested in mental health service delivery. The interviews aided in comparing staff perceptions of mental health treatment and post-release/discharge service delivery systems and in identifying potential and existing reentry barriers facing inmates. Also, the interviews helped in understanding how various prison officials responded to changes in the mental health status of inmates as well as how they managed inmates' who resisted treatment.

3. SITE VISITS AND OBSERVATIONS

Bi-weekly site visits to both prisons were made to observe and collect interview data. The observations assisted in developing a theoretical foundation as well as to construct a narrative of the environment and its social characteristics to compare the two prisons' procedures. Those comparisons included but were not limited to the admission criteria and referral to treatment; decisions about the need for mental health treatment;

diagnosis, type, and length of treatment; and the review of progress (i.e., treatment plans). In addition, the bi-weekly observations focused on the process by which prisoners were returned to the general population or to their “home” prisons.

4. REVIEW OF MENTAL HEALTH AND CORRECTIONAL POLICIES

To complete this systematic cross-national comparison, this dissertation reviews Finnish, U.S. federal laws, New Jersey state laws, policy guidelines addressing standards of care and confinement in prisons in both countries, and each nation’s standard operating procedures (SOP).

Unlike Finland, case law in the United States guides individual states and local jurisdictions regarding policies for the supervision, treatment, and management of prisoners with mental illness. This dissertation also discusses how these both countries’ policies and their practical implementation provide an understanding of the experiences of inmates with mental illness and the mental health staff that treat them. Specific psychiatric practices of psychiatric medication management, medical care, group programming, and post-release supervision are analyzed, as well. Lastly, United States and Finnish organizational policies concerning standard operating procedures for facility operations and accreditation standards are reviewed.

IMPORTANCE OF STUDY

The “get-tough” philosophy that has permeated criminal justice policies in the United States also has affected inmates with mental illnesses. This philosophy has influenced sentencing guidelines that arguably have led to prison overcrowding and cutbacks in rehabilitative programming, including programs intended for prisoners with psychiatric illnesses. At the same time, most states have continued to yield to public and

political pressure to increase punishment, particularly for drug offenders (many of whom have co-occurring mental illnesses). Moreover, as the new penology philosophy has taken hold in most U.S. prisons, prison-based rehabilitative programming, including mental health treatment, has contracted. These outcomes, particularly as they affect prisoners with mental illnesses, have created new challenges for prison management, requiring, at a minimum, a reassessment of prison security levels, viable treatment options, and staffing needs.

In contrast, Europe's correctional philosophy has contributed to individualized sentencing and treatment-oriented prison systems in Finland and the rest of Scandinavia. Humane or holistic rehabilitation itself does not disregard the prisoners' offenses but remains concerned for their welfare. It is instead concerned with inmates' performance and behavior in prison and their behavior after release from prison (Christie, 1968). A regard for prisoners' humanity and the integration of treatment under the logic of *parens patriae* are premises of Finland's correctional philosophy.

The focal argument of this dissertation is that Vantaa Prison operates under a humanistic, *parens patriae* approach, while the Northern State Prison in New Jersey operates under a more retributive, police-power driven rationale. This difference should be reflected in the type of care inmates with mental illnesses in each institution receive. Through inmate and staff interviews, document reviews and site visits, this research attempts to ascertain whether individual perceptions vary based on different correctional philosophies and the subsequent supervision and management of and housing practices for this prisoners with mental illnesses.

Much research on prisoners who are mentally ill, has focused on their prisons, the management styles of those prisons, and the prevalence rates for mental illness within those prisons (Rhodes, 2004). Despite a growing body of information, few studies examine the issues on a cross-national level. This dissertation provides a comparative context (i.e., country or treatment philosophy) that explicitly examines the connection between philosophy, supervision, management and treatment of inmates who are mentally ill.

Given the number of persons with mental illnesses confined in prisons, the results of this research should be of interest to criminal justice policy makers and treatment providers. This research builds on the existing criminal justice literature (i.e., U.S. and international prison research) by applying Denzin's (1989) "interpretative interactionist" approach, which evaluates policies targeted at "social problems" (i.e., inmates with psychiatric problems) from the viewpoint of the persons for whom the policies were designed. It will, as Denzin states, define the issues from the actors' viewpoints, judge the effectiveness and appropriateness of the approach, and look for places of intervention to improve upon the policies (i.e., social welfare, public, health, reentry, and mental health). From the viewpoint of the inmate in this study, both in New Jersey and Finland, this approach is appropriate for assessing the local effects of prison mental health policies and treatment practices. It asks about the effects of traditional retributive theories of incapacitation on prisoners with mental illness, those expected to be in place at Northern State Prison, and how they compare to the more humane approach of Finnish prison. This research will transcend borders, cultural ideology, existing methods, and languages by giving voice to inmate concerns over policy. What is more, by evaluating inmate

responses to mental health interventions a dynamic assessment of those interventions can point out where divergent correctional treatment philosophies may offer improved treatment. This dissertation will extend the scope of international and domestic prison literature by examining how joint efforts combining cross-national cultural, mental health and correctional practices intersect with the “lived experiences” of persons with mental illness in Northern State Prison and Vantaa Prison.

CHAPTER 2

THE UNITED STATES AND FINLAND: CRIMINAL JUSTICE AND PRISONS, AN OVERVIEW.

Introduction

Empirical research on prisons supports the argument that these institutions generally are self-contained, with practitioners and academics seldom glancing beyond than their own borders of expertise for points of contrast or knowledge. Of course, prisons are a reflection of the values of the societies in which they exist, but comparisons are called for to identify what is different about prisoner mental health treatment programs. This chapter describes how Finland and the United States organize, administer, and manage their respective criminal justice systems, prisons, and prison populations.

General National Characteristics

The United States of America

As of 2007, the United States Census Bureau reported that approximately 300 million people lived within the country (www.census.gov). Of this number, 39.7 million or 13.4% were African-American, 45.5 million or 15.1 % were of Hispanic origin, 199.1 million were whites (66%), 14.4 million were Asian (5%), and 4.4 million (1.5 %) were American-Indians, Native Hawaiian, or Pacific Islanders. The United States is comprised of 50 states and several territories and is one of the largest countries in the world. Over 34 million people who reside in the United States reported being foreign born (www.census.gov). According to the Census Bureau, over one half (52%) of all African-Americans lived in a central city within a metropolitan area in 2006, compared with 21% of non-Hispanic whites. In contrast, 57% of whites lived outside the central city but

within the metropolitan area. In addition, almost half of all Hispanic people lived in central cities within a metropolitan area (45.6%) (U.S. Census Bureau Demographic Supplement, 2006).

As reported by the United States Department of Labor, the American economy is fueled largely by managerial, service, and technological industries even though the economic climate today is generating enormous layoffs in all economic sectors. As of August 2007, the U.S. unemployment rate was 6.1%, suggesting that some nine and a half million people were unemployed excluding students, prisoners and those with disabilities and long-term unemployment (i.e. “not looking for work”) (Bureau of Labor Statistics, 2007).

Finland

At the end of 2006, Finland had a population of five million people. According to the Finland Census and Statistical Bureau, (www.stat.fi), projections suggest that Finland’s population growth will slow down in the years to come unless a significant increase in net immigration occurs. Ethnic groups in Finland include Finns 93.4%, Swedes 5.7%, Lapps 0.1%, Romas 0.2%, and Russians 0.04%. Some three-fifths of the Finnish population (60.4%) resided in urban municipalities, with the Helsinki metropolitan area (including the cities of Vantaa and Espoo) accounting for almost one-fifth of the total Finnish population.

The economic structure of Finland is primarily service oriented, with about two-thirds of the economically active populace in trade, transport, communications, financing, community, and other services. In 1997, 21.4% of the workforce was employed in

industry and only 6.1% in agriculture and forestry. As of the first quarter of 2006, the unemployment rate stood at 6.9 % (www.stat.fi/index_en.html).

Finland has engaged in free trade with other Western European countries since the 1950s, but the Finnish economy was greatly regulated and protectionist in numerous ways until the mid-1980s. Protectionism is an economic policy that promotes preferred domestic industries through the use of high taxes and other regulations to discourage imports (www.wikipedia.com). The disintegration of the Soviet Union in the early 1990s practically stopped all of Finland's government-led, mutual trade with this nation and contributed to a profound economic downturn in the early 1990s, which led to an unemployment rate of almost 20%. Export growth permitted Finland to recover the 1990 peak level of domestic production in 1995, and the gross domestic product grew from 1996 to 1999 at a yearly rate of between 4 and 6% (HEUNI, 2001). Finland officially joined the European Union (EU) on January 1, 1995 which increased its economic growth rate. At the end of the 1990s, the jobless rate stood at 9.6%, with the level of foreign debt and the increased costs of servicing that debt leading to government unease. Nonetheless, Finland satisfied the criteria for entrance to the EU Monetary Union that became effective on January 1, 2002 (HEUNI, 2001). The unemployment rate in 2002 was 6.9% which corresponded to roughly 150,000 unemployed people in Finland (www.stat.fi/index_en.html).

CRIMINAL COURTS, SENTENCING AND SANCTIONS

New Jersey

The criminal court system of New Jersey is comprised of several different types of courts. It includes Superior Courts, which hear felony cases, Appellate Courts, and

Municipal Courts, where misdemeanor violations are processed. Persons, including those with mental illnesses, who are arrested in New Jersey, first appear in municipal court, particularly when charges involve a violation of a city ordinance (e.g., disorderly conduct, trespassing). Close to seven million cases are filed annually in New Jersey municipal courts. The New Jersey court system, like all criminal court systems in the United States, has a bail system and plea-bargaining.

There is a Superior Court, or the trial court, in each of New Jersey's twenty-two counties and about sixty Superior Court judges in New Jersey. The majority of inmates in Northern State Prison were found guilty in the New Jersey Superior Court system. The New Jersey criminal court system utilizes both juries and plea-bargaining in reaching verdicts in felony and misdemeanor cases.

The function of the Appellate Court in New Jersey is to review lower court decisions and interpret statutes. The New Jersey Supreme Court decides cases on appeal, and their rulings are binding in New Jersey only.

Punishments in New Jersey include incarceration in prisons and jails, probation, community service, electronic monitoring, fines, and in rare circumstance the death penalty. New Jersey criminal law stipulates that children under fourteen cannot be charged as adults. Juvenile cases are adjudicated most often in juvenile courts. New Jersey has insanity defense laws and a facility, the Ann Klein Forensic Center, where people who are found incompetent to stand trial or found not guilty by reason of insanity are hospitalized.

Finland

The criminal court system in Finland consists of three levels. It includes the Court of First Instance, the Appeals Court, and the Supreme Court. The Court of First Instance is the local court that handles both felony and misdemeanor offenses. Most persons with mental illnesses will first appear in the Court of First Instance where a mental status examination, if applicable, is ordered. If the defendant is detained, he/she is taken to a local prison pending court proceedings and pre-trial hearings. Finland does not utilize a jail/prison structure as in the United States. Moreover, the Finnish criminal court system does not have a bail system or plea-bargaining. Instead, pre-trial hearings are conducted bi-weekly to determine whether the offender should remain in custody (Äikäs, 2003). Those accused of minor offenses typically are released on personal recognizance at the court's discretion.

Appeals from the Courts of First Instance are heard in one of the six three-member regional Courts of Appeals responsible for supervising lower courts. The Finnish criminal court system does not recognize juries or case law precedents. The highest court in Finland is the Supreme Court, which hears cases "only if they grant leave of appeal" (HEUNI, 2001:6). Rulings by the Supreme Court of Finland are binding throughout the entire country.

Persons under age fifteen are not considered responsible for criminal conduct and cannot be prosecuted. Cases in which offenders are under fifteen become the responsibility of Finnish child welfare agencies "for consideration in accordance with the Child Welfare Act 1983/683" (HEUNI, 2001). Juveniles aged 15 and older are processed through the adult criminal justice system.

The Finnish criminal justice system, unlike the individual state-run system of the United States, is a federal system. According to the United Nations, the Finnish criminal justice system is considered rational, humane, and effective (HEUNI, 2001:5). In Finnish criminal law, the issue of culpability and proportionality must be applied to the full criminal sentencing process. This means that criminal sentences must be proportional to the “damage and danger” caused by the offense “and to the culpability of the offender manifest in the offense” (HEUNI, 2001:5). Although the American criminal justice system is often characterized as adversarial and accusatory, both Finnish and the American criminal justice systems operate on the premise of legality, or rule of law. Similar to U.S. criminal law, the principle of legality bars punishment if an offense is “not determined punishable by a Finnish Act of Parliament at the time of its commission” (Section 8 of the Constitution). Moreover, equality and humanity toward defendants are stipulated by the Finnish Constitution. Respect for human dignity forbids the death penalty, torture, or any other treatment violating a defendant’s human dignity (Section 7 of the Constitution). The equality principle stresses that all criminal cases falling in the same category of crime must be handled the same way without unwarranted bias (Section 6 of the Constitution). This principle “implies that the court takes into consideration all official and unofficial aggravating and mitigating consequences of an offense, in order to establish the maximum punishment” (HEUNI, 2001:6).

In contrast the American criminal justice system seeks a balance between a defendant’s rights and the state’s interest in a speedy trial with desire for justice (www.law.cornell.edu). Moreover, each state has its own statutes guiding criminal procedures within the state, but each state must also adhere to the higher federal appellate

court rulings and federal legislation. Unlike in the United States where the courts recognize individual case law or case precedents in deciding case outcomes, the Finnish criminal justice system is guided by uniform criminal statutes. In practice, the Finnish principles of legality, humanity, and equality have led to wide-ranging reductions in sentencing. In addition, “there is an increased awareness of values, costs and alternatives associated with criminal policy” (Aromaa, 2001:4). For instance, in the 1990s, 60% of criminal cases handled by the courts resulted in fines and 20% in a conditional sentence.¹ Approximately 10% of offenders were sentenced to prison for short sentences (normally from 3 to 9 months) and 8% to community service. In about 2% of the cases, the courts waived further sanctioning based on lack of evidence. The average prison sentence was 6.8 months in 2000 (NSK, 2002: 14-16). The perception that prison sentences are harmful and should thus be avoided as far as possible remains powerful in Scandinavian countries (Bondeson, 1998). Long-term sentences in Finland are rare. Punishments generally include day fines (calculated as a percentage of an offender’s income), conditional imprisonment (reduction of sentence based on offender’s compliance with court ordered conditions), community service, and imprisonment. Similar to New Jersey’s Truth in Sentencing Law, all first time offenders in Finland, regardless of crime, must serve at least half of their sentence before being eligible for parole. Inmates considered habitual offenders, however, may not be eligible for early release.

PRISON ACCREDITATION AND STANDARDS OF CARE

¹ Suspension of sentence is contingent upon successful completion of court ordered stipulations

United State of America

American Correctional Association

The American Correctional Association (ACA) has advocated for corrections agencies and correctional effectiveness since 1870 when it was founded as the National Prison Association. The ACA is the oldest organization established specifically for practitioners in the correctional profession (www.aca.org). The first organizational meeting took place in Cincinnati, Ohio where the assembly elected “then-Ohio Governor and future President, Rutherford B. Hayes as the first President of the Association” (www.aca.org). During its first meeting in 1870, ACA established the Declaration of Principles, which subsequently established the guiding philosophical tenets for corrections in the United States and Europe.

The main purpose of the Standards and Accreditation Department of the ACA today is to carry out the dual task of providing services to the ACA membership and the Commission on Accreditation for Corrections (CAC). These services include: the development and dissemination of new standards; modification of current standards; management of the accreditation procedure for all correctional components of the criminal justice system; semi-annual accreditation hearings; technical support to correctional agencies; and training for consultants who are participating in the accreditation process.

NCCHC

According to the National Commission on Correctional Health Care (NCCHC), only 231 of the nation’s approximately 1,400 prisons have received NCCHC accreditation (i.e., they adhere to NCCHC guidelines and submit themselves to scrutiny

by the organization) (Human Rights Watch, 2003). The National Commission on Correctional Health Care (NCCHC) was established in the early 1970s as result of research conducted by the American Medical Association (AMA) that found many jails had inadequate and disorganized health services. In a joint effort with other organizations, the AMA established a program in the early 1980s that led to the creation of the National Commission on Correctional Health Care (NCCHC) which, in turn, established national standards and guidelines for all medical services, including psychiatry. The organization is an independent, not-for-profit 501(c)(3) agency whose initial undertaking was to evaluate, create policy, and develop programs in prisons and jails to meet the health care needs of inmates. (www.ncchc.org).

National guidelines established by the health, legal, and corrections professions have been available since the 1970s. The purpose of the guidelines is to determine whether prisons meet health and psychiatric care standards. NCCHC makes a professional judgment pertaining to services provided and aids in improvement. The Standards for Health Services published by the NCCHC are industry-wide guidelines for managing the delivery of medical and mental health care within correctional systems. The Standards address the various needs, mission, and goals of institutions like detention facilities, youth institutions, and prisons. It addresses inmate care, facility administration, environmental safety, personnel and training, medical services support, health promotion and illness prevention, special needs such as psychiatric disorders, medical records and medical-legal issues (www.ncchc.org). It has aided U.S. correctional and detention facilities in improving the delivery of health care to inmate populations by augmenting

the efficiency of health services delivery, strengthening organizational efficiency, and decreasing the threat of legal judgments.

Although the NCCHC sets forth accreditation standards and evaluation protocols, it does not oversee the actual care provided to prisoners. Some State correctional systems claim to follow NCCHC protocols but fail to adhere to them. Research by NCCHC indicates, however, that these internal quality control mechanisms are characteristically ineffective (www.ncchc.org).

CASE LAW

American courts have a long history of judgments regarding the care of persons in custodial facilities, including jails and prisons. The result is that institutions of confinement have a constitutional obligation to provide minimum health and mental health care to inmates in their custody. Such legal mandates stem from legal policy making in the federal and state court systems (Feeley & Rubin, 1998). Although federal case law pertaining to persons with mental illnesses in custody is applicable to all correctional institutions within the United States, the outcomes of mental health treatment, housing, and medications for those in need varies depending on the resources available to these institutions.

Most significant litigation concerning the treatment of health and mental health concerns has occurred in the federal courts. Plaintiffs have brought suit under a federal (civil rights) statute, 42 USC Sec. 1983, asserting that prison officials acting “under the color of state law” have violated the claimants’ constitutional rights. These court decisions set the foundation for a right-to-treatment posture in the corrections arena under the 8th Amendment of the United States Constitution.

The 8th Amendment of the U.S. Constitution explicitly prohibits cruel and unusual punishment, which the courts have interpreted as requiring prisons to provide mental health treatment to prisoners who have serious mental illnesses. Constitutional standards in the United States are primarily enforced through prison litigation, litigation that faces enormous procedural and substantive obstacles as indicated above (Cohen, 1998). The courts have ruled, however, that neither malpractice nor negligent care violate the Constitution. The 8th Amendment is only violated when prison officials are “deliberately indifferent” to inmates’ treatment needs, a legal threshold that has to be met to bring forth a lawsuit, not when they provide negligent care (Cohen, 1998).

LEGAL STANDARDS GOVERNING PRISONS

Finland

There are a number of international standards that specifically address prisoners and conditions of imprisonment. A set of minimum rules or guidelines that provide a balance to broad principles contained in legal treaties include, but are not limited to, the Standard Minimum Rules for the Treatment of Prisoners (1955), the Basic Principles for the Treatment of Prisoners (1990), and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988).

The international community, usually through the United Nations, has agreed to these standards. The standards are legally binding on all member countries of the United Nations that have ratified or acceded to them, including Finland. Most of the standards refer to the treatment of people who are deprived of liberty (www.hrw.org)

International Decrees

International decrees by the United Nations (UN) and other global treaties have created a discourse which guides Finnish prisons. According to Dr. Arpo, the Chief Medical Officer of the Department of Prison Administration of Finland, “the prisoners are sent to prison as punishment, not for punishment” (HIPP, 1997:1) as stipulated in Rule 57 of the United Nations Standard Minimum Rules of the Treatment of Prisoners. Finnish prisons are prohibited from aggravating the suffering of inmates beyond their deprivation of liberty. Normalcy, to the extent that it is feasible, must be maintained. This means that prison conditions must be made comparable to existing conditions in their particular society as much as possible. Rule 60 of the UN Standard Minimum Rules emphasizes that the regime of the institution “should seek to minimize any differences between prison life and liberty” (HIPP, 1997). Rule 60 also recognizes that inmates’ feedback must be taken into consideration when deciding housing, treatment, and work assignments. Furthermore, the Basic Principles for the Treatment of Prisoners demand that inmates have to be treated with fairness, justice, and dignity in all aspects of their incarceration. Prisons must do all they can to affect positively the inmate’s successful reintegration back to society. Hence, in Finland, unsupervised visits and prison leaves is how Finland carries out the principle.

United Nations Rules Applicable to Special Categories

A. Mentally Ill and Disturbed Prisoners

The United Nations addresses the treatment of inmates with mental illness by means of specific provisions contained in the Standard Minimum Rules for the Treatment of Prisoners (www1.umn.edu/humanrts). These provisions are applicable to all Finnish prisons.

Provisions 82-83 of the rules are listed below:

1. Persons identified as mentally ill cannot be held in prison, and their transfer to mental hospitals must be arranged as soon as possible (Part II. Rules Applicable to Special Categories).
2. Other persons suffering from mental illness problems and symptoms must be observed and provided treatment in non-prison institutions operated under health care entities (Part II. Rules Applicable to Special Categories).
3. When persons with mental illness are in prison, they must be supervised under the care of a prison doctor.
4. Prisons are to provide psychiatric care to all such prisoners who need it.
5. Prisons should develop aftercare social, psychiatric and mental health treatment care for persons leaving prisons.

RESPONSE TO INMATES WITH MENTAL ILLNESS IN FINNISH PRISONS

Hoyer (1988) reported that “altered and usually milder reactions to inmates with mental illness have been legally authorized in Scandinavia (i.e. Finland) ever since the first known legislation appeared in the early Middle Ages, as well as in the penal codes” (p. 318). However, before the Middle Ages, treatment of people with mental illness was cruel often consisting of exclusion and confinement. Lauerma (1997) reported that it was not until 1889 that a law granted inmates the right to physical and mental health treatment. These rights have not been contested in Finnish courts, a contrast to the U.S., where case law has repeatedly redefined the roles, duties and the responsibilities that correctional institutions have toward persons with mental illness.

In 1924, Finnish prisons were given specific orders on the treatment of inmates with mental illness. For example, inmates assumed to have mental illness could not be

placed in work where they could have access to sharp objects. Furthermore, disciplinary measures against persons with mental illness (inmates) had to be reviewed and justified by a doctor (Joukamaa, 1991).

In 1932, orders and policies were established for the follow up on inmate health status. Prison guards were ordered to pay attention to unusual behavior exhibited by inmates that could be an indication of an illness of the “soul,” and to report it to their immediate supervisors (v. Grunewaldt, 1983). In 1972, the Ministry of Justice formed a committee to ascertain the treatment needs for inmates with mental illness and whether existing housing for inmates with mental illnesses should be renovated or replaced or whether those inmates should be relocated. Only one committee proposal was approved. The very first psychiatric hospital was opened at Helsinki Central Prison in 1974 (Suominen, 1981). In 2002, the psychiatric hospital relocated to its present site at Vantaa Prison (www.vankeinhoito.fi).

Finnish law (RTL Sec. 2, article 8) requires prisons to provide health care to inmates who need it. The care includes basic and preventive health care, occupational therapy, specialized care, hospital care, and dental and mental health treatment. If an inmate is in need of involuntary mental health treatment, prisons are permitted under the Mental Health Law (1116/1990) to transport the individual to a psychiatric hospital for treatment. Psychologists practiced for the first time in Finnish prisons in 1968, and psychiatric treatment followed in the 1970s when the Prison Administration brought psychiatrists to prisons. Psychiatrists provide consultation and clinical treatment for inmates with psychiatric disorders. There are several psychiatrists currently working in Finnish prisons (Haaste, 2002:22).

RESPONSE TO INMATES WITH MENTAL ILLNESS IN U.S. PRISONS

Since 1980, the American prison population has exploded with about 2 % of the adult population now under some form of correctional supervision (Kanapaux, 2004). For instance, a greater proportion of people who are homeless, mentally ill, and have co-occurring substance abuse problems are ending up in prisons (BJS, 2005). Because of these dynamics, prison mental health service systems now house inmates with more acute mental health problems. Both state and federal courts have asserted that persons with mental illnesses in prisons have certain rights. In *Estelle v. Gamble* (1976), a case concerning the 8th Amendment, the prohibition of cruel and unusual punishment, the U.S. Supreme Court established legal standards for reviewing medical conditions. Medical treatment or the absence of it was ruled unconstitutional when it involved the “unnecessary and wanton infliction of pain” (*Gregg v. Georgia*, 428, U.S. 153 (1976)). That criterion was expanded to include psychological care and psychiatric treatment for mental illness in *Bowring v. Godwin* (4th Cir. 1977). Subsequently, the *Ruiz v. Estelle* (5th Cir. 1980) decision outlined the key components of what correctional mental health services must include to meet the constitutional threshold. U.S. prisons currently face two incongruent tendencies: on the one hand, fear of litigation creates pressures for of mental health service reforms, reforms that prison officials may be otherwise slow to undertake; and on the other hand, funding pressures and cutbacks make implementation of reforms more exigent and difficult to undertake. Earlier lawsuits challenged the lack of mental health services in prisons, while recent litigation has sought improvements in existing in-prison mental health delivery systems (HRW, 2003).

In their report titled U.S. Prisons and Offenders with Mental Illness, Human Rights Watch (2004) stated that for many people suffering from psychiatric illnesses, prison can be contraindicated or even noxious. Their report, however, concedes that for some inmates, prison may bring solace and severely needed treatment not available in the community. Human Rights Watch posits that for some people with mental illness “prison may also offer significant advantages over liberty.” For those prisoners who are indigent and without permanent residence, prison may provide an avenue for better access to psychiatric medication and mental health treatment. Nevertheless, making this opportunity real depends on the ability of prisons to provide the needed services. Depending on the quality of the facility, inmates with mental illnesses, often suffering from untreated and/or undiagnosed mental illnesses, prison may be less precarious, less disorganized, less disconcerting than life lived on the margins of society (HRW, 2004).

INCARCERATION IN GENERAL

American and Finnish corrections systems share some common structures. Each country has a combination of detention facilities, prisons, work-release programs, halfway houses, and probation and parole services. There is, however, a distinct contrast between Finland’s unified national prison system and the fragmented U.S. system. The United States has federal, state and municipal jails, detention and prison facilities whereas Finland has a single prison system that is managed by the government.

Since the mid-1990s, U.S. and Finnish incarceration rates have steadily increased while both systems continue to be set apart by immense differences. Due to cultural and political factors that influence contemporary correctional and treatment philosophies and approaches to inmates with mental illnesses in both countries, their prison systems are

operating in different ways. For example, in Finland rates of incarceration and duration of incarceration are among the lowest in the world, while the US has the highest rate.

THE UNITED STATES OF AMERICA

As of December 31, 2007, the American correctional population stood at 2.2 million people (International Prison Brief, 2007; Pew Report). The prison population stands at 724 persons per 100,000 people making it one of the highest in the industrialized world. At present there are eighty-four federal prisons, 1,320 state prisons, 3,500 jails, and 264 private prisons in the United States (BJS, 2007). Each state operates its prison system independent of other states or jurisdictions.

Female prisoners accounted for 7.2% of the state prison population and around 12.9% of local jail inmates in 2007 (www.ojp.usdoj.gov). Many of these inmates, according to Ditton (2002), arrive in prisons with multiple problems such as health, substance abuse, breakdown of family structure, unemployment, and mental illness. Nationwide, nonviolent offenders account for 72% of all new state prison admissions, and almost one third of new admissions were nonviolent drug offenders (Punishment and Prejudice, 2000).

New Jersey

New Jersey has thirteen prisons housing a total of 17,057 inmates. Seventy-one percent of all New Jersey adult offenders are serving mandatory minimum terms. The median mandatory minimum sentence is five years. Twenty-seven percent of all New Jersey Department of Corrections inmates are serving time for narcotics violations, including possession, sale and distribution (www.state.nj.us/corrections).

Northern State Prison

Northern State Prison is a medium security institution built for adult male offenders. Located in Essex County, the prison opened in 1987 and currently houses 2,596 inmates on 42 acres. Northern State Prison employs 152 civilian and 609 custodial personnel. Health care services – medical, dental, clinical and specialty treatments such as HIV and addictions, and mental health – are privatized (www.njd.org).

Northern State Prison is the second largest facility in New Jersey with an authorized maximum inmate population capacity of 2,781. According to the Northern State Prison Program Guide (2005), the inmate population falls under five classifications: 1) general population; 2) inmates with mental illnesses, 3) Security Threat Group Management Unit (for active members of identifiable street gangs); 4) Administrative Close Supervision Unit (for inmates with disciplinary charges); and 5) Therapeutic Community (for inmates with substance abuse problems).

Northern State offers a variety of program activities to qualified inmates. They include work release, furloughs, substance abuse (inmates taking psychiatric medications do not qualify), and community release (halfway houses) for minimum-security status inmates. Vocational training courses are offered in printing, carpentry, and electrical repair. Also located within the main prison structure is a State Use shop for the production of industrial clothing items which provides training and work opportunities for inmates. In conjunction with Union County College of New Jersey, inmates under age 25 are eligible for college courses (up to 20 credits) offered at the prison.

Specialized Housing Units

Northern State Prison accommodates inmates with mental illnesses in three different housing areas: the Crisis Stabilization Unit, the Transitional Unit, and the

Residential Treatment Unit. The Crisis Stabilization Unit (CSU) serves inmates who suffer from acute mental health crises. Once their symptoms stabilize, inmates are transferred to the Residential Treatment Unit (RTU) for supplementary psychosocial rehabilitation. Inmates have a chance to attend groups with mental health staff in addition to receiving psychological counseling and medication monitoring by the psychiatrist. Once inmates are ready to be discharged from the RTU, they are sent to the Transitional Care Unit (TCU). This unit serves higher functioning inmates who have the potential to return to the general population. It is expected that when their mental health symptoms have stabilized, they can begin some form of inmate programming (Northern State Prison Profile and Program Guide, 2005).

FINLAND

Since 2000, the Finnish prison rate has been on a steady increase due to a more punitive approach to drug and violent offenders. At the beginning of 2007, the total prison population grew to 3,551 inmates. This is 150 inmates more than in 2002 (www.vankeinhoito.fi). The incarceration rate of 64 per 100,000 people, however, remains one of the lowest in the world. At present there are 26 prisons, divided into regional open and closed facilities. Female prisoners make up 6 % of the prison population (244); juveniles make up .05% (87) and foreign prisoners 8.6% (307) of the total prison population. As of December 5, 2007, the five most common crimes for which inmates served time in Finland were 1) robbery, 2) theft, 3) property offences, 4) narcotics violations and 5) homicides (The Criminal Sanctions Agency, 2007). Typically the prison sentences in Finland are short compared to the ones in the United States. For example, inmates serving time for non-violent offenses (e.g., non-payment of fines, theft)

spend on average 7.6 months behind bars. On the other hand, inmates with homicides and narcotics convictions typically served 7.4 years (www.rikosseuraamusvirasto.fi).

In general, prisons in Finland are small (between 100-250 inmates), modern, and characterized by high staffing levels (Nordisk kriminalstatistik, 2002). Finnish prisons integrate treatment as part of their approach to inmate rehabilitation. They are also quiet. Beginning in 2003, seventeen closed prisons and 18 open prisons were in use in Finland. Inmates in closed prisons are not allowed to leave the facility to go to work or to school. Inmates classified as medium to maximum security levels are usually housed in these facilities. Open prisons house minimum security inmates who can go to work in the community, attend classes in universities, go to outside substance abuse providers, and otherwise stay integrated in their communities. They must return, however, to prison at night for the duration of their sentences. Open prisons, which house almost one-third of Finland's prisoners, are essentially halfway houses that allow prisoners to work in the community and travel as long as they return to their facility in the evening. The overall regimen in open prisons tends to be more relaxed and less structured. In addition, inmates in open prisons are paid wages comparable to what they would make in civilian life. They must pay taxes and maintenance allowance from these wages toward their family and children on top of their own room and board. Any prisoner, regardless of his/her crime, can apply for transfer to an open prison when she or he has less than three years remaining on her or his sentence.

In contrast, closed prisons are classified as either central or regional facilities. Central prisons are designed for inmates serving sentences, while regional prisons are for

pre-trial detainees awaiting trial.² Additionally, there is a prison for those between 18 and 25 that house 128 inmates, and a unit for inmates requiring acute mental health treatment at Vantaa Prison psychiatric unit (14 beds). Several psychologists and five psychiatrists are employed in Finnish prisons to provide psychological and psychiatric care to inmates. All closed prisons have medical services, and most have some form of substance abuse treatment available. Vantaa Prison is the only prison in Finland providing voluntary³ inpatient psychiatric treatment to inmates (Äikäs, 2003). The Finnish Prison Administration, under the Ministry of Justice, manages and oversees all prisons. The provision of prison health and mental health care is also the responsibility of the Ministry of Justice and medical services are organized by the Prison Administration.

Vantaa Prison

Vantaa Prison, built in 2002, is one of the most modern prisons in Finland. It houses about 220 inmates (pre-trial, minimum, and maximum security) on four different floors. Of the 220 inmates, 21 are female (10%). Foreigners constituted twelve percent of the Vantaa Prison (average monthly inmate census in 2003, recent data not available). In all, 30% of foreign inmates were Estonian, 21% were Russian, 6% were of Somali descent, 4% were Vietnamese, and 34% were native-born Finns. These percentages reflect Vantaa Prison inmate demographics over the course of one year (Vantaa Prison Annual Report, 2003).

What is unique about Vantaa Prison is that not only does it serve as a remand prison (pre-trial detention) but also houses sentenced inmates. Vantaa Prison is a closed

²U.S. jails are comparable to Finnish regional prisons

³ Prisoners must consent to mental health treatment before it can be initiated.

prison, which means inmates are not permitted to leave the facility to go to outside classes or to work. All programming for inmates occurs within the confines of the prison. Qualified inmates, however, are allowed leaves from prison to visit family and maintain ties to their communities. In these cases, the prison pays for inmate transportation to and from their destinations. Also, like Northern State Prison in New Jersey, Vantaa prison offers industrial and carpentry shop training, computer classes, educational programs, and medical, mental health, and substance abuse treatment. One of the housing units at Vantaa prison is designed for inmates committed to a substance-free lifestyle during incarceration. Once released from prison, inmates from this unit are linked to substance abuse programs in the community for aftercare. Inmates in this unit cannot be on any type of psychiatric medications.

Specialized Housing Unit

The treatment philosophy at Vantaa Prison specialized housing follows a civilian hospital, psychosocial rehabilitation framework. Treatment is holistic consisting of a variety of groups targeting diverse domains including substance abuse, mental health issues, health, acupuncture, art and music therapy, discussion groups, and an opiate treatment program. Unlike in the United States, where prison mental health services may be privately contracted, in Finnish prisons these services are typically administered by the Department of Health as part of the standard mental health delivery system. Services are integrated into the overall prison system and administered by the prison (Hoyer, 1988). Today it is the Finnish prison system that is primarily in charge of the type of care and treatment offered to inmates with mental illness at the post- adjudication level. Moreover, the implementation of these services is generally overseen by the criminal justice system

and bears a striking similarity to the way in which Northern State Prison in New Jersey delivers services to its prison inmates in specialized housing.

CHARACTERISTICS OF PRISON INMATES

United State of America

In 2006 the Bureau of Justice Statistics (BJS) estimated that 57% of male inmates in state prisons were under age 35 while the average age of females in state prisons was 33. About 57% of inmates in state prisons have a high school diploma or equivalent; 14.2% have an eighth grade education or less; 10.7% have some college education; and 2.7% are college graduates or have post-graduate degrees (BJS, 2005). In 2002, 64 percent of prison inmates were members of racial or ethnic minorities. Roughly 6% of state prison inmates were held in private facilities at year end 2001. Among the state prison inmates in 2006, a fifth were sentenced for a property crime (20%), another fifth were sentenced for a drug crime (21%), the remaining inmates were sentenced for a violent crime (49%).

Prison inmates throughout the country suffer from a variety of physical ailments. Travis et al. (2004) reported that almost 31 percent of inmates in 1997 “reported having learning or speech disability, a hearing or vision problem, or a mental or physical condition” (p. 4). According to the National Commission on Correctional Health Care (NCCHC), studies performed since the mid-1990s found “a high prevalence of infectious and chronic diseases among jail and prison inmates (NCCHC, 1997). Hammet, Harmon and Rhodes (2000) reported that 65% of the persons released from correctional facilities in 1996 had tuberculosis; 12% had Hepatitis B; 29% were infected with Hepatitis C; 17% had AIDS; and 13% were infected with the HIV virus. A more recent study by the

Bureau of Justice Statistics (2005) reported that correctional authorities throughout the U.S. reported 22,627 state inmates as being HIV positive in 2004. Research data indicate that the potential for the spread of HIV in prisons is notable and that HIV prevention education and substance abuse treatment services are imperative in corrections facilities (Patel, Hutchinson & Sienko, 1990).

New Jersey

In 2004, fifty-seven percent of all adult offenders were serving mandatory sentences for narcotics violations, including possession, sale and distribution. As a result, 38% of those released from prisons in 2002 were drug offenders (New Jersey Institute for Social Justice, 2004). The average age of a Northern State inmate is 23 (www.state.nj.us/corrections). In contrast, the average age of the 2002 release cohort was 34. The Urban Institute Analysis of New Jersey Department of Corrections (NJ DOC) Data (2002) shows that 56% of the release cohort in 2004 were single; 5% were married; 3% divorced; and another three percent were separated. For a third of the prisoners, marital status was unknown.

The Centers for Disease Control and Prevention (CDC) HIV/AIDS Surveillance Report (2002) found that prison inmates in the Northeast had the highest rate of HIV infection. New Jersey, part of the Northeast region, reported a 3.2% infection rate in the New Jersey male inmate general population and a 6.8% rate in New Jersey female inmate general population. As of December, 2004, approximately 1,407 New Jersey prison inmates (out of 27,000) had tested positive for Hepatitis C virus, “a 20% increase over a five-month period” (www.kaisernetwork.org).

The Urban Institute found that nationwide, 20% of the 2002 release cohort had at least one medical diagnosis, and 12% had two or more. Other diseases were also found in this release cohort; about 18% suffered from ailments like asthma, diabetes or hypertension. Mental health concerns were identified in 11% of the released persons. Moreover, the Urban Institute also discovered that over 50% of the release cohort had an addiction to alcohol, drugs, or both. The Office of Drug Programs in the New Jersey Department of Corrections (2003) has reported similar findings, asserting that “81 percent of inmates in custody suffered from some type of drug or alcohol problem” (p. 5). In addition, a large percentage of this population is also persistently unemployed before and after release from prison.

New Jersey Institute for Social Justice (2003) reports that “a great deal of what is known at the sub-national level on employment rates of persons with histories of incarceration in the state prison system is anecdotal” (p. 2). The data that are available suggest that some persons with prison backgrounds have secured jobs in the “light manufacturing, construction, and retail trade service sector” (p. 2). A study by Holzer, Raphael, and Stoll (2002) finds that persons with prison records have multiple barriers to entering the labor market including marginal skills, illiteracy, spotty or non-existent work history, and a host of behavioral, health and mental health issues. Moreover, surveys that focus on the labor market “do not specify previous offender status as a question; and, even if they did, responses to such questions might be untrustworthy” (p.2).

Finland

The percentage of incarcerated women in Finland is 6.1%, comparable to the U.S. figure of 6.4%. In 2003, the average age of Finnish inmates was thirty-three for males

and thirty-four women. More prisoners were divorced than married. Two thirds (66%) were single. In terms of education, approximately 80% of Finnish inmates completed up to the ninth grade; however, the majority (80%) lacked professional training or skills (www.vankeinhoito.fi). A recent survey of prisoners' health and mental health status compiled by the Finland Prison Service (2002) found that out of a total population of 3,372 inmates incarcerated in 2002, roughly 14% had a psychiatric diagnosis (unofficial), and 39% received some type of mental health treatment. Over a quarter (26.5%) were carriers of Hepatitis C, which primarily spreads among IV drug users, 1.1% had a HIV diagnosis, 39.5% were considered addicted to alcohol or using it harmfully, and another 46% had a drug dependency or had histories of drug abuse. According to The International Edition of Helsingin Sanomat (2004), cannabis (hash) and amphetamines are among the most popular drugs used in Finnish prisons today. There are inmates, however, who prefer mixing Subutex, a medication used to treat opiate dependence, and other illegal street drugs. It is important to note that the Finland Prison Administration derived these figures from inmate folders rather face-to-face interviews. Hence, some of the percentages may be higher than indicated. Conversely, the National Commission on Correctional Health Care issued a report in 2002 titled *The Health Status of Soon-To-Be-Released Inmates*. It provided a health and mental health profile of inmates in American correctional institutions. The findings revealed that 18% of the release cohort was infected with Hepatitis C virus. Also, another 2.3% of state inmates were HIV positive, and the rate of confirmed AIDS cases among the nation's incarcerated population was five times the rate in the U.S. general population (0.60versus 0.12%). Major mental illness was diagnosed in 11% of the release cohort. Over 50% of released inmates were

diagnosed as substance abuse dependent (drugs or alcohol). For New Jersey inmates, 34.2% of men and 15.8% of women had an Axis I diagnosis, 37.3% of men and almost half of the female population (47.7%) had major depression, Bipolar or major mood disorder, or borderline personality disorder (Wolf, 2003). With regard to non-mental illness diagnoses, 18% of New Jersey state prisoners who were discharged in 2002 were diagnosed with at least one chronic condition, such as asthma, diabetes, or hypertension. Ten percent were diagnosed with at least one communicable disease or condition, such as HIV, AIDS, tuberculosis, syphilis, Chlamydia, gonorrhea, Hepatitis-B, or Hepatitis-C. A 2000 study by the Bureau of Justice Statistics found that 6.8% of New Jersey women prisoners were known carriers of HIV virus, more than double the 3.2% share of the general population that had been diagnosed with HIV (Maruschak, 2002).

Vantaa Prison Inmate Characteristics

The Vantaa prison inmate profile is similar to what is described above in terms of problematic substance abuse and multiple physical and mental health problems. The most common mental health diagnoses under ICD-10 at Vantaa Prison in 2003 were F40 (anxiety disorders) and F32 (depressive disorders), diagnoses increasingly associated with substance abuse.

The majority of Vantaa Prison inmates are between the ages of thirty and thirty-nine. According to Kauhanen and Närhi (2002) about 2% of Vantaa Prison inmates have finished high school. A third (33%) had not completed grammar school. Almost all (95%) had experienced chronic unemployment before and after incarceration often associated with persistent substance abuse and the criminality linked with it. Two-thirds of inmates were single, though many have children who are being cared for by relatives

or by a non-incarcerated parent. There were more divorced than married inmates. The largest category of inmates (44.5%) at Vantaa Prison was serving time for theft related crimes. Their average length of incarceration was less than three months.

DEFINITION OF MENTAL DISORDER

In 1952, the American Psychiatric Association published the *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)*, marking the first attempt to approach the diagnosis of mental illness through standardized definitions and criteria. The latest edition, *DSM-IV*, published in 1994, provides a classification system that separates mental illnesses into diagnostic categories based on descriptions of symptoms and on the course of the illness (American Psychiatric Association, 1994).

According to Szasz (1974), some psychiatrists define mental disorders generally as any significant deviation from some ideal standard of positive mental health. Other psychiatrists would define mental disorder using a “lower threshold,” which perceives mental disorders as being any set of behaviors deemed undesirable (Cockerham, 2000). The challenge of defining mental disorder is complicated further because their definitions change over time and are culturally constructed and entrenched.

Mental illness is generally referred to as a diagnosable cognitive, behavioral, or emotional disorder over a sufficient time-span to meet the diagnostic criteria detailed in the DSM-IV. Mental disorders embrace a spectrum of impairments of thought, mood, and behavior and can and do differ from person to person. Some individuals with mental illness have phases of stability during which symptoms are in remission or minimal while others are acutely ill and symptomatic for extended periods (Andreasen, et al. 2005:441)

The DSM-IV classification for mental disorders is a multi-axial system comprising five separate axes. It divides clinical disorders into different classes, which include psychotic disorders, mood and anxiety disorders, organic brain disorders, and personality disorders. Individuals with psychotic disorders are characterized as possessing bizarre and/or disturbed thought patterns. Persons suffering from psychotic disorders may exhibit withdrawn behavior coupled with visual, olfactory, tactile, and/or auditory hallucinations. Schizophrenia is one form of psychotic disorder (www.ihdi.uky/mentalillness). The DSM-IV breaks down diagnoses into five classifications or axes. Each axis represents a syndrome of illnesses. For example, Axis I covers clinical disorders, most V codes and conditions that require clinical attention. DSM V codes classify conditions other than a disease or injury, but are not necessarily a main diagnosis. Axis II covers personality disorders including mental retardation. Axis III shows general medical conditions; Axis IV psychosocial and environmental problems and factors; and Axis V is a Global Functioning Scale (GAF) measure with a scale of 0-100. GAF rates social, psychological, and occupational functioning.

Bipolar disorder and major depression are examples of mood disorders, while panic disorder, various phobias, and post-traumatic stress disorder (PTSD) are examples of anxiety disorders. Mood and anxiety disorders “encompass a group of conditions that share extreme or pathological anxiety as the principal disturbance of mood or emotional tone.” Mania, for example, is distinguished by elevated or expansive mood, “well beyond what would be considered normal or typical” (Thigpen et al., 2004:2).

Organic mental disorders include delirium and intoxication syndromes. There are a number of potential causal factors for organic mental disorder including long term

chronic substance abuse, aging, and head trauma. To assess whether someone has an organic mental disorder, mental health clinicians assess an individual's judgment, orientation (i.e., oriented to time, place and person), cognition, affect, memory, and behavior.

According to the National Institute of Mental Health (NIMH, 1999), personality disorders are characterized by “distinctive psychological features including disturbances in self-image; inability to have successful interpersonal relationships; an inappropriate range of emotion, negative ways of perceiving themselves, others, and the world; and difficulty with proper impulse control” (p. 6). As a cluster, personality disorders can produce an all-encompassing blueprint of conduct and internal experience that is unlike the standards of the individual's culture and is likely to be demonstrated in behaviors that seem more unusual than what society considers customary (personalitydisorders.mentalhelp.net).

THE PREVALENCE OF MENTAL DISORDERS IN THE POPULATION

The United States of America

Affecting the treatment of those incarcerated or not, with mental illnesses requires a clear epidemiological understanding of the illnesses. Britannica defines epidemiology as a branch of medical science that studies the distribution of disease in human populations (www.britannica.com). The most complete of these epidemiologic studies was the 1978 Epidemiological Catchment Area Study (ECA) (Robins, 1991; Regier, 1985). ECA involved over 20,000 subjects in five distinct catchment areas (New Haven, Connecticut; Durham, North Carolina; Baltimore, Maryland; Los Angeles; and St. Louis, Missouri). ECA studied prevalence and incidence of mental disorders in the community

as well as in institutional settings (Robins, et al. 1984). The main purpose of the ECA Study was to obtain rates of particular mental disorders. Twenty percent of interviewed subjects had an active mental disorder during a given year. The ECA Study estimated the prevalence rate for severe mental illness at 2.8% of the US population (Robins, et al. 1984). In comparison, Regier et al. (1993) estimated that 22.1 percent of Americans ages 18 and older (about 1 in 5 adults) suffer from a diagnosable mental disorder in a given year. When applied to the 1998 U.S. Census residential population estimate, this figure translates to 44.3 million people. The NIMH reports that four out of ten cases of disability in the United States and other industrialized nations are mental disorders, including major depression, bipolar disorder, schizophrenia, or obsessive-compulsive disorder (Kessler, 1994; Murray and Lopez, 1996).

Finland

Like the United States, Finland is also experiencing increasing rates of mental illness among its working age population. According to Artto (2003), three thousand Finns retire annually because of mental illness. Artto (2003) explains that “this means that early retirement due to mental illness impacts one person per 1,000 during their working life” (p. 1). Moreover, the Finnish Trade Union confederation estimates that of their million members, approximately 200,000 have suffered from an episode of mental illness during their work lives. The trade union also reports that Finnish women suffer from mental illness somewhat more frequently than Finnish men, however, “no age specific characteristics have been verified” (p.1).

In 2002, according to the National Research and Developmental Centre for Welfare and Health (STAKES.fi), 32,511 Finns sought inpatient psychiatric treatment.

Thirty-nine percent suffered from schizophrenia, schizoaffective, or delusional disorders. Thirty-two percent of those seeking inpatient treatment experienced mood disorders. The most common mood disorder diagnoses under the International Classification of Diseases (ICD) were major depression, recurring depression, and bi-polar disorder (www.stakes.info/2/5/index.asp).

PREVALENCE RATES AND TREATMENT OF PERSONS WITH MENTAL ILLNESS IN U.S. AND FINNISH PRISONS

The United States of America

Based on the current U.S. prison and jail population (2.3 million), there may be 300,000 seriously mentally ill men and women incarcerated today (Bureau of Justice Statistics; Harrison & Beck, 2003). Many who enter the prison system have either a mental illness or a substance use disorder or both. The large numbers of inmates with mental illnesses has brought attention to the problem and encouraged authorities to improve care and treatment (Lurigio & Swartz, 2000:108). The legal and legislative systems are generally thought of as two separate systems in the United States. Inmate litigation has forced the improvement of care in prisons, and in some cases legislators have mandated improved standards of care.

A Bureau of Justice Statistics (BJS) report for 2005 noted that 8 to 9% of prisoners have significant psychiatric disabilities, and another 15 to 20% will require some form of psychiatric intervention during their incarceration. Moreover, on any given day, 2.3 - 3 % of inmates in state prisons are estimated to have schizophrenia or other psychotic disorders. According to the National Commission on Correctional Health

Care (NCCHC) report for 2002, between 13.1 and 18.6% of prison inmates suffered from major depression, and between 2.1 and 4.4% had a bipolar disorder or manic episode.

Ditton (1999) estimates that 16% of the state prison inmates have mental illness, although the prevalence of mental illness among state prisoners varies widely with some studies suggesting that more than one third of the population have some degree of mental health impairment. This percentage (16%) is based on estimates of inmates who reported either a mental or emotional condition or an overnight stay in a psychiatric hospital.

Conditions of confinement may exacerbate mental illnesses. Prolonged idleness, forced inactivity, the constant threat of violence, feelings of guilt, hopelessness, and helplessness may all contribute to psychological disorders or worsening existing conditions (Schetky, 1998); nonetheless, periods of incarceration also provide opportunities for treatment (Rhodes, 2004). Nearly 12% of inmates received mental health therapy or counseling in 2000, and 10% received psychotropic medications, including anti-psychotics, antidepressants, stimulants, sedatives, tranquilizers, or other psychotropic medications (Beck and Maruschak, 2001). Such estimates likely underestimate the need for mental health intervention since some individuals refuse to participate, are never identified, or are ineligible for services; for example only 61% of inmates with mental illness reported receiving counseling, medication, or other mental health services in prison (Ditton, 1999).

Finland

A paucity of information on the prevalence of mental illness in Finnish prisons makes estimating rates difficult. The most recent study by the Finnish Prison Administration (2002), however, found that 14.1% of inmates had a psychiatric

diagnosis. This figure is based on the review of inmate health and mental health records, not including inmate face-to-face contact. An earlier study of Finnish prisoners (Joukamaa, 1991) found that among 903 sentenced and pre-trial inmates, 3% suffered from psychoses, 17% had personality disorders, 44% had alcoholism, and 6% had drug addiction. Based on the annual report of Vantaa Prison Specialized Housing for 2002, they served 97 male inmates averaging between 30 and 39 years of age. Most of the 97 inmates had co-occurring substance abuse disorders and were from the metropolitan Helsinki Area. No other information is currently available.

CHARACTERISTICS OF PERSONS WITH MENTAL ILLNESS IN PRISON

The United States of America

According to the Bureau of Justice Statistics (2002), in 2000, of state prison inmates with mental illnesses 20.1% experienced homelessness the year in which they were arrested compared to 12% of inmates without mental illnesses. Almost 4% were homeless at the time of their arrests, while 38.8% were unemployed. Kesler and Sibulkin (1994) conducted a self-survey that showed 53% of inmates with reported mental illness engaged in violent crimes as opposed to 46% of inmates who reported no histories of mental illness. Inmates with mental illnesses were more likely than others to have been convicted of a violent offense (e.g., murder, sexual assault, robbery, or assault). In state facilities, 53% of mentally ill inmates were convicted of a violent offense, compared to 46 percent of other inmates (www.pbs.org/wgbh/pages/frontline). Those with mental illnesses are often minorities (60 % of New Jersey's prison population), almost always indigent, and disabled by their mental illnesses.

ORGANIZATIONAL ISSUES IN PROVIDING MENTAL HEALTH SERVICES IN PRISONS

Costs

Human Rights Watch (2003) in its report, *Ill Equipped: U.S. Prisons and Offenders with Mental Illness* pointed out that the delivery of mental health care for inmates is expensive and particularly labor intensive for correctional administrators. Prisoners with mental illnesses need different services than their non-mentally ill counterparts. According to McVey, “not only does this population require more intense general supervision and more programming, but their illnesses and presenting behaviors may warrant extra medical attention, treatment, psychotropic medication, security, suicide precautions, and case management or transition services” (McVey, 2001:5). Additionally, because of their psychiatric illness and clinical symptoms, inmates with mental illnesses may have to be housed in areas with higher inmate-staff ratios. Their needs include nurses and special equipment not necessarily found in the general population (e.g., restraint chairs, padded cells, nursing stations). In addition to the cost of providing and maintaining the appropriate ratio of treatment staff to inmates, the high costs of psychotropic medication makes up a major part of an institution’s budget. Despite looming budget shortages, many state prison systems must provide mandated care in the most cost efficient manner. In contrast to the public, community mental health system, where an individual’s ability to pay may determine the quality of care, prison systems are required to make available mental health and medical treatment on the basis of a constitutional right to treatment under the Eighth Amendment. Failure to provide treatment constitutes grounds for civil lawsuits (Cohen & Dvoskin 1992; Cohen 1993).

Linking inmates to mental health services during incarceration can be less costly and disruptive, not only for the prison system; it can at least save expenses incurred by an untreated person with mental illness when the inmate returns to the general inmate population or to the community.

Funding shortfalls in public mental health systems and their effect on the delivery of community mental health services are well documented. Departments of correction are collectively experiencing similar budget constraints, which in turn affect the delivery of mental health services to prisoners. The effect of these constraints on mental health services, however, has received less attention. Fiscal constraints, rapidly increasing prison populations with multiple health and substance abuse issues, as well as legal decisions affecting obligations to treat persons with serious mental illnesses have all influenced correctional administration in local, state and federal prisons (www.drc.ohio.gov/web/articles/article71.htm).

Difficulties Prisoners with Mental Illness Face Coping in Prison

Prisons are a challenging environment for all prisoners; it is even more challenging for persons who are experiencing acute psychiatric disorders. For instance, Morgan, Edwards, and Faulkner (1993) research on the adaptation to prison by persons with schizophrenia concludes that “serious mental illnesses are stress sensitive: changes in housing, staffing, and routine may bring about an adverse reaction” (p. 51).

Increasingly, prisoners suffering from mental illness find themselves in places filled to capacity, in situations in which all prisoners struggle to maintain self-identity, autonomy, and emotional equilibrium despite the ever-present threat of violence, exploitation, and extortion; lack of privacy; limitations on outside contacts; and a paucity of educational

and vocational programs or other productive activities (HRW, 2003). Moreover, prisoners with mental illness are expected to endure and navigate surroundings they are not prepared to negotiate (HRW, 2002).

a) Physical Conditions

Persons with mental illnesses are usually housed in same cell block areas with non-mentally ill inmates except when psychiatric episodes require a transfer to inpatient care or hospital settings. Exacerbation of the illness and a threat to psychological and psychiatric stability can be caused by inmate overcrowding; a fact of many state prisons today (Nicholas v. Garrahy, 443 F. Supp. 956 (D. R.I., 1977)). Other factors like temperature (i.e., excessive heat or cold), noise level and other environmental conditions also produce stress, and intensify the symptoms of mental illness for some inmates (Thigpen et al., 2004). Environmental factors “elicit significant adjustment reactions from inmates who may not have had previous mental health diagnoses but who become ill during their incarceration” (Thigpen et al., 2004:6).

b) Propensity to Abuse by Others

Prison officials and mental health experts throughout the United States admit that victimization of prisoners with mental illnesses often happens at the hands of fellow inmates. For example, inmates with mental illness are vulnerable to assault, sexual abuse, exploitation, and extortion based on their behavior and an inability to comprehend and cope with surroundings. Vulnerability increases due to the inadequate training of correctional staff, both uniform and civilian, to properly monitor, supervise, and protect inmates with mental illnesses (HRW, 2003). In *Managing Special Populations*, Ortiz (2000) states “the stability of the prison community allows inmate groups, gangs, and

hierarchies to develop. Some groups can be problematic while others are potentially supportive” (p. 64). Ortiz claims that low inmate turnover correlates with the emergence of inmate weaknesses and vulnerabilities, thus becoming targets for exploitation. For instance, although inmates with mental illness are sometimes kept in designated areas to better protect them, it may not be enough as prison overcrowding leads to mixing inmates with different security levels and backgrounds where beds are available, leading to opportunities for further exploitation. Such vulnerability to mistreatment can cause inmates with mental illnesses to amass disciplinary infractions for disruptive behavior, leading to loss of or restrictions on privileges including early parole hearings (DiCataldo, Greer, and Profit, 1995).

c) Rule Breaking

Prisoners with mental illness may find it difficult to comply consistently with prison rules. Some exhibit their illness through disruptive behavior, belligerence, aggression, and violence. Others may simply refuse to follow routine orders to sit down, to come out of a cell, to stand up for the count, to remove clothes from cell bars, or to take showers or their medicine. Such rule violations, even if it is a direct result of mental illness, is routinely punished (e.g. C.F. v. Terhune decision). Profit (1995) finds “an elevated rate of incident reports for subjects who had been diagnosed with schizophrenia during their first ninety days of incarceration” (1995:573). The Bureau of Justice reports that persons with mental illness are “twice as likely as other prisoners to be involved in a fight” (Ditton, 1999b). Prison officials who are not trained to recognize signs and symptoms of mental illness in their inmate populations may misunderstand an inmate’s

aberrant behavior, which can lead from a minor incident to more serious one (Morgan, Edwards, and Faulkner, 1995).

d) Discipline for Misconduct

Successful prison management is predicated on obedience to rules. Rule-breaking is subject to discipline and punishment. When a prisoner with mental illness breaks the rules, punishment traditionally remains the default response (Human Rights Watch, 2003). Deciding whether a prisoner's mental illness ought to trigger punishment for infractions and to what degree is not an easy matter (Rhodes, 2004). The question of discipline is at the heart of the inherent tension between the security mission of prisons and mental health considerations (Rhodes, 2004). Prison officials have a legitimate need to maintain order; however, correctional professionals accommodating mental illness may encourage excuses for misconduct, condone malingering, or promote a breakdown in order. Further, administrators and correctional officers may assume that misconduct by prisoners with mental illness is intentional and may find it difficult to comprehend that illness can play a role in inappropriate behavior. As a result, inmates receive institutional disciplinary charges, which can often lead to a prolonged stay in administrative segregation and further decompensation.

PRIMARY MENTAL HEALTH TREATMENT GOALS IN PRISONS

Steadman (1993) and Dvoskin and Steadman (1989) state that the purpose of correctional treatment for persons with mental illness in prison should be a successful adjustment to the general prison population, which permits participation in rehabilitation programs and other activities. Because prisons house persons for a long period, they must be viewed as communities where an integrative approach to mental illness prevails

(Steadman, 1993). Policy increasingly seeks to treat inmates' illnesses and maximizing their participation in prison programs with the goal of returning persons with mental illness to the general prison population with reduced symptoms, improved medication compliance, and a reduction in symptoms associated with major mental illnesses.

Internal Barriers to Mental Health Service Delivery

In the context of an increasing presence of persons with mental illnesses in prisons, mental health services play an ever wider role. Prison staff, including corrections officers, have an increasing responsibility to advocate for the health and well-being of inmates under their supervision. Support or advocacy may take many shapes, for instance teaching inmates about their illness, speaking up for inmates when they may be incapable of doing so, and reducing obstacles to accessing mental health services. Advocacy, however, can be trumped by internal and informal barriers. Barriers to coordinated services exist at both the level of individual clients and at the institutional service system and staff levels. According to Rossman (2001) various factors impede service coordination from prison to the community, or services integration within the prison community. Some of these barriers may manifest themselves as deficiencies in the range of available services; inadequate resources to address the full complement of needs; a shifting landscape of local service providers, and high staff turnover in the service sector which weakens stable cross-agency interaction; and an ineffective system of information sharing that leaves former inmates ill-informed about available services and unable to take full advantage of them (Jacksonville Community Council, Inc., 2001; Morley et al., 1998; Rossman et al., 1999).

Prisons often are highly independent and resistant to change (Hammett, 1998). Institutional staff also may experience “cultural clashes.” Hammet (1998) notes that there are “real differences between the philosophies, perspectives, and priorities of public health (i.e., mental health) and correctional agencies that can make collaboration difficult if they are not sensitively handled” (p. 9). Rhodes (2004) reports that collaboration between prison administration and mental health staff exists; however, it tends to be fragile. Liska (1999) adds that although both entities are to a degree established to control behavior, prisons clearly stress physical constraints whereas mental health staff emphasize physical constraints and psychological treatment (including psychiatric medication management). For instance, the primary mission for prison administrators is security; that is, protection of inmates, staff, and visitors from violence. Mental health clinicians are concerned with the mental health status and quality of life of individuals in their caseload. The social work view of client self-determination (i.e., autonomy) many not be valid or safe, and may well conflict with prison policies. For example, mental health staff often try to improve inmates’ independent decision-making and self-efficacy skills; however, prison administration may be concerned that empowering inmates in this way will undermine discipline and order in the facility (Rossman, 2001).

In *The Health Status of Soon-to-be Released Inmates*, (2002) the National Commission on Correctional Health Care (NCCHC) identifies four main obstacles that affect correctional facility efforts to improve their medical and mental health services. The barriers consisted of 1) a lack of clear leadership; 2) the logistics of operating a prison; 3) limited resources; 4) and correctional policies pertaining to security and treatment. Lack of efficient leadership can obstruct or severely hinder delivery, quality,

and access to mental health care in prison settings. The NCCHC further reports that “some corrections administrators may not believe that inmates are entitled to the level of health care that this report suggests is needed” (p. 49). The report also finds various management-level prison personnel lack knowledge, education, or training in the understanding the significance of treating mental illness and various physical ailments as a public health issue that may eventually benefit the communities to which they return (p. 50). Furthermore, some correctional administrators still believe that physical and mental health treatment should not be the responsibility of prisons.

Additional barriers to in-house mental health services delivery include the logistics of “safety-encumbered administration procedures for distributing medications” (NCCHC, 2002:50). Hornung et al. (1998) state in the NCCHC report that “medication administration schedules and inmates’ ability to go to a pharmacy or telephone a doctor can impose extra steps in securing approval for a medication.”

The NCCHC report also cited standing correctional policies as barriers that interfere with providing proper health and mental health care to inmates. Policy barriers, as NCCHC refers to them, are reflected in rules that prevent inmates with co-occurring disorders from participating in prison-based substance abuse treatment programs. Such programs usually prohibit participants from taking psychotropic medications, effectively barring inmates with mental illness from taking part in substance abuse treatment. Another policy barrier comes in the form of privatized mental health care. The NCCHC reports that the “successful bidder may cut costs by reducing inmate access to medical staff, minimizing disease screening, or excluding newer, more expensive medications from their formularies of approved drugs” (p. 52). In all, these practices can lead to a

lack of clear clinical guidelines for treatment of inmates suffering from mental illness and other medical problems.

In summary, this section has identified barriers to improving mental health services to inmates with mental illness in U.S. prisons. In spite of compelling reasons for improving mental health delivery and its accessibility to prison inmates with mental illness, significant impediments remain. According to NCCHC, however, “with political will and commitment from corrections and public health administrators, most of these obstacles can be overcome” (p. 57). Some of the above mentioned issues are also relevant to Finnish prisons and are discussed briefly in the following section to provide a comparative framework of the correctional factors and underlying influences, including systematic or structural impediments, that hinder or enable internal barriers to prison mental health treatment programs.

Finland

The documents that shape the trajectories of prison inmates in Finland establish that treating psychiatric inmates is an important issue at Vantaa Prison. They include written directives of the UN – the Universal Declaration of Human Rights and Standard Minimum Rules for the Treatment of Prisoners – and European Prison Rules. They identify collectively and set the paradigm within which Finnish prisons go about creating, adjusting, and managing space for treatment purposes, along with supplying trained mental health staff to treat mentally ill inmates. Also, these international protocols jointly encourage the implementation of concrete and recognizable standards at the local prison level to do away with or uncover correctional barriers that affect inmates who are mentally ill. In addition, the written precedents stemming from international policies have

encouraged local correctional facilities to decrease barriers to mental health treatment by establishing a specialized housing unit at Vantaa Prison. As such, the principles articulate the right to the best available mental health treatment in prison. Further, the obligation to provide treatment to inmates in the least restrictive setting and to maintain and improve their autonomy reinforces this goal. In conclusion, the prevailing declarations and human rights standards view inmates who are mentally ill as both patients and inmates at Vantaa Prison. They encourage the parallel goals of custody, safety and treatment (ec.europa.eu/health/ph.../fp_promotion_2002_frep_15_en.pdf).

CHAPTER 3 THEORY

Introduction

Because deviance is an attributed designation rather than something inherent in people, this chapter focuses on the historical, social, and cultural processes that label people, behavior, attitudes, and activities deviant (Conrad & Schneider, 1992). Foucault (1977) likens the power to define and construct reality to the structure of power in a society at a given historical period. Another way of stating this is that the historical construction of deviance is closely connected with dominant social control institutions such as prisons and psychiatric hospitals. For example, the perspective of Conrad and Schneider (1992) emphasizes a dual point of view: the attribution of deviance as a historical, social construction of reality and the activities involved in new deviance definitions or designations for social control. The sections in this chapter examine these viewpoints of deviance relative to time, place, audience, and as a feature others bestow on other people. This chapter emphasizes the process of identifying, defining, and labeling behavior as abnormal. Rather than being viewed as an objective condition, deviance is regarded as a social product.

The second purpose of this chapter is to highlight the complexity of the relationship between two conflicting categorical types of deviance, namely 1) mentally ill and 2) criminal and how they intersect and coalesce when the person in question is labeled both. This is critical to the understanding that different definitions lead to different punishment and treatment paradigms. Questions such as “what is the impact is of having a label attached to one's self,” and “how does a label influence others' perceptions of, and responses to, the stigmatized person” will be discussed. In particular

these questions will be expressed in the framework of prisons and prison-based mental health programs and how this dual role repeatedly finds itself at the divide of custody and treatment (Becker, 1963; Rubington & Weinberg, 2002; Rhodes, 2004).

LABELING THEORY AND THEORIES OF MENTAL ILLNESS

Numerous theories, both criminological and sociological, highlight situations or circumstances taking place prior to a person's entry into a role considered “deviant” (Lemert, 1967; Schur, 1973). Most theories ask whether people who demonstrate deviant behaviors are different from those individuals who conform to societal norms. Somewhere, it is alleged, the “deviant” person failed, meaning that the process of his or her socialization was unsuccessful. People who commit crimes refuse to or are unable to internalized society's norms or they have taken on the norms and values of a subculture to which they pledge allegiance. Consequently, the concept of deviance becomes an objective phenomenon (Petee, 1987). What then do people who have been labeled deviant have in common? Rubington and Weinberg (2005:355) posit that “at a minimum they share a label and the experiences of being labeled as an outsider.”

Tannenbaum (1938) was one of the earliest supporters of the labeling theory and the interactionist perspective on deviance. The interactionist perspective holds that both a person's self and social role arise in the course of social interactions (Rubington and Weinberg, 2005:225). In essence this viewpoint concentrates on the actions and definitions of both the labeler and the labeled. To illustrate, Tannenbaum notes “the process of making a criminalis a process of tagging, defining, segregating, describing, emphasizing, making conscious and self-conscious; it becomes a way of stimulating, suggesting, emphasizing, and evoking the very traits complained of...the person becomes

the thing he is described as being.” Intrinsically, this process leads to community taking action because “the community cannot deal with people whom it cannot define” (Tannenbaum, 1938:19-20). Similarly, in *The New Conception of Deviance and Its Critics*, Kitsuse (1980) explains that “imputations of deviance are central to the process through which putative deviants are progressively identified, differentiated and sanctioned” (p. 11). His approach suggests that psychiatric conditions and the behaviors attached to those conditions are meaningless (Rubington & Weinberg, 2005:201).

Kitsuse sought to discover how “people (i.e. actors) conceptualize, use, and achieve accusations, portrayals, and other illustrations of these behaviors and conditions in dealing with and talking about candidate deviants” (Rubington & Weinberg, 2005:201).

Scheff (1974) claimed that this method is similar with “chronic mental patients created by labeling and mental hospital treatment” (Conrad & Schneider, 1992:65). Moreover, Scheff adds that persons in such groups find it difficult to reenter society and into conventional roles in the face of the master status, “ex-mental patient.” To Scheff (1964:403) “authorized decision makers presume that people with mental illnesses are in fact mentally ill.” Thus, the label creates “visible and invisible barriers to ‘normal’ interpersonal relationships and employment” (Conrad & Schneider, 1992:65). According to Rubington and Weinberg (2005), it was Becker (1963) who initially distinguished between ‘master’ and ‘auxiliary’ status traits claiming that “people who commit crimes are ‘asked’ to internalize a deviant or ‘criminal’ identity, to accept that their thoughts are merely typical of that of a deviant criminal, hence adopting an essential deviance as a master status” (p. 157). Directly associated with master statuses are auxiliary statuses (or traits), which according to Becker comprise sex, gender, socio- economic status,

educational level, behavioral attributes, etc. These traits tend to be directly connected to the person's master status. Scheff (1974) later popularized the labeling theory of mental illness by claiming social groups create psychiatric deviance by constructing rules for members of their cohort to follow. Those who defy the rules and conventional rituals are disparaged, shunned, and sneered at as Tannenbaum (1938) emphasizes. Akin to Becker (1963) and Tannenbaum, Scheff (1974) defines rule breaking as behaviors violating agreed upon rules of the group (i.e., informal social control) that lead to collective rejection by former peers. Scheff states "two concepts seem suited best to the task of discussing psychiatric symptoms from a sociological point of view: rule breaking and deviance" (p. 31). He proposes, however, that rule breaking alone does not lead others to label the person mentally ill, but instead "residual rule breaking" leads to the label of "mentally ill" (Cockerham, 2000). Scheff (1966) conceptualizes residual rule breaking as infringement on prevailing social behaviors or conventions (i.e. customs), for which there are no official or clear boundaries or labels. He claims that psychiatric symptoms arise from numerous factors and the violation of "these residual conventions go[es] beyond just violating norms; it involves acting contrary to human nature. Such 'unnatural' behavior may come to be regarded by others as mental illness" (Cockerham, 2000:120). Therefore, it is germane to specify the types of norms involved in the labeling process as most norm violators are not designated as mentally ill (Scheff, 1966). Becker (1963) claims "whether the act is significant or not is immaterial if an agreement is in place subjecting that behavior as deviant, nor should it imply automatically that behaviors are either deviant or not" (p. 7). He goes on to say "being caught and branded as deviant has important consequences for one's further social participation and self-image," adding

“the most important consequence is a drastic change in the individual’s public identity” (1963: 30). As a result of these reactions, one of the next steps in the developing deviant career is that “one tends to be cut off . . . from participation in more conventional groups” (1963: 34). Additionally, Rubington and Weinberg (2005) note “we cannot know whether a given act will be categorized as deviant until the response of others has occurred” (p. 9). And once the response is adjudicated and deemed offensive, the labeled people have less privacy and can be approached, interrogated, or sometimes detained at will under the auspices of police power or *parens patriae* doctrines (Walsh & Petee, 1987). For Walsh and Petee, people’s behaviors become a gauge that attaches them to a higher or lower threshold for attention and control. For example, under police power logic, patrol officers must use discretion and informal protocols to ascertain what level of attention is reasonable and practical. Under *parens patriae* doctrine police discretion is amplified and increases the threshold under which they can act to protect individuals deemed unable to protect themselves. Appelbaum (1997) comments that strange behavior in all likelihood will not result in a referral to mental health services provided it is not troublesome. If disturbing, however, it can result in an arrest. Consequently, that person may not attract enough attention to reach the relatively high threshold that the society typically uses as signals for mental health services referrals (www.hrw.org/reports/2003). As a result the process can become their punishment. Rubington & Weinberg (2005) contend that “deviant typing is also more apt to be effective if there is a sense that the alleged deviant is violating important norms and that the violations are extreme” (p. 4). Individuals found to break social rules (i.e., serious deviance) find themselves incapacitated in correctional or psychiatric institutions,

systems which not only differ in their balance of physical constraints but also in psychological therapy and economic sanctions (Liska, 1999:1745). Rosenhan (1973) epitomized this experience with his seminal study on labeling in a psychiatric institution. He and his graduate students sought treatment for non-existent psychiatric symptoms (i.e., auditory or visual hallucinations) in various psychiatric settings across the United States. Regardless of their lack of symptoms, each case concluded with the result of involuntary hospitalization for durations ranging from two weeks to three months. Despite the fact that these “patients” were not experiencing psychiatric symptoms of schizophrenia, the psychiatric staff “built” part of their personality and family history into a shape and form that fit into the pre-determined notions indicative of schizophrenia. Rosenhan’s study illustrates how psychiatric discourse (language) contributed to the formation of an illness category such as schizophrenia more than was previously believed. He suggests that a psychiatric diagnosis biases the minds of the witness and does not accurately reflect a patient’s characteristics.

In comparison, Scheff (1966) was more interested in the social processes of placing a label of mental illness on someone rather than an etiology of behavior. He believed that people suffering from mental illness were “created” through a labeling process in the context of treatment in psychiatric hospitals. Similarly, Goffman (1963) and Szasz (1972) challenge the medical model discourse of mental illness. Scheff (1966) later conceptualized a theory of becoming mentally ill by suggesting that “most patients’ behaviors are interpreted in the assumption that they are mentally ill” (p. 33). Spohl (1994) similarly states that this process “is essential because social order defines the confines and boundaries of our shared reality; and it is intrinsic to the conception of order

in that defining what is real and expected, defining what is acceptable, and defining what is unacceptable, and who we (i.e., the society) are not” (p. 56).

THEORY OF SOCIAL CONTROL AND SOCIAL ROLES

Social control is a central theme in sociology. Developed by Edward A. Ross (1901) around the turn of the 20th century, the term was used to depict the processes societies developed for regulating themselves (Conrad & Schneider, 1992). Social control meant social regulation. Its common sociological usage has changed, however. Parsons (1951) claimed that social control began to be used in a narrower sense to mean the control of deviance and the promotion of conformity. Because roles are concerned with action, social control is conceptualized as the means by which a society secures adherence to social norms, especially how it minimizes, eliminates, or normalizes deviant behavior (p. 7). He depicted society as a system and elaborated this view in detail in his seminal book, *The Social System*. In it Parsons states that institutions of social control (the media, the family, religion, law, medicine, criminal justice, prisons) are seen as sub-systems of the social system and serve to socialize society’s members according to appropriate roles, norms, and values. Parsons later broadened the theory of the social system through the articulation of the sick role by postulating that illness could only be understood properly if the patient was seen as a “whole person” (i.e., in a holistic framework) and within a total social context. For Parsons, human action cannot simply be understood by individualistic self-interests; rather it is based on the normative standards of the society in which it takes place. Moreover, Parsons formulates the concept of the sick role around four major aspects directly related to the central notion of the normative standards of his theory of social systems. He conceptualizes illness as

deviance largely based on its perceived threat “to the stability of a social system through its impact on role performance” (Conrad & Schneider, 1992). Criminal behavior and mental illness are considered violations of norms (social (actually legal) and medical) and can interrupt social life; the attributions of the etiology of these deviant behaviors are dissimilar (p. 32). It is within this framework that Parsons expands his concept of the sick role by highlighting those institutionalized expectations or normative standards that society holds for persons defined as sick:

1. “They are exempted from their usual social role obligations and expectations” (p. 437).
2. “They are not responsible for their incapacity because they are in a condition that must be taken care of” (p. 439).
3. “They can only enter the sick role on condition that they want to get well and leave the sick role because becoming a sick person is socially undesirable” (p. 440).
4. “They are obliged to seek technically qualified help and to cooperate in the prescribed therapy” (p. 441).

Concerning the first theme, Parsons argued that exemption from normal social roles is considered a right of the sick person (i.e., inmates with mental illness) and that the exemption is legitimized by others (i.e., prison psychiatrists). He further argued that the responsibility to seek that exemption has a moral quality because it is the obligation of others (prison staff) to identify the illness condition (i.e., mental illness) of the sick person (inmate). Rhodes (2004), however, modifies Parsons: “This exemption is limited, temporary, and subject to ongoing negotiation. It creates space for the possibility that

involuntary states of mind require specific forms of attention, while, at the same time, revealing the enmeshment of treatment in the project of control” (p. 103). Rhodes made this statement based on her ethnographic research, including participant observation and semi-structured interviews with prison staff and inmates with mental illnesses conducted over an eight year span (Sundt, 2004).

The second theme is closely associated with the normative standard that the sick person cannot be expected to get well by an act of will; they must be “taken care of” by, for example, group therapy or psychiatric medication, etc. Parsons argues that “there exists for the sick a culturally available ‘sick role’ that serves to conditionally legitimate the deviance of illness and channel the sick into the reintegrating physician-patient relationship” (Conrad & Schneider, 1992:32). Moreover, it is the goal of the doctor-patient relationship to “alter the conditions that prevent their conventionality” (Conrad & Schneider, 1992:32). It is this relationship, Conrad and Schneider claim, that becomes the essence of a social control function, of which the goal is “minimizing the disruptiveness of sickness to the group or society” (p. 32).

The third component is the definition of the state of being ill (i.e., psychotic behavior) as itself unwanted, with obligations to “want to get well” (Parsons, 1950, Twaddle, 1979). Parsons claims that the exemptions from the responsibilities of normal life (being in the general inmate population) and the privileges of the sick role (specialized housing) for sick persons entail social obligations. Patients or inmates must have the will to get well. The sick may be defined as responsible for their condition, if the continuation of being sick is seen as the result of a lack of motivation or “malingering” (Twaddle, 1979:43). And lastly, Parsons (1950) argues that the above

privileges should be seen as conditional because acknowledgement of the sick role obliges the sick (i.e., inmates) and others to seek competent help (i.e., referral to prison mental health staff). If being sick (i.e., mentally ill) is regarded as “deviant,” it is distinguished from other deviant roles because the sick person is not regarded as “responsible for his condition, he cannot help it” (Aubert & Messinger, 1958: 22). Such instances, Rhodes (2004) states, “shift the focus away from the individual choice and open up the potential for a slight softening of custodial power” (p. 108). Rhodes draws on the themes of power, knowledge, and self-regulation identified by Foucault in *Discipline and Punish* (1977). For instance, she emphasizes that Foucault “defined power as ‘action on action’ with diffuse effects that cannot be separated from those of knowledge” (Rhodes, 2004:261). Rhodes continues, “the outcome demonstrates the effects of power (police power) and knowledge (psychiatric) while revealing that neither is able or willing to fully encompass the other.” As an alternative, she posits that “custody and mental health treatment enter into a shifting tension that begins with disruption in the routines of containment taking place in total institutions where humanistic *parens patriae* approach to persons with mental illness frequently remains under the supervision of police power model” (p. 108).

Despite the criticism over sick roles mentioned above, positive benefits exist for persons assuming those roles. Parsons (1950) points out that individuals within sick roles are exempt from many day-to-day responsibilities. The sick role then presents itself as a form of temporary deviance (i.e. license to deviate). Additionally, by faking illness or malingering, some people such as inmates may “escape” from the general inmate population areas to more secluded or smaller specialized housing units. Complaining of

active symptoms of mental illness offers inmates respite from daily inmate routines and responsibilities. Mental health units offer a potential reprieve where a different set of questions – about the prisoner’s history, mental state, and responses to the prison environment - can be asked (Rhodes, 2004). Link et al. (1987,1989) note five positive consequences that result from labeling, institutional processing and treatment, and the ensuing stigmatization: 1) labeling provides patients “with legitimation for their post- and some pre-treatment behavior: 2) it exempts them from usual role obligations and relieves them from taxing, arduous duties; 3) it provides them with certain adaptive opportunities; 4) in some instances, it leads to stronger familial ties (cf. Link et al., 1989); and 5) for some, it serves as a personal growth experience” (Rubington & Weinberg, 2005:240). In addition to those five factors, efficient treatment of inmates frequently involves services provided by a multidisciplinary treatment team that sometimes includes correctional officers. Corrections officer involvement is particularly important. They assist in making continuing observations and interventions, and they take part in a unique position in specialized housing units. Successful teamwork between prison officers, prison management, and mental health treatment teams necessitates a basis of reciprocated respect, joint training, and constant communication and cooperation. With these essentials in place, correctional officers can help the treatment team and establish vital and useful contributions to the evaluation and supervision of inmates who have mental disorders (Applebaum et al. 2001). Numerous researchers, however, report differences in correctional philosophy between prison security staff and mental health staff result in conflict between the two groups (Powelson and Bendix, 1951; Cormier, 1973; Cumming & Solway, 1973; Kaufman, 1973).

CHANGING DESIGNATIONS OF DEVIANCE AND SOCIAL CONTROL

Who is purported to be deviant? According to Kittrie (1971) deviants are not at all a homogenous group, and the symptoms that distinguish them for collective attention are not simple to classify. The manifestations of some symptoms are mainly medical. Others may manifest their alleged deviance through intellectual, social, economic, sexual, or doctrinal eccentricity. What they all have in common, however, is that their deviant behavior is regularly forbidden or controlled by law (Kittrie, 1971). They also share the distinction of being increasingly sought out for punishment instead of treatment (based on prevailing public policies). While no all-inclusive term has been coined to encompass these diverse groups that, when labeled as patients, become subjected to therapeutic controls, they are called “deviants” in order to differentiate them from “criminals” who remain subject to the traditional criminal sanctions (Kittrie, 1971).

Social control by means of criminal sanctions is the power to have a particular set of definitions of the world realized in both spirit and practice (Kittrie, 1971). To the extent that such definitions receive widespread and/or significant social support, this power becomes ubiquitous authority and thereby considerably more secure from attack and challenge from the people it is meant to control. This authority, not uncommonly, may become vested in dominant institutions (Foucault, 1977). Foucault, among other social historians, studied the emergence of dominant institutions of social control in Europe and the United States during the 17th, 18th, and 19th centuries which included asylums, prisons, reformatories, orphanages, and almshouses” (Liska et al. 1999:1746). Even though these institutions seem to have achieved more control than reform and rehabilitation, Liska et al. (1999) posit that they “embed the social reformers in the class culture of capitalism by

explaining the emergence of these institutions as response by the elite classes to discipline and control the masses to the rhythm of capitalism” (p. 1747). Although some social theorists may disagree with the assertions of Ignatieff (1978) and Scull (1977), Liska et al. point out that “social historians tend to agree that contemporary correctional and mental health systems emerged together as complementary responses by authorities and elites to the threat of urban disorder associated with urbanization, industrialization, and capitalism.” As a result, “theoretical issues underlining treatment and correctional philosophies that cut across these forms are blurred, and the boundaries that define them are often diffuse and vague” (Liska et al., 1999:1747). Moreover, Conrad and Schneider (1992) claim “in the face of entrenched criminal definitions of deviance, the medicalization of deviance cannot occur without some type of approval by the state” (p. 270). What is considered deviant in a society is also a product of a political process of decision making because behaviors or activities regarded as deviant in any society are not self-evident; they are defined by groups with the ability to legitimate and enforce their definitions (Conrad & Schneider, 1992). Those failing to adapt to the definitions set forth for them are sometimes persuaded to adopt the master status which comes with a set of “new rights and duties or changes in old ones and a new set of expectations about future conduct” (Rubington & Weinberg, 2005:5; Goffman, 1963).

SHIFT BETWEEN MEDICALIZATION AND CRIMINALIZATION OF MENTAL ILLNESS OVER TIME USA

After World War II, Deutsch (1949) began reporting and exposing abuses taking place in many state-run mental hospitals in the United States, portraying them as “snake

pits” that did nothing more than “warehouse” persons with mental illnesses. Deutsch found a supporter in Groups for the Advancement of Psychiatry (GAP), an organization which decried the inhumane conditions of many psychiatric hospitals. GAP claimed mental hospitals did nothing more than keep people off the streets, while yet stigmatizing them (Grob, 1991).

With the arrival of effective psychotropic medications in the early 1950s, the institutional warehousing of persons with mental illnesses was “declared deleterious, unnecessary, and obsolete” (Thomas, 1998). In the early 1960s, community mental health centers were established to address the needs of people being released from psychiatric hospitals (Grob, 1991). In 1963, the Federal government passed the Community Mental Health Act (CMHA), which aimed to change radically the way in which persons with mental illnesses were to be treated (i.e. more humane). The primary goal of CMHA was to reduce the volume of persons with mental illnesses lingering in state psychiatric hospitals and allow them to live in their communities under least restrictive settings while getting treatment (Grob, 1991). The locus of treatment changed. Deinstitutionalization ensued. Durham (1989) posits that this policy shift in psychiatric treatment, dubbed “deinstitutionalization” “was at the core of a bold new treatment of mental illness” (p. 119). This policy, however, was never entirely funded and fell far short of its mission (Dumont, 1982). By default and connected to deinstitutionalization policies, law enforcement officials throughout major cities bore the initial impact of these failed policies by being the default front-line workers, often with no training in mental illness yet with increased contact and exposure to persons with mental illnesses. Deinstitutionalization sent scores of persons with mental illnesses from state psychiatric

hospitals to communities where their bizarre or unusual behaviors were met with disdain, hostility, and greater police presence. Arrests and incarcerations of persons with mental illnesses frequently followed for nuisance and other minor offences (Link et al. 1987). Also, because of more restrictive civil commitment laws, persons with mental illnesses were at times channeled through the criminal justice system rather than civil commitment procedures. Rothman (1971), and later Arvanites (1988) argued that public psychiatric hospitals traditionally controlled (i.e., institutionalized) a broad range of people considered non-threatening who might otherwise have ended up in the criminal justice system. This marks the beginning of the medicalization of deviance (Liska et al., 1999).

The criminal justice system today functions as a conduit or gateway to the mental health system. It has adopted an increasingly punitive approach to the handling and treatment of people who do not fit societal norms. The police accomplish this repeatedly by arresting persons with mental illnesses and transporting them to jail via “mercy bookings” (Torrey, 1992). In addition, persons with mental illness may be more likely to demonstrate behaviors that bring them to the attention of local police departments mainly under local quality of life and zero tolerance policies. Likewise, mandatory minimum sentences that carry long penalties for drug offenses and restrictions on access to support systems like welfare are all reflections of a punitive rather than problem-solving (i.e., *parens patriae*) approach. Some claim that deinstitutionalization has led to the criminalization of persons suffering from psychiatric disorders because they are frequently arrested under the auspices of these policies. The criminalization hypothesis posits that people with mental illness are being processed improperly through the criminal justice system rather than through the mental health and social service system.

Police officers may resort to arrest even when treatment is clearly needed. Dvoskin and Steadman (1994) reported that “without recourse to state hospitals or community mental health centers, police frequently have had to arrest persons with mental illnesses, even for minor offenses that resulted from their mental illness rather than from their criminality” (p. 313). Arrests by police were more likely “when the public behaviors of people with mental illnesses were construed as intimidating” (Lurigio & Lewis, 1987). Teplin (1984a, b) conducted over 1,000 observations of encounters between police and civilians and found that “for similar behaviors and offenses, persons showing obvious signs and symptoms of mental illnesses had greater chances of being arrested than those who did not” (p. 314). Moreover, Teplin (1984a,b) observed that persons were arrested when their behavior went beyond the limits of tolerance, was considered deviant, likely to continue, proliferate, or required later police intervention. Teplin’s research (1984; 1990), by focusing on police judgment and decision making processes, also found that police resorted to arrest when treatment facilities refused to accept a person with a mental disorder. She discovered that “police frequently divert problematic people to mental hospitals via arrest (police power) and pretrial jail admission” (1999: 1752). According to the Group for the Advancement of Psychiatry (1994) the principal justification for coercive power is centered on the argument that the society has the need and right to protect its members, both individually and collectively, from those who will not or cannot exert self-control.

Police Power vs. Parens Patriae in Psychiatry

Police power is exerted after the fact, not before, but parens patriae is preemptive in nature. Coercive police power follows an act or behavior: the threat of criminal acts is

typically understood as a crime and thus calls for coercive police power. Schopp (2001) states that police power and *parens patriae* doctrines both “intrude on individual liberty” (p. 3) and together represent traditional sources of authority for government intrusion into individual action and limitation on individual liberty” (p. 75). Both have the power to isolate and remove. Many would argue that psychiatry typically invokes *parens patriae* in order to treat people who need treatment, sometimes against their will. The state has the right to take coercive action against individuals for the benefit of the society in order to protect itself from “dangerous people.” Police power (i.e., a punitive approach under *parens patriae*) is based on the contention that preventive detention can prevent future dangerous behavior. Cockerham (2000) notes, that “their (persons with mental illness) commitment (or detention) is based upon a psychiatric prediction that is made before they actually have acted as predicted. In contrast, under criminal law a person has to be found guilty of committing a crime before being confined” (p. 294). According to Cockerham (2000), such action became permissible under the humanistic principle of *parens patriae* as a response to deviance.

Police Power vs. *Parens Patriae* in Criminal Justice

Under the doctrine of *parens patriae* parenting becomes the central metaphor for how the state creates a space for law enforcement officials and criminal justice personnel to act with compassion toward persons with mental illnesses (Rhodes, 2004). Within this general framework of helping, there are two major approaches available for law enforcement, court personnel, and prison staff: one looks to offender histories for explanations, an approach that is psychotherapeutically oriented (e.g. behavior modification, client centered therapy, or crisis intervention) although not necessarily

dependent upon any particular orientation. The other looks to behavior. These two guidelines coexist despite contradictions between them, and in combination they make up the main alternatives available to criminal justice workers attempting to intervene in the lives of their charges (Rose, 1998). Consequently, the individual rights of offenders with mental illnesses are balanced against the rights of the greater community. As social control institutions take formal control over aspects of the mental health treatment of persons under police power or *parens patriae*, the individuals in the custody and care of these institutions lose their autonomy to make decisions that will affect their course of treatment.

Historical Foundations of Coercive Control

According to Foucault (1965) “throughout history there have been recordings of the deviations of the insane, both kind and frenzied.” Moreover, Kittrie (1971) writes that the contrasting images of the village fool, on the one hand, and the violent demoniac, on the other, are deeply embedded in the folk literature of all people. The concept of madness and the madman have long conveyed ambiguous images of both mockery and menace (Foucault, 1965).

Society in the Middle Ages exhibited a great intolerance for deviance. Widespread poverty, disease, mass movements of populations, and religious fanaticism made the lot of persons with mental illnesses unbearable. They were thought to be possessed by the devil. To prevent them from doing harm strict controls were implemented on persons with mental illness, as well as on a large number of others considered deviant (Kittrie, 1971).

While during the Middle Ages persons with mental illnesses faced social expulsion, the Renaissance confined them (Foucault, 1961). Historians see this as a predictable change, not as a chance development. The vacated institutions formerly occupied by leprosy patients provided the space and the facilities for the next step in the treatment of the socially unfit in Europe (Foucault, 1961; Kittrie, 1971).

In Europe, persons with mental illness were often executed as witches, chained, or thrown into gate houses and prisons, where they might furnish horrible diversion for the other prisoners (Ives, 1914; Erickson, 1966). Those who were more fortunate were driven out of the city into forced exile. In Northern Europe, two modes of ritual exclusion were developed: the Ship of Fools (das Narrenschiff) and pilgrimages to holy places (Foucault, 1961). Entire ships were chartered, and persons with mental illness were entrusted to seamen to be dropped off in uninhabitable places. People considered to be “mad” were taken on pilgrimages to specially created shrines in the hope of recovery (Kittrie, 1971). It should be noted that following differences in definitions, perceived threats, and prognoses treatment of persons with mental illnesses vacillated between punishment and rehabilitation (Veysey, 2005).

SOURCES OF STATE RESPONSIBILITY FOR PERSONS WITH MENTAL ILLNESSES

USA

Penrose (1939) states in *Mental Disease and Crime: Outline for Comparative Study of European Statistics* that agencies of social control develop from physically controlling people (prisons) to medically treating them (asylums, hospitals) and contends that an inverse relationship exists between correctional and psychiatric hospital

populations (Liska et al. 1999:1748). Analogous to Penrose's hypothesis, Abramson (1972) describes how people with mental illness, when arrested, are shuttled through their respective criminal justice system, which serves as a gateway to mental health treatment. Kagan (1990) notes that the criminal justice system has been assuming the state hospital's role of moving people with mental illnesses from the streets into custodial care and initiating the process of medicalization of deviance (p. 313). A second belief linking mental illness with the criminal justice system is that persons with mental illness are dangerous and likely to commit crimes, especially violent crimes. Going back at least to the Greco-Roman period, the public has believed that a disproportionate number of the people who are mentally ill were volatile and terrifying (Monahan 1992; Rosen 1968). According to Wahl (1995) "the frenzied madman, the 'psycho' who is driven to harm others and the delusional paranoid who unexpectedly and randomly kills is regular grist for television and motion picture studios as well as features for the news media" (p. 46). These beliefs continue to be reinforced today in imaginary tales and news stories targeted as human interest stories (Gerbner et al. 1981; Steadman & Cocozza, 1978). They also fuel the demand for the state to continue maintaining responsibility for this population.

Durkheim (1893/1933) notes in *The Division of Labor in Society* that "as societies develop from simple to complex, sanctions for deviance change from repressive to restitutive or from punishment to rehabilitation" (p.32). Although Durkheim failed to foresee the beginning of the medicalization of deviance, he felt "it is clear that medicine is the central restitutive agent in our society" (Conrad & Schneider, 1992:33). Rieff (1966) moves the symbolic center of the Western society away from the church and later parliament to the hospital. In *Profession of Medicine*, Freidson (1970a) claims that "the

medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively” (p. 251).

According to Deutch (1949), the state’s authority to exercise power over persons with mental illnesses derives from three distinct conceptual sources fundamental to the Anglo-American political system. The state as protector of the peace may exercise its general policing powers in all cases where public order is disturbed or threatened. As previously stated, this power of the state to protect the peace and the public welfare by necessity included the right to restrain violent people (Freund, 1904; American Jurist, 1964). New York State provided one of the first examples of coercive power over those with mental illness in a law that allowed for confining the “furiously mad” to prevent acts of violence (New York Laws of 1788, ch. 31). Specific commitment laws later amplified police power over violently disturbed persons, but general police power still serves as authority for the control of persons with mental illness when specific legislation is lacking (Teplin & Pruett, 1992).

The second source for the state authority is contained in the doctrine of *parens patriae* (Blackstone, 1783). According to Wilson, (1973), “Western law treats the state as a protector and arbiter of justice. But this is not the only conceivable relation of the state to its citizens” (p. 22). He continues “from Roman law comes the idea that in some circumstances the state should relate to the citizens as the parent to his child, a doctrine known as ‘*parens patriae*’” (p. 2). Historically, the therapeutic ideal behind *parens patriae* is traceable to the common law concept of the benevolent role of the sovereign as the guardian of his people. Szasz (1963) comments that “with parental gift comes parental discipline” (p. 35). Similarly Kittrie (1971) states “the King, as *parens patriae*, has the

general superintendence of all charities” Kittrie continues, “The subject of these proceedings was not punished or burdened with a criminal record, but she or he was confined for a long and often indefinite period” (p. 84). Repression and police power were the major tools of post-medieval society’s search for social order and tranquility. In United Kingdom, common law and the traditional criminal process flourished, although the role of the sovereign as *parens patriae* was rather limited in the common-law-tradition (Attenborough, 1922). But by the middle of the 14th century common law and customary criminal process procedures were extended to people with mental illness and were made a duty of the Crown. Prior to that churches and feudal lords had responsibility for the care of individuals who were mentally ill.

The power asserted by the Crown over indigent persons with mental illness as members of the pauper community was the third source of state authority. Until the beginning of the 16th century, the Church was responsible for meeting the needs of poor people (American Jurist, 1960). In addition, economic changes of the time enlarged the pauper class. The conversion of cultivated lands into enclosed pastures for sheep farming in connection with England’s wool industry led to massive unemployment. The Church could not meet the new welfare demands with its weakened resources, and civil authorities were forced to assume responsibility for a large uprooted population (Gash, 1973).

Until modern times, Western societies for the most part failed to differentiate between common criminals, vagrants, the indigent, and people with mental illnesses. Everyone was subjected to the criminal law and customary criminal penalties; authorities applied the death sentence, bondage, transportation, and later incarceration without

distinction to the sane and mentally ill or to the violent offender and meek social outcasts, whose only crime was poverty and an inability to care for themselves (Kittrie, 1971).

Utilizing recently abandoned monasteries and leprosaria allowed the development of internment programs for the growing number of common paupers and other social misfits. Leprosy had vanished; however, its structures remained. "Often, in these same places, the formulas of exclusion would be repeated....[p]oor vagabonds... and 'deranged minds' [taking] the part played by the leper" (Foucault, 1961).

Society's recognition of the special character of the persons with mental illness came in two different phases (Kittrie, 1971). The first was a belief that they were relatively harmless, yet the indigent with mental illness, charged with nothing more than mental illness, continued to be thrown into jails and workhouses together with idlers, alcoholics, and beggars. The growth in the number of specific institutions for the care of people with mental illnesses during the first quarter of the 19th century led to the second stage in divesting the criminal processing system of authority over persons deemed insane. Bringing together various features of the workhouse and the public hospital, the mental asylum grew out of these earlier institutions (Halliday, 1828). The hospitalization of persons with mental illness was institutional progeny of the 17th and 18th centuries (Kittrie, 1971). According to Foucault (1961) "[I]n the history of unreason, it marked a decisive event: the moment when madness was perceived on the social horizon of poverty, of incapacity to work, of inability to integrate with the group, the moment when madness began to rank among the problems of the city" (1961:55). The new institutional model, however, was also compulsory and, like incarceration, stood for total exclusion (Carter, 1819, Goffman, 1961). As long as therapeutic science, the skills in treating and

the etiology of mental illness, remained undeveloped, confinement in the name of *parens patriae* functioned more as a preventive detention measure (i.e., police power) for the benefit of the society than as an individually oriented program of treatment (Conrad & Schneider, 1992).

Parens patriae symbolizes various American social experiments in crime prevention rather than crime management (Kittrie, 1971). In criminal law the state takes on the role of the accuser and penalizer; in *parens patriae* doctrine, the state functions in a paternal and therapeutic role. Szasz (1963) contends that *parens patriae* creates interventionism. The premise of interventionism centers on the justification of interfering with the choices people make. Thus, the *parens patriae* approach presents an opportunity for ever-expanding the territory over which American society shifts from crime repression and management to prevention (Allen, 1964; Deflem, 1992).

POLICE AND THE CONCEPTS OF PARENS PATRIAE AND POLICE POWER

Finland

In Finland, the protocol for involuntary admission (commitment) to a psychiatric hospital by police is governed by the 1990 Mental Health Act. The Act combines three separate laws, which include the Police Law passed in 1995, the Finnish Constitution, and the Law Governing Pre-Trial Detainees ratified in 1987. The Police Law is similar to *parens patriae* doctrine and police power in the United States because it allows patrol officers to detain people in order to protect them from themselves and/or others. This approach is based on paternalism coupled with an emphasis on the basic human rights of the detainees. It means that the autonomy of the detainee becomes a central aspect in the process, though people can be committed under a lower standard or threshold to protect

them. In addition, general Finnish mental health law does not contain “dangerousness” as a decisive factor or precondition for involuntary admission or detention of people with mental illnesses. Although Finnish mental health law does not absolve people with mental illness from criminal responsibility, humanistic and paternal emphases prevail which means detainees are initially diverted from the criminal justice system to other forms of social control institutions. According to the WHO (2001), Finnish mental health legislation stresses interagency collaboration between agencies responsible for supervising, providing treatment, and treating persons with mental illnesses and criminal justice agencies. Particularly, “an explicit requirement that the specialized and primary health care services work together, as well as requiring cooperation between health care, police agencies, correctional system and welfare services” (2001:27). Based on this synergy, police detainees are first transported to the nearest health center for a psychiatric evaluation rather than to a detention center. The main purpose of this tactic is to reduce incidences via prisons or other social control agencies of forced admittance to mental health care (Wall et al., 1999). It should also be noted that under the 1973 Substance Abuse Legislation, police have the right to detain and transport people who are under the influence of substances, to the nearest police lock-up⁴ for detoxification.

HISTORY OF TREATMENT OF PEOPLE WITH MENTAL ILLNESS

Finland

In the city of Turku, places called “Holy Spirit Rooms” were established for people with mental illnesses. Their function was similar to that of asylums. The first asylum was built in Helsinki, the capital of Finland, in 1555. Subsequently, the Church

⁴ City jails have a dual function of holding pre-trial detainees and people in need of sobering up.

Law of 1686 mandated that various congregations had the moral responsibility for people with mental illnesses. According to Sarvilinna (1938) the responsibility to care for people with mental illness at that moment in time was assigned to local churches because the prevailing belief was that they were possessed by demons. With the permission of the Church, treatment consisted of going from house to house to offer help. Most of those suffering mental illness were held in shackles by their keepers because the general population considered them dangerous (Finnish Central Association for Mental Health, 2000).

As early as the 16th century, Finland began building hospitals to treat people with infectious diseases. At the same time, Finland also experienced a growth in its leprosy population. According to Turunen and Achte (1983), an island off the coast of Turku was designated for people with leprosy and mental illness. The island was called Nauvo and the hospital/leprosarium was named Seili. The island began officially accepting leprosy and psychiatric patients in 1624.

The island residents were mostly left to fend for themselves. Each month they received an allocation of meat, fish, butter, salt, and grain from which they had to prepare their own meals. If patients were lucky enough to have money, they were permitted to accompany non-mentally ill island residents to shop in nearby villages. The hospital staff was sparse consisting of local pastors, farmers, and blacksmiths. The pastor served as the overseer of the staff and patients. Subsequently various churches built leprosaria specifically to house not only people with mental illness but those considered deviant in character, behavior, or appearance (Eskola, 1983). Leprosaria like Seili were called “Hospitaali” (in Finnish) where patients were held in segregation and restrained in hand

and leg irons, cuffs, and shackles (Eskola, 1983:203-204). Treatment was religious; with prayers and rituals of repentance. Humanistic treatment of people with mental illness had not yet taken hold in Finland. The functions of this and similar institutions changed in the 17th century to house solely persons with mental illnesses. Such places were derogatorily referred to as “crazy rooms” (Mielekäs, 1999).

The responsibility of individual counties toward people with mental illnesses increased towards the end of the 19th century. In 1889, the Mandate of the Caesar increased county responsibilities for long-term care of people with mental illnesses. In 1929 the Republic Law urged counties to build county mental hospitals throughout Finland. This began in earnest in 1952. That same year laws governing treatment for mental illness were passed, creating regional psychiatric hospitals with government support. From 1952 to 1970, many more psychiatric hospitals were built. At the end of the 1970s, community based mental health care began to develop, and in 1978, changes in the law strengthened the position of community mental health agencies and brought supportive psychiatric housing programs under the economic umbrella of the government. Starting in 1976 and continuing until 1991, a population-based (i.e. catchment area) psychiatric blueprint was developed and the organization of psychiatric services was assigned entirely to local counties starting in 1993.

In the 1980s there were still approximately 20,000 psychiatric beds (4.2 per 1,000 residents) in Finland, most of them in psychiatric hospitals. The beds were distributed among 100 different hospitals; none of which had more than 1,000 beds each (WHO, 2001). During the 1980's, the number of psychiatric beds decreased from 20,000 to 12,000 (www.euro.who.int/mentalhealth) as result of deinstitutionalization. By the end of

the 1990s 6,200 beds were in use. The loss in psychiatric beds was compensated for by increased out-patient psychiatric treatment options; the most common method of treatment for people with mental illness in Finland today.

THE EARLY EXPERIENCES OF PEOPLE WITH MENTAL ILLNESSES

USA

Although a few special institutions for persons with mental illness existed in America in the latter part of the 18th century, widespread involuntary commitment practices were not instituted until the first quarter of the 19th century. Still, persons with mental illness encountered the law long before that, usually in conjunction with the general criminal law or the poor laws (Deutch, 1937; Kittrie, 1971). Those who committed criminal law offenses or were predisposed to violence were detained in jails or similar facilities. The housing and treatment of both criminal offenders and individuals with mental illness in prisons and jails have been recurring themes in corrections since confinement became a socially accepted means of punishment (Roberts, 1997). Under common law, offenders who were insane or mentally ill were exempted from criminal punishment, but they were often committed to the care of a magistrate who confined them in local jails as a means of protecting the public (Deutsch, 1937). People who were considered violent and persons with mental illnesses were treated similarly to persons who were paupers, meaning some communities provided them with food and shelter while others prosecuted them. Carefully following the patterns of the Elizabethan Poor Law Act of 1601, the American colonies' welfare programs emphasized repression rather than relief (Drake, 1878). There were few distinctions among tools of repression, correction, and therapy for persons with mental illness and others considered deviant in

early colonial America. When houses of corrections were first built they were intended to hold criminals, the poor, and people considered mad. Similarly, until the middle of the 19th century almshouses functioned as a dumping ground for the abandoned, sick, aged, infirm, young, mentally ill people, “feeble-minded,” vagrant, and the like (Gillin, 1926). In Essex County, New Jersey, present day home of Northern State Prison, men, women, and children, including people with mental illnesses, were frequently sent to jail together, often in the same facility (McShane & Williams, 1996).

The practice of dumping resulted in deplorable living circumstances and prompted reformers such as Dorothea Dix to lobby state legislators in New Jersey and other states for separate facilities to house persons with mental illness. The ideas of the asylum and the asylum cure required proponents to spread the word (Conrad & Schneider, 1992). During the early 1800s, Dix arrived in New Jersey to buttress support for the construction of a modern state asylum. To demonstrate her point, she traveled around the state making observations while documenting deplorable living conditions in which she found many people with mental illness confined. She found people living in dirt, chained, and subject to regular beatings. At the Morris County Poor House, she discovered that people with serious mental illnesses were detained in the cellar, unsuitable for even animals (Mappen, 2004). During her journey, Dix faced stiff opposition from policy and law makers, though in the end, her success was extraordinary. The New Jersey State Lunatic Asylum, currently known as Trenton Psychiatric Hospital, was built in Ewing Township in 1848. By 1880 there were 75 state asylums, 32 of which were founded as a direct result of her efforts (Conrad & Schneider, 1992). With Dix’ success came the advent of mental asylums and the removal of many noncriminal people

with mental disorders from prisons and jail. The movement for reform held out the hope of treatment rather than punishment.

MENTAL ILLNESS, TOTAL INSTITUTIONS AND THE ROLE OF STIGMA USA

Erving Goffman's (1963) contribution to sociology is remarkable, and he was influential in reforming American psychiatric institutions and the treatment provided in them. His book, *Asylum* contains a collection of essays on psychiatric hospitals and other total institutions such as hospitals, army barracks, boarding schools, and prisons. He depicts these organizations as "total institutions" because they are bureaucratically organized residential establishments where people conduct all of their daily activities of sleeping, eating and playing with the same people and under the same authority. These institutions have subjects (i.e., inmates, patients, etc.) supervised by managers (i.e., prison guards, nurses, doctors, etc.). Goffman describes an elaborate system of formal rules established to protect the community against what are felt to be intentional or impending dangers. His intent in *Asylum* is to develop a sociological view of the structure of the self within the framework of a total institution where self-identity is "stripped off." In other words, he explains what is "normal" can be understood and examined by looking at what is not "normal." He reveals that psychiatric patients experience a "moral career" and argues that the process of institutionalization (i.e., incarceration) is social – among other socially defined issues incarceration contends with is the visibility of "abnormal behavior." Hospital regimes (or prison management) undermine the "civilian self" (or the free self of prisoners) by stipulating every aspect of how to behave. They enact a

ritual of “mortification” which consists of a process that strips personal identity and replaces it with a substitute for what has been taken (i.e. an inmate with mental illness).

Stigma plays a significant role in institutions like prisons, and it can determine the attitude of prison staff toward inmates with mental illness. For example, prisoners with substance abuse problems may be perceived as having a weak disposition or moral character. Prisoners with mental illness may be seen as “crazy,” “loony,” or intentionally causing trouble. Moreover, merely being ill (i.e., mentally ill) can attract a condescending attitude not only from other inmates but from prison officers and staff as well. Prison guards and non-mentally ill inmates may ignore inmates with mental illness or denigrate their actions when they ask questions or seek to clarify information concerning their mental health condition, types of psychiatric treatment available, or cell assignments. Furthermore, demeaning reactions are a common feature of total institutions (prisons) that seek to streamline treatment and of medical (psychiatric) dominance in which doctors and other staff seek to control patients (inmates) (Becker, 1963; Williams, 1987; Rhodes, 2004). Sociologists influenced by Goffman’s work argue that in terms of mental health treatment, the process of institutionalization can have several negative effects because management of the institution overrides the more general concerns about patient welfare (i.e., police power over *parens patriae*). For Goffman (1959:125) “the passage from a person to mental health inmate (in prison setting) can function as a type of betrayal funnel and be effected through a series of linked stages, each managed by a different agent.” Rubington and Weinberg (2005:131) add that each agent’s framework of operation is reflected by the rules, beliefs, and practices that underlie the formal processing of stigmatized deviants.

Goffman (1963) argues that stigma is a relationship of devaluation in which people are disqualified from full social acceptance. Stigma is inherent in theories of deviance and non-conformity. Consequently, stigma is a process of applying a label to describe someone's non-conformist, or simply different, behavior. The value of Goffman's definition of stigma lies in its applicability as a conceptual framework, a prototypic blueprint for the analysis of stigmatizing illness conditions (Williams, 1987). Stigmatization also appears in the psychiatric context or discourse (Foucault, 1961). It is evidenced in patients (i.e., inmates) with psychotic behaviors or in "special need inmates." Stigma can occur as a result of chronic illness (i.e., schizophrenia, ex-offender) or from one's mental health record (i.e., prison mental health jacket), which may prevent or assist in accessing services. Furthermore, inherent in the process of stigmatization is the issue of social control. In some instances the label is never removed (eg. schizophrenia in remission). The labeled person becomes the label. Becker (1963) claimed that labels are subjectively attached and persons may be wrongly labeled deviant even in the absence of guilt. Deviants are not an aggregate of people who have committed similar acts, but are a collection of individuals who have been stigmatized as deviants by various social control agents (Conrad & Schneider, 1992).

TREATMENT STAFF STANCE IN A PUNITIVE ENVIRONMENT

Morison and Pollard (2000:8) note that correctional treatment staff must constantly juggle and deal with tension inherent in the diverging goals of treatment and security. The most important of these tensions can be the decision where to house prisoners with mental illnesses inside the prison (i.e. initial cell assignment, movement between prisons and housing units, and transfer and discharge from specialized housing).

Treatment staff must adhere to the imperative that security prevails as the absolute arbiter of all treatment-related decisions (Morison & Pollard, 2000). Within this framework, however, there will be choices between treatment placement and security requirements. This happens frequently within the context of a punitive atmosphere in which two divergent, and at times hostile, correctional philosophies coexist and share a reciprocal codependence. In situations like these, cross-alignment may occur suggesting a corresponding complexity along custody, treatment philosophies, and boundary lines (Rhodes, 2004:133).

In their study of the goals of corrections, Kifer, Hemmes and Stohr (2003) ask whether custody workers ought to punish those whose awareness of what they are doing seems limited but not entirely absent. The staff wishes to help inmates with mental illnesses and the need for power over those same prisoners creates friction. This conflict can inevitably lead to role confusion (Poole & Regoli, 1980; Toch & Klofas, 1982). Specifically, prison mental health staff may align themselves with custody personnel based on prevailing perception of prisoners' behavior. Rhodes (2004) calls this "the shifting and tentative alliance" through which custody and treatment sort out their relationship (2004:134). This alliance is characterized by constant fluidity and change where cross-alliances form and dissolve based on mutual dependency.

Rhodes notes that the friction between custody and treatment staff results from their differential possession of power and knowledge over the inmate population. Custodial staff have the power to inflict punishment, whereas mental health staff take their stand on psychiatric categories and approaches. This specialized form of knowledge sometimes avoids and sometimes supports custodial power because treatment is made

available in a punitive setting in which inmates' psychiatric statuses may be constantly questioned. This questioning and monitoring by the mental health staff, however, remains constrained on all sides by the structures and correctional philosophy that holds custodial power over and above mental health treatment (Rhodes, 2004:134). Custodial power can lead treatment staff to complain about the ways in which prison rules, schedules, and regulations interfere with their efforts to provide treatment, which fueled by stress, role ambiguity, lack of organizational support and unmet treatment goals, in turn, leads staff to assume a punitive rather than humanistic stance toward inmates. Thus Rhodes posits that some treatment staff will stand firmly on the punitive end of the correctional treatment spectrum while others may reflect a more humanistic approach (Rhodes, 2004:156).

CONFLICT BETWEEN INMATES WITH MENTAL ILLNESS AND CORRECTIONS OFFICERS

The culture of corrections officers entails regimentation: universally applied rules, explicit authority of security staff, and punitive sanctions for violations committed by prison inmates including inmates with mental illness (Appelbaum, et al. 2001). Wilkinson (2002) reports that effective supervision of inmates with mental illness is both a health issue and a management challenge. In *Correctional Mental Health Report*, Wilkinson (2000) indicated that "for years, corrections personnel have attempted to discern the difference between prisoners who are 'mad' and those considered to be bad." (p. 196). In addition, Seifert (2004) stated in *Work Stressors and Stress Outcomes among Correctional Officers* that "The task of managing inmates with mental illness often involves the interpretation and application of existing rules and regulations as well as a

set of unwritten rules” (p.44). Cullen et al. (1985) suggest that informal rules are passed on to officers in a socialization process which leads to role ambiguity and conflict within the correctional officer role (Cheek & Miller, 1983). Wilkinson (2000) adds that it is crucial for corrections officers to know, for both security and health reasons, whether “offenders are demonstrating purposeful negative behavior as opposed to those who are acting out because of their mental illness” (p. 54). If inmates with mental illness experience acute psychiatric episodes, prison officers should be concerned with preventing subsequent deterioration (Wilkinson, 2000). Additionally, “volatile behavior by inmates who have mental illnesses not only impairs the ability of officers and administrators to operate safe and orderly facilities but also results in stress for correctional employees at all levels” (Appelbaum, et al. 2001:1343). Prison guards also play a crucial part in the care of psychiatric inmates. As a result, “prevention and amelioration of mental health related problems, from the management and clinical perspective, is a conscious, ongoing mission” (p. 1345). Successful treatment of inmates with mental illness can decrease the stress experienced by both those inmates and the officers’ assigned to guard them (Appelbaum et al. 2001).

Corrections officers perform an essential role in maintaining order and safety in prison and among inmates. According to Sullivan and Bhagat (1992), prison guards frequently experience chronic stress due to inescapable job factors like performing difficult but needed job tasks. Finn (2000) finds that prison systems in many states function with persistent understaffing, mandatory overtime, rotating shift work, and low salaries. Additionally, “always outnumbered by the inmates they supervise, officers inside prison walls typically are armed with nothing more deadly than ballpoint pens with

which they can write infractions for rule violations” (Appelbaum et al. 2001:1344).

Finally, Applebaum comments that “everyone benefits when the prison environment is characterized by mutual respect and the reliance on the expertise of both security professionals and mental health professionals working in conjunction to help prisoners with mental illness adjust” (p. 1347).

CHAPTER 4 RESEARCH DESIGN

Methods⁵

Northern State Prison in New Jersey and Vantaa Prison in Vantaa, Finland both provide basic mental health treatment services to prisoners with mental illness. The rationale for this research is to discern whether 1) correctional environments differ in regards to humaneness and punitiveness, and 2) treatment practices are a reflection of correctional philosophy and perceptions of necessary care at Vantaa Prison in Vantaa, Finland and at Northern State Prison in Newark, New Jersey.

This study is primarily qualitative. There are a number of benefits from research derived from prison-based qualitative data. Primary among these benefits is the opportunity to gather data that may otherwise be hidden from prison administrators and policymakers. Maxwell (1996) argues for the legitimacy of research questions in realist terms. A realist approach focuses on the meaning of events to the subjects who are interviewed while minimizing the validity threats that arise from this approach.

This research was designed to be narrow in scope because it seeks to answer specific questions about interactions between inmates with mental illness and their treatment professionals in Finnish and U.S. prisons. It uses non-probability purposive sampling because these prisons and inmates represent an opportunity to conduct a preliminary investigation of perceptions and practices. The subjects and the settings present information that could not have been obtained from other sources.

This research utilizes grounded theory. The framework of grounded theory involves theory generation through a continuous analysis of qualitative data and theories

⁵ This study was conducted within the Federal guidelines for human subjects' protection, Rutgers University Institutional Review Board #03-235Rp.

that develop from the collection of those data. Grounded theory emphasizes the dynamic quality of that process, the building of theory through constant comparison of data and ideas. Recently, grounded theory has found favor with researchers interested in exploring, understanding, and explaining the organizational context of human interaction in controlled environments like prison settings (Patenaude, 2000).

Goals and Objectives

This dissertation focuses on contrasts in correctional philosophies and their impact on treatment, supervision policies, and management issues of persons with mental illnesses in specialized housing in Vantaa Prison in Finland and Northern State Prison in New Jersey. Specifically, this research seeks to address the following questions:

1. Are persons with mental illness in Vantaa Prison in Finland and the Northern State Prison in New Jersey different?
2. Do persons with mental illness perceive themselves to be treated differently? (i.e., perceived quality, access, usefulness and helpfulness of mental health services available to them).
3. How do Vantaa Prison and Northern State Prison mental health staffs perceive the ways in which their prisons identify, treat and discharge persons with mental illness?
4. How do official prison policies and practices differ between the two countries and prisons regarding inmates who are mentally ill?

Four different data collection methods were utilized to collect information. First, inmates were interviewed in both countries for the purpose of eliciting opinions about mental health services provided to them. Second, mental health staff were interviewed for the purpose of gaining an understanding of the process by which they provide mental

health services to inmates and what they think about these procedures. In addition, site visits and observations in both prisons assisted in providing a context for this research. Fourth, a document review, comprised of a review of U.S. federal and case law, Finnish and international law, New Jersey state statutes, Finnish and New Jersey accreditation standards, prison policies, and standard operational procedures pertaining to inmates with mental illness, was conducted.

Phase I (Finland) and Phase II (the United States) of this research study were approved by the Rutgers University Institutional Review Board (IRB) (IRB#03-235Rp). All subjects were provided a written informed consent (in English or Finnish) to participate, following a thorough discussion of the study's procedures, risks and benefits, and no subject was found to lack adequate decision making capacity during this process.

RESEARCH SITES

Vantaa Prison, Finland

The first part of the research study was carried out in Vantaa Prison, located thirty minutes from Helsinki, the capital of Finland. Vantaa Prison was selected because: (1) it is the only prison in Finland that provides in-patient psychiatric treatment; (2) it has a 14-bed specialized housing unit; (3) the primary researcher has an established relationship with the chief forensic psychiatrist of the prison; (4) no language barriers because the writer speaks Finnish; and (5) physical proximity of Vantaa Prison to the writer's residence in nearby Helsinki, Finland.

Vantaa prison has specialized housing that offers a range of psychiatric and psychosocial rehabilitation for up to 15 inmates with mental illness. Altogether, the prison houses, on average, about 230 male inmates (and eleven female inmates) and it is

the only prison in Finland with a specialized inpatient unit. Therefore, it functions as a receiving facility for the seven other prisons in its regional “catchment” area. The hospital also functions as an autonomous civilian hospital although bound by the prison rules and regulations. For example, the hospital must abide by the prison schedule regarding opening and closing of cell doors, canteen and visitation hours, medication distribution, and staff shift changes. Unlike Northern State Prison in New Jersey, Vantaa Prison does not have step-down mental health units for inmates who are no longer acutely mentally ill but not quite ready to return to the general population or to their return prisons. As a result, treatment space permitting, some inmates remain in specialized housing longer than the average thirty day period. Moreover, Vantaa Prison specialized housing did not have onsite 24-hour psychiatric coverage; therefore no inmates are admitted afterhours or on weekends (Personal Observations, 2003). If need for admittance emerged, the psychiatrist was contacted, necessary paperwork filled out, and the inmate in question transferred to the Psychiatric Hospital for Prisoners in Turku for further treatment.

Northern State Prison, New Jersey

Phase II of this research took place at Northern State Prison, Newark, New Jersey. This was selected as the second research site because the prison houses a significant number of inmates with mental illness (15%) in its specialized housing units and the general population as well, its proximity to the University, and its history of treatment of prisoners with mental illnesses. The specialized housing consists of three separate housing areas. The Crisis Stabilization Unit (CSU) was designed to evaluate and manage inmates’ acute mental illness through intensive treatment. The Residential Treatment

Unit was a different unit designed to further stabilize and provide intensive mental health treatment for inmates who experience sub-acute episodes. The Transitional Care Unit was also a unit designed to assist inmates' transition back to the general population or to their assigned prison. Northern State Prison is permitted to treat inmates' involuntarily because one of their specialized housing units (CSU) is staffed 24 hours a day as stipulated in the Terhune decision.

SAMPLE of PARTICIPANTS

According to Miles and Huberman, qualitative sampling is driven by the conceptual framework and research question of the study. Qualitative studies usually have smaller samples in fewer settings than do surveys (Miles & Huberman, 1984). Two samples of participants, a sample of inmates and a sample of staff, were included in this study. The following sections will describe the sampling frame and the sampling methodology for inmates and staff in both facilities.

INMATE PARTICIPANTS

Northern State Prison

1. Sampling Frame

The population from which the sample was drawn was the population of persons with mental illness at Northern State Prison, more specifically, male subjects with a primary DSM-IV Axis I diagnosis of mental illness. In the absence of any systematic, rigorous mental health screening of the entire prison population (N= 2,700), the psychology department staff were asked to identify and submit a list of names of potential interviewees among their caseload (n=445) who were mentally ill. With the assistance of the department secretary the researcher could then contact them. Forty

inmates were selected by choosing every 10th person from the list until 40 inmates were selected. The sampling frame therefore included all 445 inmates with Axis I diagnosis of mental illness who were identified by Northern State Prison mental health staff during this research (January - December, 2004).

2. Sampling Method

Purposive sampling is utilized when a population is either unique or when a researcher wishes to collect exploratory data from a population in a “natural setting” that reflects the lived experiences of that population. Maxfield & Babbie (2001), state “occasionally it may be appropriate to select a sample on the basis of our own knowledge of the population, its elements, and the nature of our research aims” (p. 238).

Persons qualifying for this study were granted a movement pass to go to the visitation area to meet with this researcher. They had been informed that they would be asked by their individual counselors, group facilitators, psychiatrists and psychologists to participate in research. The researcher introduced herself to the inmate subjects’ and explained the purpose of the study. If the subjects gave consent to be interviewed, the primary researcher described the study and the study’s procedures, risks and benefits. Also, before the interview, a psychiatrist or a psychologist determined whether each subject was mentally competent to give consent for the interview. One interview was conducted with each participant. All subject interviews were structured using initial informational questions that established a chronology of the subject’s incarceration and psychiatric diagnoses and events relevant to the study. The aim of the informational questioning was the production of primary data in the subject’s exact words with only nominal prompting by the researcher (Douglas, 2003:49).

Pending approval from the New Jersey Department of Corrections (NJ DOC), each interview was going to be audio taped. NJ DOC, however, did not grant approval which meant that this researcher manually recorded all inmate answers to research questions. Data collection began in January 2004 and concluded in mid-June 2004.

Vantaa Prison

1. Sampling Frame

The population from which the sample was drawn was inmates with mental illnesses at Vantaa Prison. The sampling frame consisted of those inmates who resided in specialized housing and were scheduled to see the psychiatrist during weekly consultation hours. Although the number of subjects that were scheduled to see the prison psychiatrists varied from week to week, 40 male subjects with a primary ICD-10 diagnosis of mental illness comprised the Finnish subject group. In the absence of a systematic, rigorous mental health assessment of the entire prison population (N=230), the psychiatrist and the mental health staff at Vantaa Prison specialize housing were asked to assist in identifying potential participants for interviews.

2. Sampling Method

Inmate subjects (n=40) were recruited during specialized housing community meetings or other meetings during which all inmates were usually present. The researcher was introduced to the inmates in these meetings on a weekly basis until 40 subjects were identified. The hospital staff assisted this researcher in identifying and recruiting inmates and explaining the purpose of the study. Inmates who agreed to be interviewed were scheduled individually to meet with the researcher. In addition, the hospital staff was asked to identify additional potential subjects from their caseloads and then contact the

researcher in the event that previously selected inmates cancelled their interviews. Also, before any interview took place, the psychiatrist determined whether inmates were mentally competent to give informed consent for interviews. To facilitate further the recruitment process, the researcher joined the psychiatrist during consultation in the medical department and with the inmate's consent observed the psychiatric consultation process. Once the consultations were over, potential subjects were asked for an interview. Each candidate was told that the purpose of the interview was to ascertain how they accessed mental health services, treatment, and medication and managed day-to-day routines in their housing units.

The Finnish Prison Administration approved audio taping which was done for each interview. Because the interviews were translated from Finnish into English, tape recording was essential. Tape recorded interviews increase validity of responses by providing more precise and comprehensive replies than hand-written notes, which may not capture everything. Vantaa Prison subjects were informed that tape recording could be turned off at any time during the interview and that any comments subjects requested "off the record" or made without attribution, taped or not taped, would not be recorded (Carroll, 1999). An interview was conducted with each participant.

STAFF SAMPLING

Vantaa Prison and Northern State Prison

Staff members, including psychiatrists, psychologists, nurses, and corrections officers assigned to specialized housing who worked with inmates with mental illnesses were selected from each prison using a purposive sampling method. Both facilities had contact persons (Dr. Ahlgren at Vantaa Prison and Dr. Abrams at Northern State Prison)

for the project. Both contact persons were provided a sample list of the research questions as well as the consent form that was to be distributed to their respective staff members during staff meetings. Although the mental health staff in each facility received a copy of the questionnaire, their participation, which was explained to them again, was voluntary. The primary researcher was present during at least one or two staff meetings in both facilities to answer any questions and recruit potential participants.

The mental health staff of both facilities (Vantaa Prison N=6 and Northern State Prison N=4) were asked to be interviewed about their experiences in working with prisoners with mental illness. It was expected that between eight and ten staff members from each prison would agree to participate. Fewer staff participated than had been anticipated. Interview questions were expected to create a better understanding of how various mental health approaches in both countries responded to inmates with mental illness. Also, the interviews were expected to shed light on why certain medications were used over others and whether these clinical choices related to better discharge planning or inmate adaptation in the general population or after release. The interviews took place in the offices of the mental health staff.

DATA COLLECTION METHODOLOGY

Inmate Interviews

Miles and Huberman (1984) argue that qualitative methods are “far better than solely quantitative approaches at developing causations that we call local causality – the actual events and processes that led to specific outcomes” (p. 132). Therefore, for this dissertation, in-depth interviews focused on gaining and understanding the meaning and

processes of treatment within prison specialized housing areas at Northern State and Vantaa.

A standardized open-ended interview schedule was used to interview inmate subjects while they were incarcerated. The research questions consisted of a range of themes that included adjustment in prison, types and severity of psychiatric symptoms, methods of treatment available to subjects in their housing units, availability and access of mental health clinicians, weekend mental health coverage and programming, types of release planning, psychiatric symptom management during lock down periods, coping with activity and inactivity, etc. This type of interview permitted respondents to provide their own answers to each of the nineteen questions. The exact wording and sequence of questions were determined in advance. The subjects in both countries were asked questions in the same order although their content changed slightly to reflect different housing areas, inmate security status, and previous prison mental health treatment experiences, to improve the comparability of responses. Interviews were conducted in English and Finnish. . During interviews, it was possible for the interviewer to make observations, clarify questions, and correct any misunderstandings. The interviewer was also able to make notes of the environment in which interviews took place. The interviews at Vantaa Prison were held in specialized housing meeting rooms. All New Jersey interviews took place in the prison visitation area (VS). Moreover, the interviews at Northern State Prison were not tape recorded per the New Jersey Department of Corrections directive. Instead, the answers were handwritten and subsequently transcribed into Microsoft Word word-processing format. In the early phases of the transcribing process, the interviews were analyzed and preliminary codes (i.e., emerging

themes) were developed on the basis of the data. The interviews at the Vantaa Prison specialized housing were tape recorded. Each inmate subject was interviewed once.

Staff Interviews

A questionnaire format similar to the one administered to inmate subjects was used to elicit answers from the staff in both prisons. The questions asked about staff perceptions of mental health treatment, types of inmates served in specialized housing units, how staff managed dually diagnosed inmates, identification of structural barriers that may have complicated internal mental health delivery system, and the role of the C.F. v. Terhune decision on the level of mental health care including discharge planning. In an effort to get interviewees to elaborate on their responses, follow-up questions were conversational in tone. As more inmate-mental health staff interactions were observed, further questions arose about emerging conclusions and the context of interactions (Maxwell, 1996). Staff answers were tape-recorded in both prisons in order to provide clarity and consistency of answers. The interviews took place, pending room availability, in the psychology office at Northern State Prison and in the staff offices at Vantaa Prison's specialized housing. Each staff member was interviewed only once.

SITE VISITS

Systematic observations at Vantaa and Northern State Prison specialized housing units took place to increase understanding of practices and procedures. Observing the spatial (e.g., specialized housing, mental health offices) interactions of different types of people, as well as the regulations and policies of these spaces, produced new insights into mental health treatment barriers at both prisons. The regulatory and structural elements of prison systems, which tend to emphasize separateness and exclusion, are

inclined to be in opposition to the humanistic, interconnected attitude of most prison mental health professionals (Stroller, 2003). More specifically, this writer's observations have aided in developing theoretical groundwork for the cross-national procedural comparisons between the two prisons when looking at admission criteria to specialized housing, available mental health treatments, movement about the prison compound, and the decision to refer inmates for psychiatric treatment and to specialized housing. Site visits allowed for observations of mental health treatments and validation of inmate narratives.

Vantaa Prison

Vantaa Prison Specialized Housing was visited for four hours twice a week. The primary researcher also attended numerous clinical rounds with the psychiatrist, watched inmate mandatory community meetings, sat in on inmate groups, was present during inmate treatment meetings with staff, observed case conferences and shift change reports, and attended medication report meetings to discover how new inmates were assigned to staff and how unusual behavior was addressed clinically and administratively. Lastly, the mental health staff were followed on crisis calls to see how inmates were linked to community mental health services upon release from prison.

Northern State Prison

Site visits to Northern State Prison were made bi-weekly for the purposes of observation and data collection. Each visit took about four hours. Additionally, visits consisted of attending weekly classification committee meetings where incoming (new and transfer) prisoners were assigned to different security levels, housing areas, work programs, and specialized housing. Such meetings reviewed Terhune-required

disciplinary protocols applicable to special need inmates. Observing these meetings contextualized the process by which prisoners with mental illnesses were classified, housed, and disciplined at Northern State Prison. Psychology department staff meetings and specialized housing community meetings hearings were observed. New inmate orientation meetings were also attended to learn how inmates were informed of available mental health services. Additionally, the lead psychologist gave permission to shadow mental health staff on clinical rounds throughout the prison, including at new inmate mental health evaluations. The shadowing of mental health staff provided data on how Northern State inmates accessed mental health services. Further comparisons were made concerning how decisions about inmate mental health treatment are made, including determination of psychiatric diagnosis, type and length of mental health treatment, and how inmate treatment progress was reviewed. And finally, the research compared mental health staff decisions about when inmates with mental illnesses were ready for transfer to the general population.

DOCUMENT REVIEW

Document reviews provided relevant background and contextual information, providing a framework for standards of clinical mental health treatment in U.S and Finnish prisons. In addition, prison-specific requirements for the provision of institutionalized care were analyzed. These requirements were minimum conditions for meeting accreditation standards set by the National Corrections Commission for Health Care (NCCHC) in the U.S. and the Standard Minimum Rules for the Treatment of Prisoners set by the United Nations and used as guiding principles for prisons in Finland.

Finland

The primary researcher used the Finnish Prison Personnel Training Center Library to identify, review, and examine prison policies applicable to Vantaa Prison. The Mental Health Law of 1990 revealed how prisons must handle inmates in need of involuntary treatment. The United Nations Standard Minimum Rules for the Treatment of Prisoners was examined along with the European Prison Rules to ascertain their applicability to Vantaa Prison specialized housing. The Finland Prison Administration's standard operating procedures detailed the steps that inmates who needed mental health services yet were housed in the general population went through. Finnish Prison Administration manuals showed training for correction officer and medical staff who managed and supervised inmates with psychiatric disorders. Vantaa Prison general discharge policies explained non-mentally ill inmate release procedures.

United States of America

This research component reviewed U.S case law, federal and New Jersey state laws pertaining to prisoners with mental illness, New Jersey Department of Corrections guidelines and policies dealing with mentally ill inmates, involuntary inmate commitments, standards of mental health and medical care, New Jersey prison accreditation standards, and right to refuse psychiatric medications in prisons policies. The primary researcher used LexisNexis, Criminal Justice Abstracts, and Westlaw literature searches to identify and categorize appropriate documents for further analysis, and synthesize them into a concise summary of the main points.

CODING AND DATA ANALYSIS PLAN

Overview

Grounded theory was used in coding inmate interview transcripts. This component of the study is intended to address one of the primary research questions posed (Research Question #2, see page 113 for greater detail): specifically, are inmates with mental illnesses at Northern State Prison and Vantaa Prison treated differently? Was the perceived quality, access, and usefulness of mental health services equally available to inmates at both prisons?

Prisoners were asked these identical questions:

1. How were you identified as having mental health problems or wanting treatment?
2. What are specialized housing units like?
3. What kinds of treatment are you currently receiving and what is your opinion of them?
4. What is the staff like in this prison?

From these questions, three major topical areas emerged: the (1) environment, (2) treatment, and (3) staff.

The Vantaa Prison interviews were transcribed verbatim from taped interviews. This process consisted of listening to the taped interviews, reading, translating and transcribing them to construct a printed record of the interviews. Northern State Prison inmate responses were recorded manually. Replies were written down verbatim as much as possible. Upon completion of all transcription, the responses were read several times to ensure that the answers were recorded correctly.

Theme Development

The first step of theme development consisted of axial coding. Strauss and Corbin (1998:123) define axial coding as “the process of relating categories to their subcategories because coding occurs around the axis of a category, linking categories at

the level of properties and dimensions.” In other words, themes are related to their sub-themes to form more precise and complete explanation of phenomena (Strauss & Corbin, 1998:124). This method was followed to examine categories and subcategories for each of the three major themes (i.e., environment, treatment, and staff) to ascertain whether and how they were interconnected. This process undertaken during the open coding phase consisted of analyzing inmates’ responses to interview questions for concurrent opposites and similarities that emerged most frequently from inmate conversation themes. Through readings of both existing literature and the raw data, key ideas were identified and placed into lists of sub-themes together with the direct quotes. The third stage of grounded theory, selective coding, was then conducted. For Strauss and Corbin (1990:21), “selective coding is the process by which all categories are unified around a ‘core’ category, and categories that need further explication are filled-in with descriptive details.” They also state that core categories are those that surface and are repeatedly mentioned more than others. These emerging categories may be linked to other categories as well. In practice, the process that was used is described below.

For each interview, a written summary was created that followed a clear and logical format from the beginning to end. All interviews were read again to ensure accuracy and gauge a preliminary feeling from them. Verbatim responses were identified to capture “indigenous categories,” or in vivo coding (Patton, 1980; Strauss 1987:28-32; Strauss & Corbin 1990:61-74). In vivo coding helped capture inmate experiences in which special vocabulary, exclusive to them and reflective meanings they attached to their environment. A line by line analysis highlighted meaningful inmate phrases in different colors; then key statements were extracted from the transcripts for further theme

development. All interviews were number coded (e.g., VP #22; NSP #21) so that transcripts could be identified with the related number codes as well as pseudonyms. This process helped deconstruct large amounts of raw data into smaller and more manageable chunks leading to category construction based on property types. According to Strauss and Corbin (1998), properties are characteristics or units of analysis that define and describe concepts which are words that stand for ideas contained in data. After analyzing the first five interviews from each prison using this method, categories began to be developed; then the next five interviews were analyzed, and the categories compared with those in the first five interviews. Saturation of categories occurred when no new categories, concepts, dimensions or incidents emerge during the theory development process (Strauss and Corbin, 1998). By the time the last five interviews were analyzed, no new themes or concepts emerged that did not fit previously identified and defined categories. Saturation of categories was therefore reached (adapted from Baszanger, 1995:12).

Reading and rereading inmate interviews and comparing the same questions eventually resulted in the recurrence of three key themes and their sub-themes from the shared interview narratives. The themes were: (1) environment, (2) treatment, and (3) staff. Environment sub-themes consisted of specialized housing and inmate cells. Treatment sub-themes included referrals, individual and group therapy, prescribed medications (including medication refusals), and discharge planning. Prison staff sub-themes consisted of nurses, mental health staff, and corrections officers.

Table 1 presents the themes, sub-themes, and categories that emerged from the theme development phase. Inmates in both prisons discussed two major things in regard

to their environment: their perceptions of specialized housing (in direct response to the interview question) and the general conditions of their personal space (i.e., cells). When discussing their perceptions of specialized housing, inmates commonly commented on five topics: helpfulness, cleanliness, activities, lockdown, and security/safety. For example, for some inmates, specialized housing represented safety and predictability with prearranged activities that made being there helpful. For others, specialized housing represented prolonged lockdown with minimal activities. Regarding cleanliness, the inmates commented on the showers and other common areas used by the inmates. In addition, liberty to move about including built-in safeguards from the stresses related to residing in the general population also represented safety. All five of these thematic categories contained both positive and negative statements.

Inmate perception of personal space (i.e., cells) formed the second sub-theme within environment. The four thematic categories that emerged from inmate reports were size, materials, furnishing, and electronics and personal items. The inmates commented about the dimensions of their cells, materials used to build them, type of material their cell furnishing were made of, and personal items permitted in their cells.

Table 1. Coding Themes, Sub-themes and Categories

Theme	Sub-theme	Thematic Categories
1. Environment	Specialized Housing	1) Helpfulness 2) Cleanliness 3) Activities 4) Lockdown 5) Security
	Perception of Personal Space	1) Size 2) Materials 3) Furnishing 4) Electronics/Personal Items
2. Treatment	Referral to Care	1) Screening by Staff 2) Self-initiated
	Individual/Group Therapy	1) Helpful 2) Educational
	Medications and Medication Refusals	1) Helpfulness 2) Consequences
	Discharge from Specialized Housing/ Release from Prison	1) Monitoring 2) Referrals
3. Staff	Nurses	1) Respect 2) Professionalism 3) Helpfulness
	Mental Health Treatment Staff	1) Respect 2) Professionalism 3) Helpfulness
	Corrections Officers	1) Respect 2) Professionalism

Under the treatment theme, analysis of inmate answers yielded four treatment-related sub-themes: referrals, treatment (individual/group), prescribed medications and medication refusals, and discharge planning. All four of these categories contained both positive and negative comments.

Within the staff theme, inmates in both prisons commonly discussed the three types of staff members who are coincidentally also the staff with whom they have the most contact. Within each staff type, similar sub-themes emerged. Under nursing staff, three sub-categories emerged: respect, professionalism, and helpfulness. Inmate commentary elicited divergent feedback about the nurses from them being helpful to treating them as outcasts. The comments about the nurses' professionalism also figured prominently with the feedback citing their professionalism and unprofessionalism regarding medication handling and communication styles that showed varying degrees of respect. Under mental health staff, three sub-categories also emerged: respect, professionalism, and helpfulness. Both inmate groups described similar themes. Inmates liked the mental health treatment staff because the staff respected them as inmates and as persons with mental illnesses. The availability of treatment staff was a factor in their helpfulness, and inmates appreciate being spoken to rather than spoken at. Under corrections officers, there were two-subcategories that emerged from inmate comments: respect and professionalism. Each of the thematic categories included positive and negative comments. For example, inmates expressed their interactions with corrections officers in both forceful and malleable language. Some inmates expressed hostility towards corrections officers, invoking a feeling of being disrespected or not helped by them while others felt that corrections officers acted in a respectful and helpful manner.

Analysis

After the coding was complete, the analysis identified counts of individuals in each prison who made category area statements, identifying whether the statement was positive or negative and adding examples of the categories (i.e., quotes). These counts and quotes were to be contrasted by prison to determine whether general trends existed (while acknowledging that no formal significance test can be conducted).

VALIDITY AND RELIABILITY

Validity

Babbie (1995) points out that qualitative designs are superior to survey and experimental methods in validity because research is carried out in natural settings rather than in artificial ones. While they are less generalizable because they focus on fewer people or a single environment, they produce potentially more valid results because they offer observations and interview subjects in their environment.

Qualitative research methods were chosen to increase the validity of the research findings. They present the social world and perspectives of the subjects in their world in terms of their ideas, behaviors and accounts. Qualitative research therefore emphasizes the need for depth and detail, and seeing things in context. They are guided by natural conversations and the research questions of the interviewer. Overall, qualitative research is particularly useful where subjects may not have been adequately understood (e.g., inmates with psychiatric diagnoses in controlled environments). Thus, qualitative methods as grounded theory become important in this study of two different prison systems and correctional philosophies because the findings are open to change and development as they unfold from the data.

Generalizability

Northern State and Vantaa Prisons were selected because they epitomize two opposing correctional approaches and philosophies of treatment of prisoners with mental illnesses. Such differences, however, present challenges to the generalizability of the findings. A common critique of qualitative studies with small samples (single site studies) revolves around the ability to generalize results because they are not sampled as a representative group of the entire population (i.e. prison populations). According to Eisenhardt, there is at least one way of overcoming or limiting the generalizability problem when doing cross-national prison research. First, through this study, the primary researcher demonstrated how the context was similar to other contexts although it was challenging particularly since this dissertation research involved two polar examples when building theory (Eisenhardt, 1989; Pettigrew, 1990). Findings from this study cannot be generalized to the entire U.S. or New Jersey prison system or Finnish prisons because regional as well as local prison policies and procedures with regard to prisoners with mental illness vary. An in-depth look at the process and meaning of treatment, supervision, and management of prisoners with mental illnesses, however, can be valuable in informing public policy on this issue by providing a detailed look at this issue in a particular place and under two different viewpoints. Furthermore, it is imperative that this type of research is cautiously generalized and only in part because the unique quality of the time, place, and interchange between staff and patients affects results.

Steps that were taken to control bias

Bias can be anything in research that produces systematic (but unintended) variation in findings. The following protocols were used with the intention of reducing or eliminating such bias.

1. The researcher read and reread her notes repeatedly to make sure that what was observed and recorded was properly reflected in the notes.
2. Emerging explanatory themes and categories were compared to existing cross-national prison research (where applicable) to decipher similar meaning. This method is recommended to examine whether prior research found similar themes or if such studies used alternative explanations for the same phenomena (Hammersley & Atkinson, 1995).
3. Triangulation was used to corroborate observations, subject accounts, and various other events such as site visits. Triangulation is a method to verify research data against numerous other sources. Westbrook (1994) and Hammersley & Atkinson (1995:232) conveyed triangulation this way, “if a position or an explanation is reliable across several data collection sources then it may more likely be an integral part to understanding phenomena will be found.”
4. The researcher met with Dr. Veysey regularly to discuss concerns and issues stemming from internal biases that may have arisen and how best to deal with them.

General Chapter Summary

One of the goals of this dissertation is to ascertain how inmates with mental illness go about accessing mental health services in two nations’ prison systems. If one prison system is considered more humanitarian in its approach to inmates with serious mental illness, and the other more punitive under police power, then individual mental health treatment outcomes should be different based on differing correctional

philosophies. For example, this dissertation seeks to answer whether mental health services offered at Northern State Prison are more expedient or effective because of the C.F. vs. Terhune ruling. Are specific psychiatric practices at Vantaa Prison specialized housing considered more effective because intervention there stress inmate-patient autonomy, persuasion, multi-disciplinary treatment approaches, and inmate-patient involvement in all aspects of treatment? By interviewing and making observations of inmates and mental health staff, this study will offer insight into documented practices of the mental health service delivery systems in Finland and New Jersey and shed light on individual treatment patterns that affect treatment outcomes. For these reasons, the most important goal of this study is to illustrate how two countries with divergent correctional philosophies managed, treated, and supervised prisoners who have mental illnesses.

CHAPTER 5

SITE VISITS AND OBSERVATIONS

The purpose of site visits to Vantaa Prison in Finland and Northern State Prison in Newark, New Jersey was to observe the prisons' environment and services. The visit included getting a feel for the organizational and managerial climate of the prisons and inmates and staff's daily experiences in such an environment. In addition, the site visits provided an opportunity to witness how prison operational procedures were implemented and how these practices influenced, assisted, or in some cases hindered mental health treatment goals. The site visits also offered a venue in which to watch face-to-face encounters between inmates and prison staff in different work and treatment related contexts could be viewed.

Site Visits and Observations at Vantaa Prison

Site visits at Vantaa Prison began March 1, 2003 and concluded August 20, 2003. Altogether, 62 visits were made to Vantaa Prison to conduct observations and inmate and staff interviews. The site visit observations included: walking around the prison yard, observing inmate interactions, shadowing the psychiatrist and mental health staff, sitting in on staff meetings, observing inmate group sessions, and observing corrections officers' interactions throughout the prison. Added information came from observing inmate clinical treatment team meetings, visiting different housing units, administrative offices, and other structures on the compound. These observations provided an understanding of how Vantaa Prison's correctional treatment philosophy translates into custody and correctional treatment decisions regarding inmates who are mentally ill.

As a principle, Vantaa Prison inmates maintain their basic civil rights under the concept of “normalization,” a well-established concept in the Mission Statement of the Finnish Prison Administration. Normalcy entails a philosophy that emphasizes behavior-based treatment and focuses on psychosocial rehabilitation addressing an array of deficits and strengths in vocational, educational, substance abuse, psychiatric treatment, and family reunification programs. These observations highlighted how basic elements of normalcy, including the way in which Vantaa Prison is constructed, were put into practice in everyday life in the prison’s specialized housing and beyond, (Kaj Raundrup, 1993).

The outer structure of Vantaa Prison is painted with earth colors, and each floor, of which there are four, is painted with subdued but distinctive colors. The purpose of the color scheme is to assist staff and inmates to familiarize themselves with various locations and housing areas. In addition, surveillance cameras can determine the location of a disturbance based on the color of the floor or location. Each housing floor was built in a slanting design so that cell windows open up to the prison yard rather than opposing cell windows which means no inmate is able to see or communicate with another through a cell window. All cells, which are called rooms, have beds, dressers, a desk, and chairs. Each cell is also equipped with a TV and a PlayStation videogame player. Cells normally house one person and all come with a private bathroom and shower. Inmates are provided shower sandals and bathrobes. There are no bars on cell windows; instead the windows are made of thick Plexiglas and almost impossible to break. Cells are located on all four floors and each floor has its own day room, kitchen, sauna, and laundry facility. Inmates can wash their own clothes and prepare their own meals, if they choose. Corrections

officers are located in a control booth in the hallway where they monitor all inmate activity through closed circuit cameras. The control booth is located adjacent to cells hindering the correction officers' surveillance activity, except through TV monitors.

In spring 2003, Vantaa Prison housed roughly 160 inmates including about 20 women. Inmates were both pre-trial and sentenced prisoners; Finland does not have a pre-trial detention system similar to the U.S. Juvenile offenders are not incarcerated at Vantaa Prison. No painted lines symbolizing restricted inmate access were observed anywhere in the prison compound. The yard, with rudimentary weightlifting equipment and benches to sit on, was barren covered with sand rather than concrete, and enclosed by a gray 19 foot high concrete wall. Forest and foliage surrounded the prison and ran parallel to major highways providing the constant sound of traffic.

Vantaa Prison, like most other Finnish prisons, lacks guard towers or fortress like exteriors. In many instances, camera surveillance and electronic alert networks are used for the same function; to protect and observe. Absent are iron gates, metal passageways, or sparsely furnished cells (except when discipline calls for them). Inmates speak to the psychiatrist on a first name basis. The prison warden and other high ranking staff are addressed by non-military titles such as manager or governor, and prisoners are at times referred to as clients or patients rather than inmates. This informality is a reflection of the Mission Statement's philosophy, which specifies that the only purpose of incarceration is the deprivation of freedom. The argot of the correctional philosophy further establishes the parameters of corrections officer roles and behavior toward general population inmates and those in specialized housing.

Corrections Officers at Vantaa Prison

Vantaa Prison corrections officer (CO) uniforms convey overt discipline. They consist of short or long sleeve, navy blue shirts, a blue tie with polka dots, and dark blue trousers. Epaulets familiar to military blouse design are prominent. Quite a few officers sported open toe sandals with socks underneath. They are unarmed. Weapons are only be used during transfer of prisoners or in dangerous situations. Corrections officers are also prohibited from handcuffing inmates unless there is an imminent threat that can compromise prison security (see Chapter 6).

The COs are integral to carrying out some of the duties stipulated in prison policies and protocols. This is most apparent in monitoring, feeding, distributing psychiatric medications, and transporting inmates to various parts of the prison. COs initiate referrals to mental health treatment, communicators of inmate floor behavior, and passers of pertinent information between two contrasting worlds: the custodial and mental health treatment worlds. Without an overnight mental health staff, it is mostly left to the COs to determine and shape, in part, the trajectories that mentally ill inmates experience in custody and care. Most COs perform these tasks with limited or no training in mental illness intervention. In spite of this lack of training, COs assume, by default, salient boundary spanner roles when they communicate with mental health staff. It appears as if the COs constantly have to interpret policies regarding inmate behaviors that may be correlated with mental illness. Depending on the context, they have to shape the extent that their individual responses are disciplinary. They furthermore appear to find it a challenge to treat inmates with mental illnesses compassionately and control the same population (Personal Observations, 2003; Fellner, 2006).

Medication Distribution

Because the medical staff in 2003 did not routinely make rounds on the housing floors, inmates had to put in requests to nurses for psychiatric medications ('rutina lappu') via COs. This protocol was disquieting, as Elliott (1997) stated and observations supported his thesis. New inmates may be disoriented, have short- or long-term memory impairment, or paranoid features that make it challenging to ask for or write their concerns on routine request forms. Moreover, in 2003, without orientation sessions, incoming inmates may not have known how to obtain such forms. Furthermore, it was unclear how Vantaa Prison inmates who were on psychotropic medications but resided in the general population were evaluated for side effects, for adverse drug reactions, or how Vantaa Prison responded to medication non-compliance. Additionally, some inmates reported that they themselves decided to stop current psychiatric medications because of a lack of psychiatric oversight in the general population. Whether such decisions were clinically indicated or monitored remains unknown at this time.

Cos are responsible for documenting inmate behavior on the floors. This documentation brings noteworthy events to nurses' attention. This protocol is unsettling (to observe), however, because the COs, who lack training in major mental illnesses and associated behavioral cues, make mental health diagnosis and treatment decisions. The threshold for acceptable or "normal" inmate behavior at Vantaa Prison is sometimes a guessing game because the threshold between normal and abnormal is fluid. Nearly every CO in the facility carries pens and writing pads to document behavior for further attention. While Vantaa Prison COs are in charge of distributing psychiatric medications to the entire inmate population (including specialized housing) during afterhours and weekends, on a weekly basis nurses fill up the pillboxes, which are stored in control

rooms, stacked on top of each other or in a drawer in red colored plastic containers.

None are locked away. Medications is distributed three times a day and the distribution time is in accordance with prison schedules rather than clinical or treatment decisions.

This prison-directed schedule causes problems because medication distribution calls take place early in the evening rather than at inmates' actual sleep time. When medications are handed to inmates, cell doors are opened and inmates step to the door. The medicine has to be taken with a cup of water and in the presence of the two COs. Although they watched inmates take their medications, this practice provided inmates opportunities to hoard medicine. Inmates do not always swallow their medications as instructed but remove them from their mouths when the COs exit the housing areas.

Inmate Classification

Based on observations on the third and fourth floors of Vantaa Prison, many new inmates including several with psychiatric histories and drug addictions, are placed in one- to two-man cells for prolonged periods of time directly after being processed in the booking area. New inmates are not screened for mental illness or drug withdrawal prior to placement in their cells. Inmates, as is their basic right, can seek medical treatment by putting in a request through the floor officers. The COs forward them to the nurses who, based on a cursory visual evaluation of the inmates, schedule them for psychiatric consultation at the medical clinic. It was quite surprising to learn that the nurses do not make regular rounds in the general population floors. Rather, inmates are expected to initiate requests for nurses themselves. The nurses, however, go to the floors for medical emergencies and to refill pill boxes. As a result, several inmates seemed to require attention for psychiatric and substance abuse problems. Also, it is rare to observe inmates

mingling in hallways or in multipurpose rooms of those floors. Most are locked inside their cells. No group sessions were seen taking place on the third and fourth floors underscoring the disparity between mental health treatment in the general population compared to what was offered to psychiatric patients just a few floors below. In addition, the extent to which Vantaa Prison informs its new inmates about services offered in the facility and how to access them remains unknown. Unlike at Northern State Prison where inmate orientation sessions for new inmates are conducted weekly, Vantaa Prison did not have such program in place in 2003 when these observations took place.

Specialized Housing

The layout of the specialized housing makes it feel as if one were visiting a civilian hospital rather a prison-based facility. The design and layout of the place give an illusion of a civilian hospital, a place where the cells are referred to as rooms. The rooms have color TVs, radios, individual coffee makers, and other permissible personal belongings. Like those on the general population floors, rooms are equipped with private showers and toilets and every inmate is given a bathrobe and slippers. The multipurpose room or the living room is decorated with floor and wall rugs, cushioned chairs and plants in accordance with the policy of normalization. This is based on a correctional philosophy that articulates through its mission statement that incarceration equates to a loss of freedom only and the inmates cannot be punished by relegating them to substandard housing, treatment or other services. Vantaa Prison is obligated to provide resources that meet community standards for “normalcy,” including housing, meals, social spaces, and educational programs. This philosophy is observable in specialized housing where flowers and plants decorate windows, and the inmate living room has a

wall covered with a colorful wall carpet and a rug on the floor. The multipurpose room functions as a common eating area where inmates eat using regular dinner ware and metal utensils. Moreover, there are no bars on any windows in specialized housing, treatment areas, or staff offices. Rather, the windows are draped with curtains resembling apartment windows albeit windows made of Plexiglas. The day room, equipped with a TV, a seating area, a communal kitchen with a refrigerator, stove, and an area in which to prepare individual meals, is reminiscent of a communal living room. Inmates are permitted to have a bi-weekly sauna on the premises.

The laundry room is also on the premises, and inmates can use it to wash their own laundry. Pre-trial inmates wear street clothes and jewelry until their cases are adjudicated. None of the inmates with mental illnesses, including those already convicted of crimes, wear prison identification bracelets. Specialized housing, however, is bound by Vantaa Prison rules and regulations regarding psychiatric medication distribution, the closing and opening of cell doors, food delivery and eating times, canteen and general visiting hours, and scheduled prison releases and court appearances.

Inmates discharged from specialized housing for reasons other than those clinically indicated, such as non-compliance with treatment, return back to the general population or to their home prisons, or they are released from prison altogether. Due to a lack of personnel mental health staff tend not to follow up on inmates after their discharge from specialized housing. Inmates transferred to distant prisons do not receive follow-up attention either. Since most Finnish prisons do not have on-site, full-time psychiatrists on duty, aftercare treatment needs are left to psychologists. It was unknown at the time of this research how well this system worked. Because the average stay in

specialized housing is about a month, only the most acutely ill inmates are admitted to aftercare. Vantaa Prison specialized housing staff do not discharge stabilized inmates into transitional housing units because they do not exist at Vantaa Prison. Rather, the specialized housing functions as an integrated treatment space in which inmates in various stages of mental illness are treated. Mental health treatment within specialized housing is structured, but it does not include phases of graduated housing in which higher functioning inmates move through treatment stages. Current space does not allow for graduated housing, nor do Vantaa Prison policies and procedures call for it.

Because of Vantaa Prison's design, the specialized housing is situated in the basement level, where inmates tend to be more physically, socially, and emotionally separate from the general population. Based on discussions with mental health staff, this factor reduces the flow of illegal drugs from entering specialized housing. On the other hand, due to inmates' physical separation from the general population, interaction between the staff and inmates is reportedly more intensive and tedious; at times taxing the energy and other resources of the clinical staff. This intensive interaction, some staff members state, is due to the mental health staff's function as primary "life line" for inmates who no longer have other outlets for socializing.

The prevailing correctional philosophy mandates that no inmate is released directly from Vantaa Prison to the streets unless necessary. Reentry without release planning contravenes the philosophy dictated in the United Nation's Standard Minimum Rules for the Treatment of Prisoners. Section 83 of the Minimum Rules advises treatment staff to provide inmates who have mental illnesses to post-release psychosocial

services, including housing. Neglecting this task may be tantamount to inflicting additional harm on inmates suffering from psychiatric disorders.

On the other hand, the success of the specialized housing inmate-mental health staff relationship is integral to making the transition to the community or another prison more successful. Successful transitions depend on mental health staff playing the pro-active role of prison “continuity agent” and “boundary spanner,” a position linking two or more systems whose goals and expectations are likely to be at least partially conflicting (Dvoskin, 1989; Steadman, 1992). Such roles positively affect the likelihood that inmates will avoid recurrences of the worst aspects of their psychiatric illnesses upon release or transfer to other prisons. These pro-active interventions may reduce re-offending and subsequent returns to Vantaa Prison. Continuity agents, whether COs, nurses, or mental health staff, act on “shifting and tentative alliance” (Rhodes, 2000: 134) with inmates to overcome barriers to optimal access and care. They may negotiate service provider hours of operations that meet inmate needs. Continuity agents are able to do so because they separate self-interests that adhere to their personal roles from issues of custody and treatment and reduce lack of trust that arises between those who perform the two roles. Based on site visits and observations, it seems the mental health staff skillfully and continually adapt themselves to their roles by utilizing their expertise and advocacy on behalf of patients. Additionally, since no apparent policy of “inter-agency agreements” exists between specialized housing and area community mental health centers or civilian hospitals, the ability of the mental health staff to expand these skills is indispensable. These roles encourage persuasion and soft coercion as the primary treatment modalities beyond medication management.

Psychiatric Treatment

Based on observations in specialized housing, psychiatric treatment provided to inmates at Vantaa Prison by mental health staff was structured psychosocial rehabilitation. It included: individual psychotherapy, group meetings, medication management, treatment plan meetings, acupuncture, and community meetings. The staff collectively felt that psychiatric treatment was essential for inmates with chronic mental illnesses and substance abuse problems who entered specialized housing and needed relief from psychiatric symptoms as well as assistance to develop coping skills for better function during residence in the special housing unit and after release.

Northern State Prison

Site visits at Northern State Prison began November 4, 2003 and concluded June 20, 2004. In all, 32 visits were made to Northern State Prison for the purpose of conducting observations and interviews with inmates and staff. The site visit observations involved: walking around the compound, watching classification meetings, shadowing psychology staff and sitting in on staff meetings, and observing inmate group sessions. Additional information came from observing mentally ill inmate disciplinary review hearings and in visits to different housing units, offices, and other structures. These observations aided in providing a broader understanding of how Northern State Prison's correctional treatment policies are translated into practical custody and treatment decisions.

The prison compound is comprised of a set of gray buildings spread out on both sides of an inner quad or walkway, which creates a vast observational space. With a population of 2,700 inmates during the period of site visits, there were many

opportunities to watch staff and inmates interact in their natural setting. Altogether these observations provided layers of rich information that focused on the dynamics of supervision, management, housing and disciplinary policies toward inmates with psychiatric disorders.

New Jersey Department of Corrections Mission Statement

The Mission of the New Jersey Department of Corrections is to ensure that all persons committed to the state correctional institutions are confined with the level of custody necessary to protect the public and that they are provided with the care, discipline, training, and treatment needed to prepare them for reintegration into the community (www.state.nj.us/corrections).

Description of the Physical Plant

Northern State Prison complex communicated control and containment through its physical architecture and barren landscape. In *Discipline and Punish* (1978), Foucault notes prisons are “complete and austere institutions,” “structures whose walls mark the very horizons of their inhabitants and concealed the machinery of a larger system of justice” (p. 72). Northern State Prison regulates sounds, movement, and space all of which have key roles, which are manifested through numerous devices and apparatus that serve practical security purposes. They include surveillance cameras, intercoms and two-way radios for corrections officers, handcuffs and leg irons, pepper spray, signs in bold letters prohibiting inmate entrance to various spaces, an absence of greenery eliminating possible blind spots, and thick metal doors at entrances.

Moreover, a variety of both cultural and symbolic values are expressed through the prison’s construction materials, cinderblocks. The buildings are grayish and institutional white, and uniforms for COs and inmates are blue and khaki. The hard

rectangular shapes and building forms create an aura of a fortress, with small inmate cells and a barren outdoor landscape. Northern State Prison's architecture also enforces spatial exclusion. The structural design of interior hallways, some with painted lines on floors, inmate walkways, and housing areas spreading out like wings encourages relationships based on institutional roles (e.g., inmates who are mentally ill). The housing units were constructed to enclose areas with mostly reflective surface materials that resulted in noisy spaces, particularly inmate common areas. Security and maintenance requirements prohibit the use of fragile materials. In addition, Northern State Prison is near a major airport and highways that further establish visible boundaries marking the surrounded borders of the prison.

Visitors to Northern State Prison have to present identification to an officer staffing a shabby front desk where they sign in in a book, tattered, ripped, and with loose pages, dutifully indicating who they are and the purpose of their visit. . Visitor belongings are put through a metal detector before visitors walk through themselves. All these procedures are standard NJ DOC protocol. Finally, the desk officer calls the Psychology office (2nd level) and someone from their office accompanies the writer in.

Northern State Prison is constructed of concrete and steel; asphalt covers the compound. Trees are absent for security reasons although sparse green patches of grass dot the landscape. Gray rectangular housing blocks⁶ surround both sides of the main compound forming an enclosed movement area. All housing units are located closely together giving an impression that the structures are conjoined, but each building is narrowly separated from the others by multiple layers of barbed wiring.

⁶ Prisoners are housed based on security threat/risk, mental illness diagnosis, medical illness and/or gang affiliation

Two imposing guard towers are situated on either side of the administration building and manned by armed COs.⁷ Throughout the compound inside the main prison quad inmates have to walk inside two yellow lines painted on gritty walkways. The yellow lines function as a control mechanism with inmates caught trespassing over the yellow stripes subject to an institutional infraction or “blue sheet.” The omnipresent yellow line effectively restricts inmate foot traffic. The experience of walking through the compound proves humbling as every person walking by is either an inmate or a CO. For this writer, an outsider, it created a sense of defenselessness. NJ DOC policy prohibits civilians from carrying personal items on their person and further left this writer with a sense of extreme vulnerability. On the left of the compound are the previously mentioned metal cages built into a recreation area, which holds mostly brown and black men. There is nothing that separates civilians from inmates except yellow parallel lines. Yet, there is an odd sense of safety that the lines generate. It is extraordinary to see inmates obey these lines; creating a strange juxtaposition of correctional philosophy that trusts inmates on the compound to remain within marked spaces yet limits their movements in their cellblocks.

Small black recreation patches are scattered in front of each housing block with metal fences bolted down and enclosing a smaller space for some housing blocks. According to COs, they keep rival street gangs from attacking each other. All recreation areas are fenced in, keeping inmates from entering or exiting the main walkway.

At one end of the prison yard stands an unremarkable gray and windowless structure, a warehouse and an industrial size kitchen with several walk-in ovens where a number of inmates prepare pre-cooked meals for prisoners. A CO stated that meal costs

⁷ No armed correction officers or prison towers exist in the Finnish prison system

in 2003-4 averaged less than four dollars a day.⁸ Other structures on the compound included a building for religious services, a staff cafeteria, a separate 96-bed inmate-run substance abuse program called Fresh Start, a building that provides services for inmates with HIV and AIDS, and the administration building with offices for the warden and his staff.

Descriptions of Institutional Functions

Inmate Classification

The authority to decide where new inmates, including ones with mental illnesses, are housed and how they are disciplined for institutional infractions rests with the Northern State Prison Classification Committee. Generally, in Classification Committee meetings, the staff discuss factors associated with decisions regarding housing and work placements, referrals to psychiatric treatment and education, and institutional punishment options. The Committee is also responsible for disciplining inmates with psychiatric disorders.

The following describes a typical meeting (observation visit November, 2003). The meeting held in the Visitation South (VS) area, in a nondescript room with metal chairs and a long wooden table, began at 9:00 AM and concluded at 1:00 PM. Five Northern State staff members were present, and they comprised the Classification Committee, and included a representative from the Education Department, a lieutenant representing custody, the Committee chairperson representing the administration, a staff person from Social Services and a classification clerk who took notes of inmate dispositions and recorded them in their “jackets,” or files. The clerk took minutes of all inmate-related decisions and subsequently entered these notes into the classification

⁸ Vantaa Prison inmates are entitled to the same food prepared for staff (Personal Observations, 2003).

computer system. A book cart containing folders for each incoming inmate sat next to the clerk. The cart was overflowing with folders this morning.

The morning session focused on disciplinary infraction or “blue sheets” reviews accrued by inmates with mental illnesses⁹ and found guilty by New Jersey Department of Corrections disciplinary hearing officers. The hearing officers rotate among New Jersey prisons where they adjudicate disciplinary charges against inmates including those with mental illnesses. This protocol based on the U.S. Supreme Court decision in *Wolff v. McDonnell* (1974) offers a modicum of due process to inmates. Title 10A Corrections, New Jersey Administrative Code (N.J.A.C.) stipulates that hearing officers may consider mental illness as a mitigating factor in determining punishment. The Committee reviewed each disposition individually and only a unanimous agreement made the punishments official. This process permitted a degree of recognition of the different circumstances prisoners who exhibit symptoms of mental illnesses face. No inmates were present during the review period. Listed below were the “offenses” of which several inmates were found guilty:

1. Self-mutilation
2. Threatening bodily harm
3. Disobeying orders
4. Refusal to obey and/or accept assignment
5. Setting fires

It is perplexing that self-mutilation is considered an institutional infraction subject to punishment. Specifically it is unclear whether the Committee was aware of the documented correlation linking psychiatric decompensation and prolonged disciplinary related isolation. The institutional response by the Northern State Classification

⁹ There were 500-700 inmates with psychiatric disorders in NSP (Special Needs Roster, 11/2003)

Committee seemed harsh which was further underscored by how inmate infractions were not discussed beyond the context of custody and control.

New Jersey's correctional philosophy places mental health treatment secondary to Northern State security goals. Security is the final arbiter of Classification Committee decision-making. This is further demonstrated by the absence of mental health staff from the Committee, which, as a result, lacks valuable feedback on the impact of disciplinary practices on the inmate and his treatment.

Generally the witnessed punishments seemed harsh in relation to the offenses committed by inmates with psychiatric disorders. For example, one inmate's recreational privileges were suspended for 30 days, another lost all compensatory time, yet another inmate had his contact visits taken away and the last one was sentenced to Administrative Segregation (Ad Seg) for an entire year. It should be noted that disciplinary time in Ad Seg does not count towards an inmates' sentences, which means that time served in Ad Seg does not run concurrently and leads, in some cases, to longer incarceration for inmates with mental illnesses. This policy is confirmed in the language of the N.J.A.C. governing New Jersey Prisons (Title 10A). Moreover, Title 10A directly influences Northern State Prison's administrative, housing, and management practices toward inmates with mental illnesses. As such, N.J.A.C Title 10A creates police power for the sake of control and safety through enforcement of Northern State Prison administrative rules. Power resides in the institution's Classification Committee and in its display of the extent to which discipline is the foundation on which management of inmates with psychiatric disorders rests (source).

Role of Mental Health in Classification Decisions

Before the Classification Committee meeting commenced, Committee members informed this writer that every new inmate who is sentenced to prison in New Jersey goes through the Central Receiving and Assessment Facility (CRAF) in Trenton where their most appropriate institutional placement is determined. From CRAF, inmates are sent to prisons throughout New Jersey including Northern State. Inmates who display unusual behavior or report a history of mental illness are seen by CRAF nurses for further evaluation. The evaluations identify inmate needs and level of mental illness and treatment. All evaluation notes and reports written at CRAF are entered into the New Jersey Department of Corrections inmate electronic medical record or EMR, which is accessible to Correctional Medical Services mental health staff throughout New Jersey prisons. CRAF is an important part of the New Jersey Department of Corrections mental health treatment paradigm and clinical decision-making because psychiatric intervention, if detected, almost always is started at CRAF. Its role as a screener and gatekeeper to Northern State Prison mental health services is critical now that three of the 15 New Jersey Prisons have specialized housing for mentally ill inmates.

Mental Health Evaluations

Correctional Medical Services (CMS), a for-profit contractor, employs Northern State Prison mental health staff who have the sole responsibility for evaluating incoming inmates for mental illness, a daunting task considering the volume of inmates who enter Northern State Prison every week. The mental health staff have access to the inmate EMR system, which serves as a guide to the initial inmate evaluation process. By policy, Northern State psychiatric and psychological evaluations are good for one year and are used for a variety of classification related reasons. New Jersey Department of

Corrections Mental Health Services Policy and Procedures Manual (Policy Number 35.00) stipulates that internal psychiatric evaluations have to be completed within 30 days of CRAF referrals. A member of the Classification Committee reported, however, that there were 157 inmates on the waiting list for psychiatric evaluations. When asked about the backlog, a respondent stated, psychiatrists and psychologists did not conduct evaluations in a timely manner. This backlog, the Committee posited, led to new evaluation requests of the same inmates, with no guarantee that they would be completed within the required thirty days, illustrating a difference between stated policy and actual practice, and an ongoing concern to the Committee. More important, Classification Committee members, absent a representative from the psychology office, had to decipher the psychiatric evaluations.

In Northern State Prison parlance, “positive” psychiatric evaluations mean that inmates are mentally stable and eligible for various job placements on and off prison grounds including lower custody levels and community placement. The Committee voices concerns over “negative” psychiatric reports because they are often lack concrete information regarding negative findings. The Committee is in a difficult position, which was observed several times, because the vague reports rendered the Committee unable to determine custody levels and programmatic needs. These concerns are accentuated by the absence of mental health staff on the Committee. During the observed meeting, Committee members had an opportunity to review a negative psychiatric evaluation written in vague and generic format. They found that for the inmate in question community placement release was inappropriate. No explanation, however, was provided to the Committee for the negative finding. Without representatives from mental

health in attendance, it was not known how this information would be used by the classification committee.

Throughout the site visits it became apparent that the classification committee did not know nor was trained to recognize signs and symptoms of major mental illnesses. This issue was highlighted several times when the Committee deliberated about an inmate and seemed to rely on common sense behavioral and verbal cues to decide whether he was “right” or “normal.” In one meeting, a new inmate told the Committee that he was taking Depakote for symptoms associated with Bipolar disorder. One Committee member asked the inmate if the medication was used to treat heart problems. Other Committee members appeared equally perplexed and nobody made an effort to find out what the medication was used for.

Overall, the classification committee functioned rather efficiently in general, taking into account the volume of inmates arriving at Northern State Prison on a weekly basis. Nonetheless, one overarching theme emerged; the information and document flow between Classification and other in-house departments was fragmented which was evidenced numerous times as relevant information went missing or failed to be documented in inmate folders, leaving the Committee unable to decide upon appropriate, inmate program placements for.

Specialized Housing Units

As stated earlier, Northern State Prison inmates are referred to the psychologist and to specialized housing through internal mechanisms that are stipulated in the policies and protocols of NJDOC. Referrals from CRAF,¹⁰ CMS staff, COs and administrators affect EMR records and may result in direct transfers to Ad Seg or the Crisis Stabilization Unit.

¹⁰ Central Reception and Assessment Facility, Trenton, NJ

In U.S. prisons in which litigation has taken place, more resources are usually available than in other prisons. This was true of Northern State Prison where specialized housing units were created as a result of the Terhune decision. The three units were the Crisis Stabilization Unit (CSU), the Residential Treatment Unit (RTU) and the Transitional Care Unit (TCU). Each unit is described in detail below.

The Crisis Stabilization Unit

The Crisis Stabilization Unit's (CSU) mission, stated in the NJ DOC Mental Health Services Policy and Procedures Manual (#1.05), is to offer limited (3-10 days) stabilization to inmates experiencing acute psychiatric crises. Treatment consists of psychiatric medication management with a limited offering of group therapy. The CSU is located in C1 West block. It is disconcerting to visit. With no windows in the dayroom and metal cage observation cells it looks grim. The noise, the muffled yelling of inmates and banging on cell doors, makes being there unpleasant. The observation cells, built on two different tiers, are small and untidy. During the site visit, an on-site unit psychologist was stationed on the lower tier at a desk, which functioned as this staff member's office space. This particular staff member was in charge of the CTU's day-to-day psychiatric crises and treatment plans. Attached to the cinderblock wall next to the psychologist was a white board listing names of inmates currently in the CSU. Only a few names were written on the board which gave the impression that there were only a handful of inmates in the facility who were undergoing acute psychiatric crises. During this data collection period, ten to 12 inmates were housed in the CSU on any given day: the cells on the first tier are all CSU while those on the second tier house both CSU and Residential Treatment Unit (RTU) inmates.

The CSU nursing station, operating 24 hours a day, is situated in an adjacent room to the right of the psychologist's station. It is small and cluttered without plants or windows. Psychotropic medications, medication records, and medical equipment are also stored there. In terms of clinical responsibilities, registered nurses distribute psychiatric medications (as elsewhere in the prison), while social workers run group sessions and write treatment plans.¹¹ On average, the inmates remain in the CSU for ten days before being transferred to the Residential Treatment Unit or the Transitional Care Unit, depending on symptoms. Inmates who cannot be stabilized in the CSU are transferred to Ann Klein Forensic Psychiatric Hospital in Trenton, New Jersey.

The Residential Treatment Unit

The Northern State Prison Program Guide¹² states that the Residential Treatment Unit (RTU) follows a day-treatment program model that consists of multi-disciplinary staff who provide treatment for psychiatrically ill inmates. The programming is provided 12 hours per day from 8:00 A.M to 8:00 P.M Monday through Friday and eight hours on Saturdays and Sundays. The inmates assigned to the RTU and the TCU are allotted as much out-of-cell time as is clinically indicated by their treatment plans. Also, within 24 hours of placement in the RTU, the nursing staff completes a nursing assessment and documents relevant findings on the inmate's medical and dental record. Furthermore, "within 48 hours of placement on the RTU, the inmate is interviewed by a psychiatrist and psychologist and has a treatment plan developed outlining short-term and long-term goals"(Northern State Prison Program Guide).

¹¹ As stipulated by NJ DOC and CMS Policy

¹² Exhibit B, p.10 - NSP guide

The Residential Treatment Unit (RTU) houses approximately 80 inmates with mental illnesses at any given time (March 2004 Mentally Ill Inmate Roster). The average length of stay in the RTU is three months or longer, if necessary. It is designed to treat and stabilize inmates who were experiencing chronic or severe symptoms of mental illness and, as a result, are unable to live in the general population. Many inmates are transferred to the RTU from the CSU for further stabilization. Structurally, the RTU is indistinguishable from the general population housing units.¹³ The common area (i.e., the day room) evokes a sad ambiance because of a lack of bright colors or light. The inmates who occupy the common area move about silently as if invisible to outsiders. They blend in with the metal and cinderblock fixtures and furniture of the unit. The colors of the inmate khakis help create an illusion of the men blending into their cell and day room surroundings. The furniture along with the inmates evoke a sense of lifelessness, which is underscored by many inmates' fatigued and sad affect. They walk about with slow gaits and express few signs of life amid their concrete surroundings. The furnishings show signs of wear and tear: metal tables (bolted to the floor) situated throughout the room are matched with equally worn metal chairs exposing their original metal color under fading paint.

Mental Health Staff

The mental health staff for the entire prison number about 20, nearly all of whom are white. The mental health office houses four social workers and four psychologists, a mix of men and women. The average caseload for each psychologist is roughly 30 inmates. Moreover, staff members also reported that there were at the time 340 “outpatient” inmates with mental illnesses who resided in the general population, 180

¹³ No comparable space at Vantaa Prison exists.

inmates in the RTU and the TCU combined, and between ten to 12 inmates in the CSU. Altogether there were 446 inmates out of 2,600 on the Northern State Prison roster for mental illness representing 16% of the total prison population. This roster was generated by the Department of Corrections and included all prison inmates in custody in New Jersey prisons who had been diagnosed mentally ill.

Correction Officers

The corrections officers (COs) who are assigned to Northern State Prison specialized housing units wear navy blue one- or two-piece jumpsuit-like uniforms. The COs are unarmed; they do not carry handcuffs or electric Taser guns. In other words, the COs do not present themselves as threatening. They carry pens and writing pads on their person, but they appear to be their most effective weapons besides their visible symbols of authority. The pens and writing pads convey a more helpful demeanor precisely because these objects are not weapons.

Integrated Chapter Summary

The focal point of Finnish correctional philosophy is that incarceration amounts to deprivation of freedom only. To that end, the philosophy promulgates the idea that inmates have the right to mental health treatment equivalent to that which is provided to the general public by the Finnish government. A correctional treatment philosophy grounded in a humane orientation is discernible at Vantaa Prison on various levels, yet it is the most transparent in their specialized housing than anywhere else in the facility. Unlike Northern State Prison with its three separate specialized housing areas and an outpatient program that provide ample space and layout to support different inmate behaviors, Vantaa Prison does not have such space other than its fourteen bed inpatient

program. As result, the space functions as an integrated treatment space in which the most acutely mentally ill inmates are treated until stabilization and then discharged to make room for new inmates. No separate step-down mental health units exist either. Aftercare is left for the staff to provide in the inmates' receiving prisons or elsewhere in Vantaa Prison.

It is within this context that Vantaa Prison and Northern State Prison correctional philosophies toward mentally ill inmates are most observable and divergent. In this regard, a noticeable gap emerges between policy and actual practice regarding how Vantaa Prison administratively and therapeutically handles the challenges posed by mentally ill inmates. Northern State Prison seems better equipped than Vantaa Prison to handle a larger number of mentally ill inmates in space that allows for maximum treatment flexibility. It is more likely to facilitate inmates' adaptive functioning related to their mental illnesses. At Northern State Prison, specialized housing units follow specific practices, which resulted from the Terhune decision and subsequent Correctional Medical Services policies. These same housing units at the same time bear a striking similarity to regular housing units, making them essentially undistinguishable from non-specialized housing areas. In comparison, Vantaa Prison specialized housing space embodies a more therapeutic milieu that includes different structural design from the rest of the prison. Absent are heavy doors and partitions. Other means of confinement besides bars are employed. Bars on doors or in windows are not visible, a salient difference between the two facilities. At Northern State Prison, traditional security cellblocks abound, steel and solid iron doors appear throughout specialized housing areas, and the feel of the place is about security and control. At Vantaa Prison, the feel of

the specialized housing space is more relaxing as there are fewer correctional reminders throughout. For example, inmate movement is less controlled, and no daytime room lock-downs are apparent.

Different perceptions of specialized housing emerge between inmates in the two systems. While most Vantaa inmates express appreciation for the freedom of movement afforded them within specialized housing, Northern State inmate responses suggest specialized housing is governed by a significantly higher degree of control over daily activities and restrictions in movement than is the case at Vantaa Prison.

Inmate classification process, which stresses inmate supervision, custody, and control, is a fundamental component of the overall Northern State Prison organization model and is reflected in its Mission Statement. This approach is observable at Northern State Prison classification and inmate disciplinary committee meetings. Committee meetings frequently miss relevant behavioral or psychological cues on inmates who may be mentally ill. How those inmates are later identified is uncertain, though. Furthermore, the mental health staff is absent from these meetings. The same is true for Vantaa Prison where the mental health staff does not participate in meetings where inmate classification or disciplinary decisions are discussed.

During the period of site visits, no inmates were observed in handcuffs at Vantaa Prison. This conveys an adherence to prevailing rules governing Finnish prisons that strictly limits the use of physical restraints. In addition, Vantaa Prison COs are prohibited from carrying them, and they are usually stored in the main control room and can only be retrieved from there in the event of an emergency. At Northern State Prison, many COs carry handcuffs. Also, the noise that is generated by walking, talking, yelling, radios and

televisions is incessant, as are ever present hard surfaces such as cemented floors that reflect rather than absorb noise. This is mostly absent in Vantaa Prison where inmate corridors and hallways are quiet. Conversations between the COs and inmates seem softer and less aggressive than in Northern State Prison where relationships and communication between inmates and COs seem tenuous and laden with mutual distrust. Tension between inmates and the COs at Vantaa Prison was noted; however it appeared less common than at Northern State Prison. This may have been the result of Vantaa Prison's small inmate population of 220 individuals. Northern State Prison has 2,700 inmates. In addition, more inmates may generate more opportunities for inmate instigated aggression, security breaches, and tension. The crux of the interactions between inmates and COs at Northern State often seems to convey this tension, whereas at Vantaa Prison conflict appears less pronounced. This lack of tension in Vantaa may be attributable to a specialized housing CO working alongside mental health staff. This aspect may have diffused friction between COs and the inmates as the mental health staff functions as something of a buffer, whereas Northern State Prison COs frequently work without the benefit of mental health staff in close proximity. Furthermore, Northern State Prison COs operate in a more paramilitary-like setting, guarding specialized housing areas in which the inmates far outnumbered them and where their relationship is more adversarial. In addition, Vantaa Prison COs function more as front line workers and gatekeepers to mental health services, whereas at Northern State Prison inmates arrive from CRAF with diagnoses that set them on pre-determined mental health treatment trajectories. Vantaa Prison did not have a similar system in place at the time of this data collection took place. Additionally, unlike CRAF where standard mental health policies

dictate how inmates are identified and diagnosed mentally ill, Vantaa Prison does not have a comparable system in place. Thus, this task often falls on the COs whose job it is to sort out inmates' psychiatric symptoms based on their floor observations. In essence, the Finnish COs become de facto diagnosticians whereas their Northern State Prison counterparts engaged in more security and control oriented tasks. Furthermore, Northern State Prison COs are not permitted to distribute psychiatric medications to inmates whereas at Vantaa Prison it is standard CO practice particularly overnight and on weekends and holidays.

In summary, subtle similarities and noticeable differences surface regarding how the correctional philosophies in both facilities are enacted. They guide the mental health program operations in both prisons although the guidelines are more detailed and far reaching at Northern State Prison. The policies and practices also ensure standardization of treatment and continued safety monitoring to which the specialized housing space attests. These aspects, however, are more likely to be present at Northern State Prison where mentally ill inmates follow predetermined routes of mental health care that commence at CRAF and continue at Northern State. In both prisons the mental health staff engage in continued inmate monitoring for mental illness and decisions regarding levels of treatment. At Vantaa Prison this practice is observed most often during psychiatric consultations for the general population inmates and treatment meetings in specialized housing. At Northern State Prison, the CMS policies stipulate mental health staff responsibilities regarding inmate needs and levels of psychiatric intervention. Treatment team meetings take place in both facilities, although at Vantaa Prison inmate participation in treatment plan team meetings is observed taking place more often.

Similarly, the staff in both prisons meet to discuss inmate related issues, which consist of target areas such as treatment focus, setting discharge dates (at Vantaa Prison), and release planning.

CHAPTER 6 - DOCUMENT REVIEW

Introduction

This chapter provides a review of Vantaa Prison and Northern State Prison standard operating procedures (SOPs) and mental health policies and procedures. The following sections will critique facility-specific rules and regulations to offer a framework for how the two prisons operate and how the language of their respective SOPs reflects each facility's current correctional practices toward inmates who are mentally ill. Chapter Six analyzes parts of the United Nations Standard Minimum Rules for the Treatment of Prisoners; European Prison Rules, and sections of Finnish legislation governing prisons as they pertain to Vantaa Prison's specialized housing unit. Compared to them and covering inmates with psychiatric disorders are several sections of the New Jersey Administrative Code, Title 10A Corrections, NJ DOC standard operating procedures, and Correctional Medical Services (CMS) Mental Health Services Policy and Procedures Manual. These documents lay out a framework to determine if written policies (discourse) adopt elements of a disciplinary or more rehabilitative philosophy toward inmates, in general, and those with mental illnesses, in particular. Conflicting correctional philosophies can lead to resistance between custody and treatment staff, both of whom must function within the boundaries of their stipulated regulations and policies. Therefore, some rules and regulations tend to be disciplinary while others lean toward a therapeutic approach.

Among other sets of rules and policies, Finnish national legislation governs Vantaa Prison. The rehabilitative posture embedded in the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955; 1957) and the European Prison

Rules (1987) greatly influences discourse found in Finnish legislation. Both provide the operating framework for the legislation. Vantaa Prison's Specialized Housing unit's internal rules and regulations are a compilation of the above three documents.

DECREEES, RULES, AND REGULATIONS RELEVANT TO VANTAA PRISON

Although the guiding documents for the Finnish prison system are not treaties per se, they constitute authoritative benchmarks for prison management and treatment of inmates through binding treaty standards and customary international law. They assert an obligation of corrections facilities to treat inmates humanely and establish a therapeutic and a compassionate orientation toward them. The documents affirm every inmate's right to health and mental health treatment and to basic human rights. These international documents affirm that the basic goals of incarceration are deprivation of freedom and rehabilitation. They also promote separate facilities for inmates who are mentally ill because such facilities are more treatment focused and designed to promote treatment rather than confinement. They encourage treatment modalities that apply therapeutic methods to behavioral problems. For example, hospitals have treatment staff on hand to provide therapy rather than incapacitation.

Prison mental health practices are governed by the principle of parity. The stated goal is to provide inmates access to the same quality and choice of mental health treatment and health care as is generally available to Finnish society. International documents are inclined to take a more forward-looking and rehabilitative framework. They endorse separate treatment facilities for inmates with psychiatric disorders where possible. United Nations (UN) prison rules set forth civil rights that all prisoners have by virtue of being human, detail specific policy mandates (right to treatment, to maintain

outside contact, to education, etc.), and obligate prison systems to provide remedies when those rights are violated.

Vantaa Prison specialized housing policies and regulations cover day-to-day administration, staffing patterns, and controlled supervision of inmates. They are an integral part of the mental health treatment that inmates with mental illnesses receive. The six rules listed in Part I, below, form the basic foundation of the correctional philosophy and management of Finnish prisons. The rules stress humanistic principles of justice and respect for human dignity. They also state that under no circumstances should Vantaa Prison depart from these policies or compromise its integrity when interpreting them. In addition, they set forth, in writing, a stance toward inmates who are mentally ill that recognizes inmate needs for treatment and non-custodial accessibility where possible (source: www.uncjin.org/Laws/prisul.htm). In the following sections, Vantaa Prisons' standard operating procedures regarding organizational functioning, supervision, treatment, and management of inmates with psychiatric disorders are reviewed.

UN Standard Minimum Rules for the Treatment of Prisoners

United Nations (UN) Standard Minimum Rules establish a positive correctional treatment ideology that supports inmate rehabilitation as a correctional system's main goal. They also institute a concrete framework for generally acceptable minimum rules of incarceration. The Rules aim to limit unnecessary disciplining and reduce excessive use of force and restraint devices. The rules and regulations that are discussed in the following sections apply to Vantaa Prison and also underscore the notion that the fundamental norms of justice do not cease at the Vantaa Prison gate. They address inmate discipline protocols by declaring that prison officials must specify what kind of

conduct constitutes a violation. In addition, prison authorities must provide inmates certain procedural rights parallel to due process (in New Jersey) before disciplinary action can commence. The rules that address treatment, management, discipline and housing of inmates with (and without) psychiatric disorders are reviewed in the following sections starting with the UN Rules for General Application. They are prison-related standards and norms that were adopted in 1955.

Part I. Rules for General Application

The main point emerging from the Rules for General Application is that by bridging the gap between treatment and custody amid their often incongruous values and goals prison facilities must function as catalysts for inmate change. The three philosophical principles comprising the Rules for General Application recognize that custody and treatment can co-exist for the benefit of inmates. The principles promote identification and treatment. They are:

1. Specialized institutions or sections (within prisons) managed by medical staff are recommended. They should be made available for observation and treatment of inmates who experience acute psychiatric illnesses or mental health related problems.
2. Prison administrators must make available in their institutions health and mental health treatment to all inmates who request or need them (therapeutic orientation).
3. Prison administrators are expected to take a proactive stance when forming reentry linkages with community treatment providers to assure, where possible, that inmates' post-release treatment will not be interrupted. The idea that release planning begins on arrival to prison emerges as the main policy theme. This can be considered a

rehabilitative orientation toward inmates because it promotes forward looking responses to inmate reentry needs.

Rule 22 - Medical Services

Prison facilities must have at least one medical doctor on the premises who is trained in psychiatry and in providing psychiatric care. Also, prison-based medical treatment should be arranged in close collaboration with local or national health care administration policy thus reinforcing the notion of normality regarding standards of care. Upon arrival in prison, the medical staff has a duty to evaluate inmates as soon as possible. This evaluation component encompasses multiple domains that include screening for mental illness and seeking internal and external resources to address mental, vocational, and physical deficits that may hinder rehabilitation. The staff must also evaluate inmates for job and vocational program readiness. Rule 22 designates the responsibility for the sick call routine to the medical director of the facility and requires that all sick call inmates are seen daily. Components of an adequate treatment program, whether medical or mental health related, must offer individual treatment planning, medication management, and off-site treatment options when in-house resources are insufficient.

Rule 27 - Discipline and Punishment

Rule 27 affirms prison administrators' right to discipline inmates who violate institutional rules. It also sets parameters for how they can respond to rule breakers, thus limiting or reducing unnecessary or arbitrary punishment. This rule also defines what kind of disciplinary action and methods of restraint can be used on inmates and sets the tone for a therapeutic orientation. It details agreed upon disciplinary practices to manage

disruptive prisoners. It prohibits corporal punishment, restriction to a dark cell, and use of handcuffs, leg restraints, and straitjackets.

Rule 33 - Instruments of Restraint

Rule 33 states that instruments such as handcuffs, chains, irons, and strait-jackets may never be applied as punishment but only for treatment-oriented purposes. Chains or manacles are prohibited as methods of inmate restraint as well. There are, however, three exceptions where restraints may be authorized:

(a) as a safety protocol to prevent escape during a transfer. Restraints must be removed when inmates appear before a judge or other court officials;

(b) for medical reasons authorized by the prison medical staff, if other methods of control fail, to prevent a prisoner from injuring himself or others or from damaging property, for example, an inmate who attempts to harm himself or is under illegal intoxicants and acting violently;

(c) by order of a prison warden, after other measures have failed, to prevent prisoners from self-harm or harming others or from destroying property. In such cases, a warden must consult with the prison medical staff for appropriate measures. In these instance handcuffs may be used.

Part II – Rules Applicable to Special Categories

Part II rules target inmates who fall under one of three special categories: section A (convicted inmates), section B (inmates who are mentally ill), and section C (pre-trial inmates). For the purposes of this document review, rules pertaining to category A and B inmates are discussed in more detail because Vantaa Prison inmate subjects fell into one of these two categories.

A. Sentenced Prisoners (Category A)

Rule 62 orders that every inmate must be evaluated and treated for medical and mental illness and that all necessary health and psychiatric services must be provided to that end at the expense of the corrections facilities to which they have been sentenced.

B. Insane and Mentally Abnormal Prisoners (Category B)

Rule 82 (2) echoes the Rules of General Application by affirming a rehabilitative approach to inmates who are characterized as “insane” or “mentally abnormal.” The theme of the Rules of General Application is repeated by asserting that such inmates should be medically supervised and provided treatment in non-correctional settings. If this is not possible, monitoring and managing them becomes the responsibility of the medical department of the prison in which they are housed. Rule 83 focuses on release planning by endorsing the continuation of psychiatric treatment after release from prison. It calls for treatment agencies to become active participants in the discharge planning phase, thereby assuring community agency partnership as part of a re-entry strategy. Vantaa Prison release planning policy is derived from Rules 82 (2) and 83.

B. Legal Framework - Finnish Legislation Governing Vantaa Prison

This section summarizes various legal regulations relevant for decisions made about inmates who are mentally ill. National legislation prevails over everything since Finland has no constitutional equivalent of the U.S. Bill of Rights. Legislation forms the national prison policy through statutes (articles) that cover all aspects of prison administration, including the management of inmates. Vantaa Prison is subject to these statutes. They contain specific provisions regarding prison punishment and conditions of incarceration. The statutes that form the basis for the management of Vantaa Prison are

found in Prison Administration Decree (878/1995) RTL¹⁴ Chapter 1 through Chapter 7. They closely parallel the UN Rules. Individually they direct Vantaa Prison to comply with a number of measures detailed in those acts, including those related to medical and mental health services. The regulations, however, delegate many more specific items to the discretion of the Vantaa Prison administration, authorizing them to create institution-specific rules for the classification, treatment, work, discipline, specialized housing, and control of inmates. These statutes form the basic elements of Vantaa Prison policies regarding management, supervision, and treatment of inmates. Also, because Vantaa Prison operates within UN rules, its treatment philosophy toward inmates seeks to provide inmate therapy and insure institutional safety. The four philosophical tenets that Vantaa Prison bases its rules and regulations on are:

1. Imprisonment is a punishment in and of itself and must be structured in a way so that loss of freedom is the only outcome. Consistent with UN guidelines, inmates cannot be restrained or confined within a prison unless it is necessary for the security and safety of the institution (therapeutic orientation).
2. Prevention of harm and promotion of reentry into society: the goal of incarceration is therapeutic. Harm (physical, psychological, or social) caused by incarceration must be prevented where possible.
3. Normality: prison officials must make every effort to assure that institutional conditions are compatible with human dignity and that they meet prevailing community standards (rehabilitative orientation).
4. Inmate Hearings: Inmates must be heard when decisions about them are made regarding cell assignments, treatment goals, work assignments, or other rehabilitative

¹⁴ RTL is Finnish Penal Code covering implementation of punishment and treatment of inmates

activities, provided that the decisions would not jeopardize the safety of the institution. This allows inmates a role in treatment decisions (therapeutic orientation).

In the sections below key portions from the national legislation are highlighted and discussed in detail, especially, sections dealing with identification and treatment of inmates who are mentally ill.

C. Article Ten - Inmate Medical and Mental Health Treatment

The Finnish Prison Administration must preserve and protect the health of all prisoners under their custody and care. In this context, Vantaa Prison must employ a doctor who is a psychiatrist and who, in this position, can diagnose and treat mentally ill inmates. Article Ten requires the Vantaa Prison medical department to assess incoming inmates within two weeks of entry for health, employment readiness, substance abuse problems, mental health issues, and treatment needs. Due to a lack of funding, not every Finnish prison employs doctors; instead they rotate. This rotation reflects a value-free response to legislation.

Article 5 - Psychological Counseling and Treatment

Psychological counseling and treatment must be available to inmates who need such services. This policy can be considered rehabilitative as it helps inmates to address issues that are psychological or psychiatric in nature. To that end, Article Five stipulates that every Finnish prison must have at least one full-time psychologist on staff to assist inmates with behavior that is psychiatric or psychological in nature. Article Five cements the role of psychologists as integral members of prison mental health services.

D. Part Five - Discipline, Supervision, and Inmate Monitoring

In accordance with UN guidelines and European Prison Rules, disciplinary action against inmates cannot be capricious, retaliatory, or vengeful. Inmates who are facing disciplinary action for violating facility rules must be provided due process-like rights that include sufficient time to prepare an adequate defense, being present at a hearing, and receiving assistance, if an inmate is incapable of defending himself. Inmates have a right to know the following: a) the acts of omission or commission that comprise disciplinary offenses, b) the protocol that must be followed at disciplinary hearings, c) the type and length of punishment that can be imposed, d) the personnel authorized to impose such punishments, and e) knowledge of the authority responsible for and access to the appeals process.

Chapter 15 - Prison Order and Inmate Discipline

Article 3

Article Three authorizes the Vantaa Prison warden discretion in initiating disciplinary action against inmate rule-breakers. A therapeutic component is integrated into this policy element as it permits conditional penalties against violators. Disciplinary action can be initiated provisionally for one month but cannot surpass three months. If the inmate does not commit a new infraction during this time, the policy calls for the original punishment to expire. Institutional infractions that draw punishment include:

- 1) Commission of a violation for which the maximum penalty is a fine (may be punitive toward indigent inmates);
- 2) Leaving the prison compound or hospital without authorized permission (exiting prison premises is not characterized as an escape);
- 3) Violation of agreed upon conditions during an authorized leave from prison;

- 4) Commission of a crime so severe that authorities have to contact the police.

Article 4 - Authorized Inmate Sanctions

An informal warning is considered sufficient sanction for certain infractions under Article Four. This policy reflects a lenient approach toward inmates. Article Four's authorized sanctions include:

- 1) Warning, the most lenient punishment available;
- 2) Loss or reduction of recreation time, money and/or access to the means of monetary value, or personal items. Loss of these items or privileges cannot exceed one month nor can the restrictions hinder inmates' access to and maintaining contact with outside support systems in accordance with the therapeutic goals of hearing of inmates.

This article also calls for sanctions to be commensurate with the behaviors inmates are accused of violating.

E. Section 18 – Use of Force and Use of Restrictions

Article Three - Inmate Observation

To facilitate close observation, inmates can be placed in a room or cell with around-the-clock monitoring. Article Three specifies three criteria that justify inmate seclusion for purposes of close observation. These criteria justify restrictive apparatuses such as handcuffs. Restraint devices such as straitjackets, irons, and chains cannot be used as means of restraint. Restraints can be used:

- 1) when inmates are undergoing drug withdrawal or are intoxicated and have to be medically monitored to ensure their safety;
- 2) for prevention of suicide or self-destructive behavior; or

3) to control violent behavior that cannot be subdued using other control methods or which can place the inmate, staff, or other prisoners at risk.

Whenever inmates are placed in observation or seclusion, the medical department has to be notified immediately. The doctor or qualified medical staff must examine an inmate as soon as possible. Article Three stipulates that inmate observation cannot last longer than determined necessary by medical staff, nor can it continue without a clinical justification by the medical staff. Placing inmates in observation rooms or cells must be reviewed every seven days or discontinued. This rule indicates a posture toward inmates that promotes safeguards and staff accountability.

Conclusion

Vantaa Prison, United Nations Standard Minimum Rules, European Prison Rules, and Finnish legislation on prisons collectively affirm the human right to be safe during incarceration, respect for inmate dignity, and basic civil rights. Moreover, the policies and rules establish that the purpose of incarceration is primarily rehabilitative, and the deprivation of liberty is as a principle the limit of punishment. Inmates should not have been subjected to additional punitive measures unless, by policy, their actions warranted it.

RULES AND REGULATIONS RELEVANT TO NORTHERN STATE PRISON

New Jersey DOC rules and regulations covering Northern State Prison rely on a control- and custody-oriented discourse in their posture toward inmates. The language throughout the documents is mainly security oriented, that is, rules and regulations stress inmate control and safety at all times. This security orientation stands in contrast to Correctional Medical Service (CMS) mental health policies and procedures, which take a

therapeutic stance toward inmates with mental illnesses. The language of CMS policies recognizes that inmates who are mentally ill should be provided treatment. NJ DOC and CMS policies complement and overlap in their scope on some levels, and in others, based on different facility missions and goals, they diverge. The mutual goal of reducing inmate violence keeps custodial and mental health teams connected.

The documents describing CMS duties are very specific because the three specialized housing units have their own individual sets of written protocols. Review of NJ DOC documents reveals that as an entity NJ DOC does not presume Northern State Prison inmates who are mentally ill are a homogenous group. Consequently, CMS policies establish specific policies and procedures that identify variations in expected mental health modalities and treatment outcomes for all three housing units. The policies include duties and expectations for staff who are in charge of providing direct services.

New Jersey Administrative Code – Title 10A Corrections

This section begins with the New Jersey Administrative Code, Title 10A Corrections. Three chapters of Title 10A pertaining to inmates with mental illnesses are analyzed. Chapters Four, Five, and Sixteen are reviewed. Chapter Four considers regulations for inmate discipline, Chapter Five rules for the use of administrative segregation, and Chapter Sixteen focuses on inmate mental health services.

The New Jersey Administrative Code is a collection of general and permanent state regulations that have the force of law. New Jersey Department of Corrections regulations are found within N.J.A.C. Title 10A, Corrections. Title 10A Corrections establishes the standard operating procedures (SOPs) for all New Jersey prisons. In all there are 72 chapters that make up Title 10A. Each chapter focuses on an aspect of

corrections and articulates comprehensive instructions that Northern State Prison must follow to achieve specific tasks. The SOPs are detailed, written directives meant to achieve consistency in the performance of prison personnel tasks. The SOPs are comparable to the penal code of the New Jersey criminal justice system. Corrections officers function in many ways like police, preserving order and safety and charging inmates, including mentally ill inmates, with infractions when they violate Northern State rules.

INMATE DISCIPLINE

Subchapter 4 - Inmate Prohibited Acts 4-4.1

Northern State Prison has a procedure in place for punishing inmates who violate prison rules. Subchapter Four of Title 10A contains written policies that address how inmates are disciplined so that it is consistent with the uniform policies of NJDOC. Moreover, the written directives also set forth a comprehensive and standardized list of infractions (96 in all), which, when broken, trigger institutional punishments drawn from a pre-approved list. This process leaves no space for arbitrary, unpredictable, or retaliatory action because individual discretion cannot supersede institutional goals. Individually tailored, alternative sanctions, however, may be considered under this policy as inmate violations, committed with no understanding or intent may reflect symptoms of psychiatric disorders. In such situations the presence of mental illness or a history of documented mental illness serves as a mitigating factor. This policy, which regards mental health services as a joint rather than separate entity, incorporates mental health services within the inmate discipline process. Yet, this policy does not completely exonerate special need inmates from punishment. Behaviors which draw disciplinary

actions are listed in the following sections. They are ranked from the most severe to more lenient responses.

4-5.1 Schedule of Sanctions for Inmate Prohibited Acts at the Prison Complex

Policy 4-5.1 has a disciplinary orientation. It calls for a disciplinary response rather than, or in addition to, a therapeutic response, except Sanction Eleven, which requires the gathering up of rehabilitative resources such as group meetings. Most of the ten sanctions below center on maintaining safety and administrative procedures that increase accountability and efficiency. Also, the authorized sanctions are more severe than those at Vantaa Prison. A judgment of guilt for any of the offenses assigns to the inmate one or more of the following sanctions:

1. Up to 15 days of disciplinary detention (for a single disciplinary charge);
2. Loss of one or more facility privileges up to 30 days;
3. Administrative segregation for a specified time not to exceed one year, subject to approval by the Institutional Classification Committee;
4. Loss of commutation time equal to one year, contingent on the approval of prison officials;
5. Loss of furlough privileges for up to 60 days;
6. Up to two weeks confinement to cell or housing area;
7. Any sanction prescribed for On-the-Spot Correction (see 10A:4-7);
8. Confiscation;
9. Up to 14 hours of extra duty, to be performed within a maximum of two weeks;

10. Suspension of any one or more of the above sanctions at the discretion of the Disciplinary Hearing Officer or Adjustment Committee for 60 calendar days and/or referral to Specialized Housing for appropriate care/treatment.

The existence of Sanction ten speaks to a potential rehabilitative orientation in Policy 4-5.1. It allows Northern State Prison mental health staff to respond to mentally ill inmates with a non-disciplinary treatment alternative for example gathering up or rehabilitative resources such as group meetings. Furthermore, it promotes a range of behavioral, cognitive, and emotional domain interventions that encourage positive inmate change (Dignam, 2003). The existence of Sanction ten also affirms that mental health treatment does not exist independently from Northern State's custody-and control-oriented philosophy. It is built into the sanctions as a viable option.

Policy 4-7.3 below is a compilation of sanctions that sets forth rules, regulations, and policies that form the boundaries for the exercise of the custodial staff discretion and establish what is and is not acceptable inmate behavior. This policy covers inmates who have psychiatric disorders.

4-7.3 – Authorized Sanctions for On-the-Spot Corrections

Violation of Northern State Prison rules and the subsequent authorized sanctions can trigger rehabilitative responses. For example, less severe misconduct can be handled informally through “on-the-spot” correction, providing it does not interfere with the running of the prison or compromise its security. The six sanctions under this policy are graded by severity, ranging from a warning to restrictions or denial of personal property:

1. Verbal warning;
2. Suspension of yard privileges not to exceed five calendar days;

3. Up to four hours of extra work duty;
4. Up to four hours confinement to one's room or housing area;
5. Loss of radio or television privileges for a period of no more than five days; and/or;
6. Confiscation of personal property.

To summarize, the above mentioned sanctions are not particularly harsh and the severity of each is more dependent on how COs apply the rules than their relationship to maintaining a safe prison setting. Moreover, they speak to the general rehabilitative ideal or stance toward inmates.

4-9.17 - Disciplinary Sanctions

This policy recognizes that when considering disciplinary action, certain mitigating factors, such as mental illness, should be taken account of. Therefore, individually tailored sanctions that allow for therapeutic measures amid a disciplinary paradigm are permitted. The factors are:

1. Inmate's history of correctional facility adjustment;
2. Setting and circumstances of the prohibited behavior;
3. The account at an inmate's hearing;
4. Inmate's correctional goals; and
5. Presence or history of inmate mental illness

4-9.18 Suspending Sanctions

The policy of sanction deferral for inmates with mental illness allows authorities to integrate a regimen of treatment and punishment. It recognizes the presence of inmates with psychiatric disorders at Northern State Prison who may face challenges obeying prison rules. During the suspension of sanctions, however, inmates remain

under close custodial supervision. If further violations occur, inmates are punished for both the new infraction and the original violation, leading to doubling the length or the severity of the sanctions. This policy exceeds the harshness of the original sanction.

4-10.8 Medical and Psychiatric Services

Section 4-10.8 stipulates that inmates in disciplinary detention must be monitored daily by medical staff: nurses, doctors, or other medical personnel. This policy is consistent with the duty to protect and care because inmates experiencing psychiatric emergencies have to be attended to immediately. Non-emergency situations require designated medical staff respond within twenty-four hours. If it is determined those inmates are suffering from psychiatric illness or disturbances, the medical staff has to make arrangements with the mental health staff for psychological or psychiatric evaluation. This policy is about providing health and mental health treatment to inmates in detention. Although the policy does not suspend or terminate detention, nevertheless, it calls for psychiatric evaluation to address psychiatric emergencies.

NJ DOC and CMS Written Directives Applicable to Mentally Ill Inmates

Correctional Medical Services (CMS) contracts to provide health and mental health treatment. In 2004, it was charged with implementing, following up, screening, housing and providing wing-based psychiatric support and treatment to mentally ill inmates at Northern State Prison. CMS took a multidisciplinary team approach that centered on three key treatment goals:

- 1) to reduce the disabling effects of serious mental illness and enhance an inmate's ability to function within the prison environment;

- 2) to reduce, or when possible, eliminate suffering brought on by severe mental illness; and
- 3) to develop eventual, tangible reentry plans.

These policies and procedures were in place during Phase II data collection (2003-04) and were central to this framework because they guided the management of Northern State's specialized housing units and characterized its day to day services for this group of inmates.

The CMS mental health services policy and procedural manual is lengthy and rich in procedural detail. It covers all aspects of special need inmate care from arrival to release from prison and reflects a behavioral and cognitive treatment orientation toward mentally ill inmates whose behavior is a key indication of treatment. The language in the manual characterizes prisoners as "incarcerated individuals," "inmates," or "inmates who are mentally ill." The vernacular of the manual departs from NJDOC SOPs, which take a more custodial and security orientation toward the same population. While NJDOC SOPs focus on safety, control, and administrative efficiency, CMS policies are more patient oriented, recognizing the need to provide potentially more rehabilitative psychiatric treatment and tailored disciplinary sanctions. To that end, each CMS policy establishes specific tasks and designates who among CMS personnel is most suited to perform these tasks. The policies create functional specializations, somewhat flexible departmental boundaries (custody and mental health working together), and bureaucratic hierarchies. They make certain that treatment providers work alongside each other and prison administration in most decision-making and consultation forums. As policy mandates, they call for a host of treatment team members to assess constantly the

treatment. This approach offers an opportunity for Northern State Prison mental health staff to play a role in managing special need inmates and the establishment of a treatment culture.

CMS MENTAL HEALTH SERVICES POLICY & PROCEDURAL MANUAL

Overview of CMS Programs and Services Provided #1.01

Policy # 1.01 states that the mission of NJDOC and Correctional Medical Services (CMS) is to assist inmates in decreasing the debilitating effects of serious mental illness and enhance their ability to function within the prison setting. At its core, this directive recognizes the wide-ranging impact of mental illness on inmates, hence the need to address it comprehensively and holistically. The goal of CMS is “to maximize the safety of the prison environment” for incarcerated mentally ill inmates. This goal is manifested in three specialized housing units (SNHU) and an outpatient mental health treatment program. The policy makes it clear that the SNHUs are reserved for inmates who due to mental illness cannot be stabilized or function in the general population. What the specialized housing units offer is space for treatment of all aspects of inmates’ mental illnesses through integrated and coordinated services. The core of Policy # 1.01 is that inmates in need of psychiatric treatment are followed throughout their incarceration at Northern State Prison.

Four of the six mental health service components are featured below. Their operational functions are highlighted with a focus on the factors that influence their policies and the language that characterizes inmates who suffer from mental illness.

3) The Crisis Stabilization Unit (CSU)

The main point of Policy #1.01 spells out clear admission criteria to the CSU that allows no room for arbitrary decision making. Through its narrowly tailored admission criteria, the policy prohibits prison officials from utilizing the CSU as a place for unruly (i.e., non-mentally ill) inmates. CSU staff are mandated to provide short term (ten days or less) assessment and treatment for psychiatric emergencies. Psychologists are designated to determine when inmates need a CSU-type of intervention and whether transfer to Ann Klein Forensic Center or the RTU is necessary. Moreover, policy # 31.01, a subset of policy #1.01, stipulates that CSU inmates cannot be transferred directly to the general population from the CSU. This is another indication of a treatment-oriented stance. Mentally ill inmates receive an additional layer of protection that recognizes that return to the general population must be transitional. After initial stabilization, these inmates may be transferred to the Residential Treatment Unit for additional treatment.

4) The Residential Treatment Units (RTU)

Similar to the CSU, the policy on the Residential Treatment Unit (RTU) sets clinical criteria for admission and discharge from the RTU. It is the first stop for inmates who are transferred there from the CSU. The RTU, under this directive, offers quality mental health programming six days a week through a variety of rehabilitative groups and counseling. The language in this policy promotes recovery through rehabilitation because CMS assists “individuals in developing the necessary skills to function in the least restrictive and safest setting possible.” The RTU has become the “least restrictive and safest setting” through treatment opportunities that allow mental health staff (rather than custodial staff) to conduct transfer reviews of special need inmates and introduce

inmates to treatment and release-oriented programming facilitated by psychologists, psychiatrists, and social workers. It also provides nursing coverage around the clock. This coverage is clinically important because most mentally ill inmates remain in the RTU for the duration of their incarceration. Also, nurses perform a crucial role in providing mental health services under this policy because they are in charge of direct observation, sick calls, and medication management and distribution. Inmates who successfully transfer from the RTU are moved to the Transitional Care Unit for further stabilization.

5) The Transitional Care Unit (TCU)

By policy, the TCU operationally targets higher functioning inmates who are preparing to reintegrate back into the general population (GP). To limit inappropriate referrals, only inmates who have been clinically determined ready to reside in GP are considered for TCU. The operational requirements of the TCU involve mental health treatment programming seven days a week and around-the-clock nursing coverage, another indication of a treatment-oriented posture toward mentally ill inmates and recognition that mental health crises are not limited to daylight hours.

Psychologists, psychiatrists, social workers, and occupational therapists each have a role in multidisciplinary treatment in the TCU. Nurses engage in key duties conducting sick calls and leading groups that explore activities of daily living, life skills, and medication management. The TCU discharge criteria, which provides a list of safeguards the mental health staff should follow, does not permit arbitrary transfers to the GP. The major behavior-driven safeguards to decrease unsuitable transfers require mentally ill

inmates to be free of suicidal ideations, able to go to medication distribution voluntarily, and to be without recent disciplinary infractions.

6) Outpatient Services

The CMS outpatient mental health program is available to inmates who no longer need intensive mental health treatment. Inmates are expected to reside in the general population, where they will continue to receive group therapy, individual counseling, medication, and low levels of supervision by mental health staff. This policy extends the scope and range of mental health services to inmates who are no longer classified as having active symptoms of mental illness but remain on the mental health roll. They remain eligible for mental health services under mental health staff auspices. Under this policy, mental health staff have the discretion to remove inmates from their roster into an outpatient status.

Policy #44.03 - Alternatives to Standard Disciplinary Procedures for Mentally Ill Inmates

Northern State Prison functions within a comprehensive and multifaceted system of rules, policies, and practices that regulate all aspects of inmate conduct. Observance of the rules is paramount. A few modifications, however, are made for mentally ill inmates whose psychiatric disorders may be associated with rule breaking. To address this issue, Northern State Prison incorporates mental health considerations into its disciplinary schema. To improve mental illness and prison routine coping skills NJ DOC policies allow Northern State Prison mental health staff to design programmatically reasonable, productive, and change-oriented responses to inmate infractions. This policy reduces an over-dependence on disciplinary rather than rehabilitative sanctions by authorizing

special allowances when considering sanctions for inmates who have mental illnesses. For example, inmates facing disciplinary action are evaluated first by a psychologist or psychiatrist for the appropriateness of the sanction. Moreover, a staff person who has witnessed the infraction can request an evaluation rather than write up formal charges that carry more severe sanctions. The CMS psychologist or psychiatrist may override or support disciplinary action. The CMS mental health staff thus is involved in recommending whether special need inmates' mental status should preclude the use of some regular disciplinary sanctions. A provision of policy # 44.03 specifies what types of conduct constitute an offense as well as specifying the rights prisoners are entitled to when disciplinary action is taken, thus opening an avenue for due process under the Wolff decision. No special allowances, however, are made for inmates suffering from mental illness sent to administrative segregation.

SANCTIONS IN THE CONTEXT OF MENTAL ILLNESS

Purpose and Goals of Sanctions

Policy # 44.04 stipulates that mentally ill inmates cannot avoid discipline. Generally speaking, inmates who violate rules are sanctioned in accordance with Northern State Prison rules despite their mental illnesses. A degree of discretion, however, is authorized under policy 44.04. There are twelve different sanctions for rule violations that can be considered for this inmate population. Some of the sanctions call for restricted detention time instead of administrative segregation, increase in program activity, and loss of telephone and visitation privileges or loss of commutation credits (LOC). This policy, however, does not explain the justification for why some "alternate interventions" listed below are chosen over others and whether they are effective or

needed to maintain a safe and secure facility. Overall the Northern State Prison disciplinary structure is by and large based on degrees of graded punishments that range from restrictions to loss of privileges. “Alternative” sanctions include:

1. Loss of yard and recreation privileges
2. Extra duty
3. Restitution for property damages
4. Cell restriction
5. Loss or restriction of commissary privileges
6. Loss or restriction of phone use
7. Loss of smoking privileges
8. Required increase in program activity (reliance on therapeutic sanction)
9. Required reading/writing assignments
10. Participation in conflict resolution intervention with appropriate staff and/or other inmates
11. Loss of good commutation credits up to nine days a month
12. Administrative segregation

Concerns about whether the above sanctions mirror Northern State goals of security, order, control, and treatment have arisen. Whether the sanctions are commensurate with mental health treatment, however, is less clear. Moreover, it is unclear if some of the sanctions in the above list are more severe than necessary for achieving Northern State Prison’s mission to maintain a safe facility. While some sanctions are justified, others may exacerbate inmates’ already high stress levels and psychiatric symptoms, particularly when the sanctions hinder autonomy, movement, or

connections with others (sanctions #1, 4, 6 and 12). Also, sanction #3 can create needless harm to inmates who are indigent; sanctions #4 through #7 can be detrimental as they restrict inmates coping methods even further. Withholding privileges (#4-7), may not necessarily bring about therapeutic outcomes to inmates who are the recipient of these penalties. Rather, the loss of privileges can compromise everyone's safety by increasing inmate agitation and violence in the housing units.

Policy # 27.01 - Psychotropic Medications

Policy #27.01 states that the prescription and administration of psychiatric medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluations, is an unacceptable method of treatment.

Furthermore this policy seeks voluntary inmate participation when taking prescribed medications. The policy also spells out the exact procedures that psychologists and nurses have to follow in medication distribution and the rules regarding the purpose and management of medication. During medication distribution, CMS nurses have to observe the actual ingestion of medication. The CMS contract psychiatrist is the only staff person who can order medication for inmate treatment plans. Medications can be started by oral or written orders. Before a medication regimen is started, mentally ill inmates have to be informed of the potential risks, benefits, and side effects of their medications, making them informed consumers. Furthermore, policy #27.01 mandates that inmates who are in outpatient status are to be evaluated monthly for medication effects. The policy also calls for CMS mental health staff to monitor inmates in administrative segregation on a daily basis for changes in symptoms and behaviors indicative of worsening mental illness.

Policy # 67.01 and 67.02 – Psychiatric Medication Refusals

NJDOC authorizes the CMS mental health staff to initiate a forced medication procedure, if the staff feels that risk of harm to the inmate or others is imminent. To lessen the risk of harm taking place, inmates who reside in the RTU, the TCU, or in an outpatient status are permitted to refuse their prescribed medication on three consecutive occasions before the CMS psychiatrist can take action. However it was recommended, forced medication does not require informed consent. Psychiatrists can issue verbal orders for forced medications that are effective for 24 hours after which written orders have to be issued. The staff authorized to be part of the forced medication hearing include the prison shift commander, nurses, prison administrators, and the mental health staff. These two policies highlight the protective mechanisms that prevent or minimize arbitrary and/or abusive use of medications as a tool of control or discipline. Moreover, these policies recognized some degree of autonomy on the part of inmates by allowing them to decline medications up to three times before any action is taken. Under this policy, mentally ill inmates qualify for due process-like rights, if forced medication hearings proceeded.

Conclusion

The ultimate goal of the policies is to assure that inmate discipline and control are consistent with the correctional objectives of the New Jersey Department of Corrections and Northern State Prison. Most of these written directives address the challenging relationship between custodial and treatment goals for mentally ill inmates. The language embedded in many of the policies, however, creates therapeutic space through which increased psychiatric attention is encouraged, permitted, and provided to inmates.

General Chapter Summary

The scope and the range of Correctional Medical Services (CMS) policies and procedures regarding mental health treatment program services at Northern State Prison are more extensive than at Vantaa Prison. This extensive coverage may result from Northern State's larger population and greater number of inmates with mental illnesses. The two systems' policies reflect these differences. Northern State mental health staff carry a larger caseload and cover three distinctive specialized housing areas and an outpatient program. The document review of policies demonstrates that the mental health treatment components at Northern State Prison and Vantaa Prison specialized housing share common features in the written directives that guide mental health program services. With respect to demographic characteristics, the inmates in both prisons share needs related to their mental illnesses. As a result, the policies reflect overlapping goals of identification, treatment, and discharge of inmates suffering from mental illness. For example, the policies and procedures in both prisons cover individual counseling, therapeutic groups, cognitive-behavioral interventions, psychotropic medication monitoring, substance abuse relapse prevention, health assessments, crisis management, and preparing inmates to transition into the general population or exit from prison (adapted from Edens, Peters & Hills, 1998).

A comprehensive review of policy and procedure manuals further demonstrates that administrators at Vantaa and Northern State Prisons are accorded the task of creating and enforcing therapeutically conducive environments in which rehabilitative goals toward inmates with mental illnesses can be achieved. At Northern State Prison these goals have been influenced by the Terhune decision, U.S. Constitutional Amendments,

NJ DOC rules and regulations, and CMS policies and protocols. Together, these documents establish specialized housing units that target inmates in various stages of their mental illnesses. By policy, these units are staffed by trained mental health personnel. Vantaa Prison specialized housing serves similar therapeutic aims. It was created as result of various international mandates and accords such as UN declarations, European Prison Rules, Finnish legislation governing prisons and Vantaa Prison internal regulations. Collectively these documents recognize the presence of mentally ill inmates at Vantaa Prison, and these same documents shape Vantaa Prison's correctional philosophy. Subsequent practices assure inmates their right to mental health services. These documents jointly incorporate a therapeutic component into the security and custodial goals at Vantaa Prison, overlapping mental health treatment areas, as well. Both prisons' documents have this aspect in common.

Northern State Prison rules and regulations affirm the primary goals of security and control in their approach to inmates who are mentally ill. Yet, CMS's Mental Health Services Policy and Procedures Manual also provides a detailed and parallel clinical trajectory to address the needs of these same inmates who reside in specialized housing. As such, the CMS policies and protocols serve a dual function; first as a policy manual to mental health staff and second as a mission statement to provide psychiatric care that meets constitutional guidelines and institutional requirements. These policies also set the length of time that special need inmates are eligible for mental health services, which, per policy, can last for years. In contrast, Vantaa Prison mental health program policy does not specify length of treatment episodes or clear eligibility criteria, leaving much discretion to Vantaa Prison mental health staff. Both prisons, however, recognize the

need for their mental health staff to be proactive in their efforts to identify, treat, and reintegrate inmates back to their home communities. In other words, correctional philosophies extend their reach and scope from the start of inmates' incarceration until their release.

The document review found that disciplinary procedures are written into policy guidelines in both prisons, although at Northern State Prison they are more detailed and cover a wider range of inmate behaviors. Various disciplinary methods are allowed to be taken against inmates at Vantaa Prison and Northern State Prison; the methods, however, vary in length, intensity, type of sanctions, and degree of mental health intervention. Use of inmate restraints is prohibited at Vantaa Prison unless imminent danger exists or restraints are authorized by the warden. Northern State Prison policies do not explicitly prohibit the use of restraints; clear and convincing evidence, however, has to be apparent to justify their use. The most noticeable difference that emerges between Vantaa Prison and Northern State Prison policies centers on Administrative Segregation (Ad Seg). Northern State Prison's mentally ill inmates are not exempted despite documented history or current treatment for mental illness. To address the needs of mentally ill inmates in Ad Seg, Northern State Prison policies have also established the Special Administrative Segregation Review Committee (SASRC). SASRC is comprised of mental health staff and other prison staff whose charge is to review the status of all inmates in Ad Seg to determine continued placement or termination. In contrast, Vantaa Prison policies authorize the placement of inmates in isolation, not to exceed fourteen days. Placing inmates in isolation is not always a result of a disciplinary act but may also be therapeutic

in nature, particularly in specialized housing. Additionally, the Vantaa Prison document review did not reveal any call for the creation of a committee comparable to SASRC.

CHAPTER 7 – INMATE INTERVIEWS

Part I of this chapter describes the demographic, criminal, and clinical characteristics of the sample of inmates at Vantaa Prison in Vantaa, Finland and Northern State Prison in Newark, New Jersey. The tables in the ensuing pages are presented for comparative purposes with each accompanied by a short explanation of the findings. Part II presents the summaries of inmate responses to interview questions and is organized by the analytic plan previously described in the methodology.

Part I. Respondent Characteristics

Table 2 depicts the ethnic and racial breakdown of both inmate groups. A majority of Vantaa Prison inmates were Finnish; the sample also included two ethnic Romani inmates, one Eastern European, and one South American inmate. The Northern State Prison sample was more diverse reflecting the existing demographics of urban New Jersey. Most inmates were African-American (75%), followed by Hispanic (12.5%) and white inmates (12.5%).

Northern State Prison inmates were older compared to their Vantaa Prison counterparts, although the overall age range between the two groups did not differ much. At the time of the interviews, the average age of Vantaa Prison inmates in the sample was 27.5 years compared to 34.5 years for Northern State Prison inmates. Northern State Prison inmates ranged from 21 to 60 years of age compared to 18 to 58 years for Vantaa Prison inmates.

Table 2. Demographic Characteristics

	Vantaa Prison (n=40)	Northern State Prison (n=40)
Racial or Ethnic Group	%	%
African-American	-	75.0
Hispanic	-	12.5
White	-	12.5
Ethnic Finns	90.0	-
Other	10.0	-
Total	100.0	100.0
Age range (18-68 yrs)		
Mean age (years)	27.5	34.5
18-30	50.0	32.5
31-40	32.5	45.0
41-50	10.0	17.5
51-68	7.5	5.0
Total	100.0	100.0
Education (years)		
	7.0	11.3
Marital Status		
Never Married	85.0	92.5
Total		

Table 2 also shows that Northern State Prison inmates were, on average, more educated than their Finnish counterparts with 11.3 years of formal education compared to seven years for Vantaa Prison inmates. This means that most Vantaa Prison inmates had not entered or attended high school. Several Northern State Prison inmates received their general equivalency diplomas (GED) in prison, whereas no Vantaa Prison inmates had achieved the same credential. Similar credentials do not exist in the Finnish educational system. None of the Northern State Prison inmates were college graduates; one individual, however, had attended college and several others had completed various

vocational courses during their incarceration. Over two-thirds of Vantaa Prison inmates (70%) had quit school after finishing elementary school. Two were high school graduates, and one held a college degree. The level of education for seven Vantaa Prison inmates (17.5%) was not known. Northern State Prison inmates reported that their educational pursuits as children and young adults had been interrupted due to family instability, substance use, and juvenile incarceration. Likewise, the majority of Vantaa Prison inmates attributed their lack of education to unstable family lives, substance use, institutionalization, and concomitant criminal offending to support drug addiction. Almost none (92.5%) of the Northern State Prison cohort had ever married. Similarly, 85% of Vantaa Prison inmates had never married.

Table 3 highlights the offense profiles for which both inmate groups were sentenced or awaiting sentencing (at Vantaa Prison). It should be noted that the percentages in Table 3 total more than 100% because some inmates were incarcerated on multiple offenses. Over half (57%) of the inmate sample were incarcerated for violent crimes. Eight inmates (20%) were in prison for attempted murder and attempted manslaughter, four others for murder (10%), one for attempted manslaughter (2.5%), one for accessory to murder, four for robberies (10%) and the rest for assaults (14.5%). Seventeen percent of the crimes committed by Vantaa Prison inmate sample were drug related. In addition, 18 pre-trial inmates comprised 22.5 % of the inmate sample. Most of the violent crimes committed by the sample were directed by inmates, often under the influence of alcohol or drugs towards their intimate partners or family members. It was rare for Vantaa Prison inmates to report the use of a gun use during the commission of their crimes. Instead, most violent crimes were committed with sharp objects like knives

and axes. Hands (fists) were also used as weapons. Twenty-five percent of the sample of inmates were in prison for property theft related crimes that included forgeries, burglaries, car theft, and taking items from cars. While the entire Northern State Prison inmate group was serving time for felony crimes, in Vantaa Prison respondents included both pre-trial and sentenced inmates. Four inmates (10%) were “fine defaulters,” whose court fines (e.g., court costs, tickets, restitution) were converted into short prison sentences for failure to pay. Ninety-five percent of Northern State Prison inmates were incarcerated for violent crimes, including sexual assaults (2.5%), carjacking (2.5%),¹⁵ attempted murder, aggravated assaults and assaults (50%), murder (7.5%), robberies and armed robberies (30%), and one home invasion (2.5%). The inmates reported using handguns more often than any other weapon in the commission of their crimes. Furthermore, 17% of the crimes were connected to illegal drugs and included possession of a controlled dangerous substance, possession and trafficking of cocaine, and selling heroin. As with Vantaa Prison inmates, Northern State Prison inmates’ offense profiles demonstrated an over-representation of violent crimes and an under-representation of property and non-violent crimes. Table 3 highlights sentencing lengths and the percentage of sentenced inmates from each prison who fell into each of these categories. The average sentence length in Table 3 shows a difference between the two inmate groups. On average, sentences were 3.1 years for Vantaa Prison inmates compared to 9.8 years for Northern State Prison inmates. This disparity may be linked to prevailing sentencing guidelines in each country. For example, Northern State Prison inmate sentences reflected mandatory minimum-sentencing guidelines for various non-violent and violent crimes. Twenty-two Vantaa Prison inmates had been sentenced and the

¹⁵ Never reported by Vantaa Prison inmates

remaining 18 were awaiting sentencing, thus influencing the sentence length averages in this study.

Table 3. Offense Profiles

Offense Profile	Vantaa Prison (n=40) %	Northern State Prison (n=40) %
Murder (1 st , 2 nd , Manslaughter)	10.0	7.5
Serious Violent Assault (attempt. murder, assault, attempt. Manslaughter)	34.0	50.0
Robbery; Armed Robbery; gun related	10.5	30.0
Sexual Assault (rape; attempted rape)	2.5	2.5
Property Theft (theft, break/enter, auto theft)	25.0	12.5
Drug Possession/ Trafficking/Sales	17.0	17.5
Fine Defaulters	10.0	-
Total¹⁶		
Sentence Length		
One to 12 months ¹⁷	37.5	-
13 months to four years	50.0	22.5
Five to 10 years	2.5	45.0
Eleven to 20 years	7.5	22.5
21 to Life	-	10.0

Table 4 shows major psychiatric diagnoses of each Vantaa Prison and Northern State Prison inmate as a percentage of the sample. Among Vantaa Prison inmates, psychotic disorders represented close to 23% of the total diagnoses and mood disorders 30%. Anxiety disorders represented 17.5% of the diagnoses, and personality disorders

¹⁶ Totals exceed 100% because some inmates were incarcerated for multiple offenses.

¹⁷ Prison sentences range from weeks to years

the remaining 30%. The distribution of psychiatric disorders was similar for Northern State Prison inmates. Among the Northern State Prison inmate sample, psychotic disorders constituted 20%, mood disorders, twenty-seven and a half percent (e.g. depression, bipolar disorder and dysthymia). Anxiety disorders were diagnosed in 16% of their inmates, and personality disorders made up the fourth category, with 37% of Northern State Prison inmates diagnosed. Nearly all inmates in both prisons also had secondary substance use diagnoses.¹⁸ Diagnoses for nine Vantaa Prison inmates (22.5%) were unknown, but the nine inmate subjects were on the prison mental health roll and were assumed to have psychiatric diagnoses because they were taking psychiatric medications.

Table 4. Clinical Characteristics

Psychiatric Diagnoses	Vantaa Prison (n=40) %	Northern State Prison (n=40) %
Psychotic Disorders	22.5	20.0
Mood Disorders	30.0	27.0
Anxiety Disorders	17.5	16.0
Personality Disorders	30.0	37.0
Total	100.0	100.0

In regard to substance use, over one-third of Vantaa Prison inmates (37.5%) reported amphetamine dependency or use, followed by opiate use (30%), and then alcohol use (45%). Some Vantaa Prison inmates also disclosed long histories of self-medication for symptoms of anxiety and mental illness. Eighty percent of Northern State

¹⁸ Similar to their counterparts, some Vantaa Prison inmates were counted more than once to capture range and type of various drug uses.

Prison inmates also had secondary substance use diagnoses consisting of alcohol, cannabis, heroin, crack, and powder cocaine use.

General Section Summary

Vantaa and Northern State Prison inmate samples were found to have more similarities than differences, although variations emerged between the two groups. Northern State Prison inmates were mostly non-white, while Vantaa Prison inmates were majority white and less ethnically diverse. Northern State Prison inmates were found to be older and better educated. Similarly, the majority of the inmate sample in both prisons had never married, and most lacked high school diplomas. Northern State Prison inmates were found to have committed more violent crimes than their Vantaa Prison inmate counterparts; Northern State Prison inmates were more likely to have used guns in the commission of their crimes than Vantaa Prison inmates who used knives, axes, and their hands as weapons. Vantaa Prison inmates were serving sentences that averaged 3.1 years, while their counterparts at Northern State Prison had average sentences of 9.8 years.

Northern State Prison inmates and Vantaa Prison inmates presented similar clinical characteristics for severe mental disorders (psychotic disorders) and mood disorders. Northern State Prison inmates had slightly higher percentages (37 %) of personality disorders than the 30% among Vantaa Prison inmates. Lastly, none of the inmates in either prison presented pure, single-diagnoses. Instead, the men presented multi-problematic profiles requiring multi-focused psychiatric and substance use interventions. In terms of substance use, almost all (95%) Northern State Prison and Vantaa Prison inmates had secondary substance use diagnoses, and the majority of men

in both groups reported chronic and long histories of substance use. According to self-reports, Vantaa Prison inmates most frequently used alcohol, cannabis, and prescription medications, while Northern State Prison inmates used cocaine, crack, alcohol, and heroin.

Part II. Inmate Responses to Research Questions

The material in this section reflects the major themes that were developed from the inmate answers to research questions. The themes were developed within three primary topic areas: inmate perceptions of the prison environment, experiences with mental health treatment, and quality of interactions with staff. The major reason for asking questions in these areas was to understand the inmates' point of view. In the following sections, Vantaa Prison inmate comments are presented first, and then Northern State Prison inmate comments are provided for contrast and discussion.

ENVIRONMENT - Specialized Housing

Inmates were asked to describe specialized housing in detail; five themes emerged (see Table 5 below). They were helpfulness, cleanliness, activities, lockdown and security. Each of these themes produced positive and negative inmate comments from both inmate groups. The percentages represent the percent of respondents who commented, positively or negatively, on the theme.

Table 5. Specialized Housing

Themes	VP (n=40) %	NSP (n=40) %
1. Helpfulness	90	80
2. Cleanliness	60	50
3. Activities	95	60
4. Lockdown	50	95
5. Security	85	75

Helpfulness

VP Inmate Comments

As shown in Table 5, 90% of the Vantaa Prison inmates commented about the helpfulness of specialized housing. Ninety-five percent of helpfulness comments were positive and 5 percent negative. The positive comments were connected to the structural differences between specialized housing and the inmates' regular housing units and were considered helpful in terms of their adjustment. Nick underscored the unit's resemblance to a non-prison like facility, something that he probably did not expect to see in a correctional institution, hence its helpfulness to him.

This place is like a hotel. This place is like a paradise.

Jukka, who was being treated for mood disorder, listed several factors about specialized housing that were considered helpful.

Here I have slept less but I get along with people, being around people and having things to do. It is quite free here.

Alvo, an inmate who was being treated for schizophrenia made the following comment about being in specialized housing and his perceptions of the place.

It was scary to come here. Murderers and crazy people!

Bruno in turn commented why he did not consider specialized housing a helpful place.

Nobody knows me and I don't know them. I don't belong in the psychiatric hospital!

Cleanliness

As is illustrated in Table 5, 60% of the inmates commented about cleanliness; 85% of those comments were positive, and 15% were negative. The inmates indicated

that because their showers and toilets were in their cells, it was their responsibility to keep them clean. Treatment staff provided inmates with material to scrub the shower walls, a mop to clean the bathroom floors, and a toilet brush.

Cleaning gives me something else to do, to take my mind off being incarcerated, and I also feel good about keeping my room clean.

Activities

Heikki described specialized housing as “good,” which carries a variety of meanings, both structural and contextual. For one, he cited activities as one of the reasons they were good.

Feels like this is a good place. Small place, a lot of activities, cell doors are open and not closed all the time.

Pekka included a negative comment indicating what specialized housing, in his opinion, lacked.

More nurses. Personal discussions, half an hour a day. Also, more recreation.

Security

Because of the way specialized housing was designed, clear lines of observation by treatment staff and vice versa was possible. To Al, this type of shared surveillance seemed to convey caring.

The nurses and other staff are constantly present. They make themselves visible by walking around continually.

Alva described feeling less fearful in specialized housing because he was under constant observation, which was facilitated by technology and custodial and treatment staff members.

Now there is a better feeling. Two cameras, guards, and not feeling afraid of death.

Robert reported a feeling of safety that he attributed to human contact.

I don't remember that someone has touched me (therapeutically) in ten years unless they were police and corrections officers. Perhaps the feeling of safety comes from that.

The following quote is from Jore, who was receiving treatment for a psychotic disorder.

Being in specialized housing did not necessarily convey a sense of security to him

I feel afraid because I didn't know how they would accept me. I feel tense.

Lockdown

Many Vantaa Prison inmates reported feeling safer because of the daytime open cell door policy, the visibility of treatment staff, and not being locked in with other inmates. Also, open cell doors may provide more witnesses in the event of violence thus lessening its likelihood from taking place. Juho's commented.

There is an atmosphere of safety. The doors are open during the day and the nurses are present.

Mark had requested placement in lockdown in order to seek reprieve from anxiety and suicidal thoughts. He did so by making his request known to treatment staff. Inmate autonomy in this situation manifested itself as commitment (to treatment). Mark shared that he felt safe in lockdown despite separation from other inmates or participating in groups and other activities.

I was in (isolation cell) due to my own request. I enjoyed it there better. The cell doors were locked but it did not cause me problems.

Richard had requested to be placed in lockdown status for safety reasons precipitated by persistent suicidal thoughts. His request was manifested as a prescription for a negotiated

treatment and delivered in mutual agreement with treatment staff despite Richard's uneasiness. "It doesn't feel nice," he said while admitting some feelings of safety. The safety was generated by the rudimentary conditions of the cell and because it lacked almost anything removable. Hence, Richard felt the risk of self-harm was minimized.

In conclusion, within a single prison, the environment can vary from cell block to cell block. This was found based on inmate feedback to be the case at Vantaa Prison. An overwhelming number of inmates commented on the positive physical structure of specialized housing, especially its resemblance to a civilian psychiatric hospital. The inmates credited the quality of accommodation, helpfulness, cleanliness, activities, fewer reminders of being in a correctional facility, such as the daytime open cell door policy, and an overall feeling of security for their positive reactions.

NSP Inmate Comments

Helpfulness

The following comments about specialized housing are from the Northern State Prison inmate sample. Eighty percent of the inmates commented about helpfulness; 20% of comments were positive and 80% negative. Luis responded positively, sharing light on how he found specialized housing helpful. Being able to engage in an enjoyable activity and having less contact with corrections officers, made residing in specialized housing helpful.

It's the best in the whole prison. Don't have to worry about corrections officers harassing you. Play radio loud. I don't want to leave. It was good for the first time. They gave you your own room.

Helpfulness equated to a positive ambiance, unlike the one Roy had left behind. Hence, he felt encouraged to be himself a little more.

Because it is different. I don't have to tense up. It is a different environment here. It is a little more relaxed than the other. You deal with a lot of (guys) with mental health problems.

The following remark by Joseph, illustrates why his perception about specialized housing was negative. He found the setting to be harmful because of the stress brought on by its similarity to other correctional facilities and the behaviors that were exhibited by various prison personnel.

No incentive! It is no different than any other prison. Guards yell and scream!

Pilot stated that he threatened his cellmate which led to his transfer to specialized housing first and then to Ad Seg for thirteen days.

First I resented the stigma that goes with it. It is known as the crazy unit. I went to lock up (Ad Seg) because I didn't want to be there.

Roy remarked what specialized housing was lacking, in his opinion, and how their living environment and diet should be improved to be more helpful.

I would change the recreation room. I would put a TV back in there. Some of the guys don't have TVs' in their rooms. The food is terrible; hard meatloaf watered down mash potatoes, spaghetti with fake meat.

Cleanliness

Sixty percent of inmates mentioned the theme of cleanliness; rules of specialized housing decorum made it an important concern. While many inmates underscored the importance of keeping their cells and general housing areas clean, only 20% of the comments were positive and 80% were negative. The negative comments frequently mentioned group toilets and inmate shower areas as being the dirtiest within specialized housing areas. Aroco noted:

Our bathrooms. It's trifling. The showers are dirty. I'd be scared to take a shower!

Roy added that his discontent had to do with not being able to wear clean clothes for a prolonged period of time.

Stressful cause I only had one change of clothes for month and a half.
Sometimes the laundry is returned dirty.

Activities

Seventy percent of inmates mentioned the theme of activity. Fifty-five percent of the comments were positive, and 45% were negative. The inmates who made positive remarks felt that enough activities were offered in specialized housing, while the negative remarks claimed the contrary. Jason, for example, reported taking advantage of treatment related activities yet remarked that the unit resembled the general population areas.

Just like another unit. Just like any part of the jail except you see the psych, take medications, see psychologist.

J.A.'s comment underscores a lack of activities, which prevented him from using time constructively within specialized housing environment.

They (mental health) don't come around like they supposed to. Basically we sit around all day.

Lockdown

The fourth theme, lockdown, was mentioned by eighty percent of the inmates. Ninety-five percent of their comments were negative, and 5% were positive. According to inmate comments, extended lockdown was widely practiced within specialized housing units. It hindered Wilson's ability to engage in activities that were important to him. His statement reflects the right column of Table 5.

Twenty hours a day in cell if you are not working! Open it up ...have a chance to take a shower, to school, rec. We locked in twenty hours a day!

To Rick, the similarity with general population housing units was underscored by a lack of activities to make his time worthwhile.

You are locked in continuously. I spend 21 hours in my cell.

To L.D., being in lockdown helps him as an inmate who was battling schizophrenia.

Getting away from other inmates was part of the helpfulness as well.

Sometimes I don't wanna be around people. Sometimes lock up helps. I believe it helps. Helps me focus more.

Security

With regard to safety, one of the things that Walter noticed about living in specialized housing was the fact that inmate violence was less common, thus the chance of being victimized decreased.

I feel a certain sense of security on the unit. There are less altercations here.

The last comment is from Pilot who found it perilous to share a cell with an unstable inmate who exhibited bizarre behaviors.

He took his clothes off, he began throwing stuff; he was bathing with soap in his cell, and put pieces of paper in each corner of our cell. I wanted out of my cell because I did not want to get hurt! It sucks. I'm stuck here. Nothing I can do about it.

In conclusion, inmate perceptions of safety varied among Northern State inmates. Feelings of safety were reported by some inmates because of less inmate to inmate violence. Other inmates conveyed that psychiatrically unstable cellmates contributed negatively to their perception of safety in specialized housing; however, most inmates indicated that they were powerless to change their housing situations.

General Section Summary

Collectively, inmate perceptions varied with regard to overall feelings of comfort in specialized housing and their capability to utilize their time constructively within the environment. Important similarities and differences in inmate perceptions about the environment emerged from their responses. Most Vantaa Prison inmates felt that specialized housing was helpful; it was clean, activities were available, visibility of staff created a sense of safety, and they appreciated comfortable physical surrounding and the daytime open cell door policy. In contrast, Northern State Prison inmates reported that specialized housing was structurally identical to the general population where there were not enough activities and prolonged lockdowns were common practice. In contrast, most Vantaa Prison inmates conveyed appreciation for the freedom of movement allowed in specialized housing and noted that it was different structurally and organizationally than other parts of Vantaa Prison where their movement was more restricted. Responses suggest that Northern State Prison specialized housing operates a noticeably higher degree of control over the limited movement of inmates and their daily activities than does Vantaa Prison specialized housing.

ENVIRONMENT-Perceptions of Personal Space

VP Inmate Comments

Size

Both inmate groups were asked to describe their personal space (cells) and what they thought about them. As is shown in Table 6, the four themes that were mentioned most often by Northern State Prison and Vantaa Prison inmates included cell size, materials used to build the cells, cell furnishings, including electronics, and personal

items. Twenty percent of Vantaa Prison inmates commented about cell size; 55% of comments were negative, and 45% were positive. Size was mentioned often because cells permit only pacing or stationary exercise and not much else. Pekka, who was being in treated for mood disorder and substance use, commented:

Bunk bed for two men and the space is very small.

Material and furnishing

Thirty-five percent of Vantaa Prison inmates commented on cell furnishing, with 45% of comments positive and 55% negative. Having amenities fitted in cells was standard, and inmates could bathe daily. Moreover, inmate cells were air conditioned and open cell doors aided in air circulation; however, they could not regulate cell temperature. The next two excerpts are from Reiska and Peter. Both men had been transferred from other prisons to specialized housing at Vantaa Prison.

There is everything here, showers in your own cell!
If you ask for towels and linen, they are given right away.

Negative comments about materials available in cells were made by Pekka and Rauli. Both referred to a single person cell within specialized housing where inmates were housed due to uncomfortable symptoms, veiled or real threats of harm to themselves. The inmates often requested on their own placements there.

The mattress was thin and it was cold in there because of a draft.

The vent is blowing cold air. I had a paper blanket.

Table 6. Perception of Personal Space (i.e., cells)

Themes	VP (n=40) %	NSP (n=40) %
1. Size	20	60
2. Material	30	70
3. Furnishing	35	65
4. Electronics/Personal items	20	55

NSP Inmate Comments**Size**

At Northern State Prison, the inmates reported that their cells are built of cinderblocks with single narrow slits cut into concrete walls as windows (thus limiting natural light), metal cell doors, metal beds, sinks, and toilets, all of which are bolted into cement floors. Sixty percent of the Northern State Prison inmates commented about their individual cell size; 70% of the comments were negative, and 30% were positive. For example, one inmate could not move about freely within his cell because two occupants shared a small collective floor space. Malik and Carlos' statements reflect that more than one person shared the small space for lengthy periods.

I'm forced to double bunk (two tiers).

They got us locked up in 23 hours in a little cell

Material

Seventy percent of the inmates commented about the material out of which the cells are constructed; 85% of comments were negative and 15% positive. Art, for example, mentioned that sleeping was a challenge because of the type of material his bed was made of. Adrian similarly also vented about his bed and what made it difficult for him to be able to sleep on it.

It is very hard to sleep on metal.

You sleep on fucking steel!

Furnishing

Inmates found the physical environment of their living quarters lacking in amenities, a problem for those confined in their cells most of the time. The furnishing were bare throughout specialized housing

Change the living situation. The way we live in our cells. Swag searchers. They go through everything. Search everything.

Rob, a middle-aged inmate with a bipolar disorder related his experiences in various locations in specialized housing.

You get your clothes confiscated. You wear nothing. No mattress. Nothing in the cell. You sleep on a cold bunk!

Electronics/Personal Items

Fifty-five percent of inmates commented about electronics and personal items in their cells; 40% of comments were positive and 60% negative. To Seal, Freddy, and Pilot, the few amenities and electronics, however, may have provided some semblance or element of personal space in an impersonal space.

I have a TV, word processor. I do arts and craft in my cell. I can draw.

I have a TV and a radio in my room.

I would just read my Bible.

General Section Summary

Differences were noted in the type of material used to furnish inmate cells based on inmate feedback. Some Northern State Prison inmates expressed frustration because

sleeping on metal beds was hard. Comparable comments were not made by Vantaa Prison inmates about their personal living spaces. Rather, positive comments about the contents of their cells were shaped by what was in their cells rather than what they were lacking. In both facilities, however, simple belongings kept in cells by the inmates for the most part consisted of having a television and a radio.

TREATMENT

VP Inmate Comments

Referral to Care

The accounts given by Vantaa Prison inmates about referral to treatment differed from their Northern State Prison counterparts as illustrated in Table 7 below. None of the inmates were automatically referred to care or transferred to specialized housing upon arrival at Vantaa Prison. In other words, referral to care was not a standard institutional practice. Seventy-five percent of the inmates made comments about referrals to care; 90% of the comments mentioned self-referrals and the remaining 10% referrals by various staff including corrections officers, nurses, and mental health staff. Consequently, the inmates' answers reflect a myriad of referral paths consisting of internal routes forming an interdisciplinary correctional mental health referral network where the inmates were almost always the initiators.

Table 7. Referral to Care

Themes	VP (n=40) %	NSP (n=40) %
1. Self-initiated	90	2
1. Screening by staff	10	98

In order to facilitate the referral process, inmates first filled out request slips to see a psychiatrist and handed them to nurses or correction officers for processing. In this

capacity, the inmates became initiators in seeking treatment, although they did not control the actual outcome beyond their requests. The nurses then screened the referrals without seeing inmates face-to-face and then made decisions about who to schedule for psychiatric consultation. With 95% of Vantaa Prison inmates having been previously incarcerated, many had documented mental health and substance use histories on file. This information was accessible and used by nurses to determine appointment needs through the prison-wide electronic medical record system. The following two excerpts, from Alvo and Johnnie, offer individual accounts on how each secured consultations with the psychiatrist. Their statements reflect the left column of Table 6.

From the doctor's office reception. The nurse then put me on the list to see the psychiatrist.

Nobody asked (about mental illness). You have to put in a request separately to see the doctor. I went there... to the doctor.

Marko had unsuccessfully attempted suicide, which prompted treatment staff in his home prison to refer him to specialized housing.

The psychologist of the other prison called here inquiring if space was available. One was. I took the piss test and it was clean and then I was brought here.

Richard's journey to the psychiatrist was a bit more onerous. He reported that he had placed a razor blade inside a small tin box with a note addressed to his parents. The box was discovered by the nurses triggering a referral to mental health to assess a risk for suicide. He was one in ten inmates who prison staff, based on their assessment of the inmates' presenting symptoms, referred for psychiatric consultation

I talked with the nurse and she promised to put me here.

The corrections officers at Vantaa Prison are in positions to monitor inmates over time and across various environments and can refer inmates to care when they notice changes in their mood or behaviors. Also, they can offer critical information by consulting with nurses and in particular with mental health staff due to their restricted ability to observe the same inmates outside the parameters of specialized housing. In Tapsa's situation, a CO played a role in referring him to specialized housing. He positively stated:

Well, the corrections officers had looked at me and felt that something was not right. I did not eat and just lay in my cell depressed.

In summary, the majority of the inmates made requests for psychiatric consultation upon their arrival at Vantaa Prison, and most did so without a mandate or referral. The protocol of having to fill out a request form (for referral) and then wait to be seen by treatment staff was standard practice. Psychiatric consultation was also required in order to be considered for admission to specialized housing. Overall, Vantaa Prison inmates actively participate in their treatment by playing key roles in the referral process.

NSP Inmate Comments

All forty inmates were asked about how they were referred to care at Northern State Prison. As shown in Table 7, virtually all (98%) mentioned CRAF as the referral point based on mental health assessments that warranted referral to care within specialized housing. The remaining 2% initiated referrals on their own or through corrections officers once they had settled in at Northern State Prison. Walter's comments below describe his pathway to care. Walter arrived with adjustment disorder and

substance use dependency and shared his negative assessment of how his pathway to care unfolded.

One, transfer. Your history comes with you. Two, mental health saw me.

John, a transfer inmate from Trenton State Prison, via CRAF, also with an adjustment disorder stated the following about his referral experience.

They look over your files. Everyone goes to certain housing area and they are evaluated here first.

Section Summary

Based on Vantaa Prison and Northern State Prison inmate comments about referral to care, a protocol was in place in both facilities to facilitate inmate access to care. Inmate remarks, however, about procedural and structural differences in the referral process were different. Their comments point out that most inmates had been either system referred or self-referred to in-house treatment. The majority of Vantaa Prison inmates facilitated their self-referral, whereas Northern State Prison inmates arrived with referrals to care (and specialized housing) directly. Inmate answers also varied regarding the referral pathways that both groups took. Northern State Prison inmates described a standardized and more streamlined referral process whereas Vantaa Prison inmates described a process that seemed fragmented and without a standard method to refer all new inmates for psychiatric consultation. Hence, their excerpts reflect more varied referral pathways. In addition, that self-referred inmates met the psychiatrist meant that those who were suspected of having a mental illness were first referred for consultation to establish treatment needs including referral to specialized housing, if needed. Northern State inmates named CRAF as the facility where they had been evaluated, diagnosed, and

their treatment needs established. Referrals to care and subsequent treatment were continued at Northern State Prison where treatment spaces were available to this inmate group. In contrast, Vantaa inmates' voluntary self-referrals were the instrumental part that formed their initial step in referral to care. Also, many of these referrals lacked clinical information because mental health staff relied on self-referred inmates for informing about treatment. In contrast, referrals that were initiated at NJDOC/CRAF were personalized, at least at first. The affixation of a psychiatric diagnosis on Northern State Prison inmates lead to their referral to care first and foremost.

Individual and Group Therapy

VP Inmate Comments

The inmates in specialized housing at Vantaa Prison had excellent opportunities to participate in individual therapy due to in-house therapy meetings, ample treatment staff, space, and no waiting list. Individual therapy was most often discussed by the inmates in positive terms as they found it both helpful and educational.

Table 8. Individual Therapy

Themes	VP (n=40) %	NSP (n=40) %
1. Helpful	85	85
2. Educational	80	80

As is shown in Table 8 above, all forty Vantaa Prison inmates commented about individual therapy of which 85% of comments were positive about therapy and 15% were negative. Regarding positive comments, the inmates mentioned helpfulness of individual therapy because it provided an outlet to let out frustration and learn about managing and coping with mental illness and addiction. Moreover, the opportunity to engage in on-

going therapy with staff without barriers to participation was part of the helpfulness to Kai and Jesuki.

Well, I have my own nurse and we see each other two to three times a week for talk about my problems. It helps a lot.

I can relieve pressure by talking. Well, it is easier to talk to a stranger rather than to family members. Brothers and fathers are family, here they are nurses. They are experts.

NSP Inmate Comments

Ninety percent of Northern State Prison inmates talked about individual therapy; 85% of the comments were positive and the remaining 15% negative. Communication and trust building were considered helpful as were consistent meetings with treatment staff. The following response by Poet mulls aspects of therapy he found helpful.

I see Dr. X every week. I can talk to her. She helps.

A gradual trust building made therapy worthwhile to Pilot. Moreover, face-to-face contact with treatment staff served as a journey to expose layers of interpersonal distrust, and suspicion, and to learn about trust in a distrusting environment.

I have been a little more open. I found out that talking helps. It is a whole new thing. I did not trust nobody here first.

Five percent of the inmate comments considered therapy unhelpful. Tuck, for example, expressed his feelings about participating in individual therapy and whether its helpfulness to him.

No! They don't care. They don't do nothing!

In summary, individual therapy at Northern State Prison constituted a focal point of the inmates' overall mental health treatment program. Thus, therapy emerged as a significant conversation topic because it was helpful, instructive, and a constant part of the mental health treatment continuum. Moreover, the opportunity to talk and share confidentially with treatment staff helped to lessen the isolation and stress of incarceration.

General Section Summary

Part of the mental health treatment at Vantaa Prison and Northern State Prison specialized housing consisted of regularly scheduled therapy sessions with mental health staff. The majority of the inmates in both prisons regarded therapy in positive fashion and felt that it was helpful in addressing their problems. Helpfulness was conceptualized as stress relief, goal oriented, and educational. It permitted inmates some level of autonomy regarding discussion themes. Moreover, an equality of access to therapy was also mentioned as a benefit of residing in specialized housing. It was in this context that commonality between inmates comments was found across both facilities.

Group Therapy

VP Inmate Comments

Vantaa Prison specialized housing provided a selection of small groups, usually between seven to ten inmates each, that met five days a week for about an hour at a time. Based on inmate feedback, mental health staff facilitated groups with no correction officers in the immediate vicinity. Group therapy provided inmates a space in which to discuss difficult issues, both individually and collectively. Group therapy and the content of groups were mentioned by 70% of the inmates; 35% of their comments were negative

and 65% positive. Helpfulness was conceptualized as being able to talk, express ideas, learn about the opinions of other inmates, and initiate face-to-face contact with treatment staff and other inmates. In addition, 70% of the inmates commented on learning in group therapy; 60% mentioned educational aspects to group participation.

Table 9. Group Therapy

Themes	VP (n=40) %	NSP (n=40) %
1. Helpful	65	70
2. Educational	60	65

A comment from Jesuki about group therapy below mentions specific benefits gained by the participating inmate. It centered on talking as a method of self-exploration and education.

They help me to gain insight, to open up when I feel bad. The discussions clear away bad feelings.

Probed why he liked group therapy, Fred indicated that he valued diverse feedback and saw it as helpful and educational in particular because no one was singled out in the process. The sharing or universality of the problems were other factors that inmates mentioned positively.

They can... like...be harmless. They don't look at your problem or my problem. We take a topic and everyone can voice their opinion.

The following inmate offered his insight about group therapy including the focus of the group and his wish for it to be longer in duration.

Well, violence. But forty-five minutes is such a short time. About violence, what causes it? Like...does anyone here have tendencies to do something violent to a person here? I think they are good because you can open up in them. It helps when you get to talk. It is like therapy.

Over one-third of the inmates held negative perceptions about group therapy because participation, even passive, generated uncomfortable symptom for them. Jorma and Ossie found it challenging to tolerate the anxiety and vulnerability that often characterized group process.

People just stare at each other and nobody thinks of anything to say!

Anxiety producing. A moment of panic! I have difficulty in groups.
My chest starts to tighten up!

In conclusion, various groups existed for inmates who resided in specialized housing at Vantaa Prison. The majority of the inmates agreed that group therapy was helpful because they presented opportunities to talk, to connect socially with other inmates and learn about mental illness and addiction. For a number of inmates, however, group therapy was equally unhelpful because it exacerbated the symptoms associated with participation in a group engagement.

NSP Inmate Comments

Group Therapy

Based on inmate comments, specialized housing provided group therapy as part of its standard mental health programming. The three graduated specialized housing areas provided groups, each with topics that were tailored to address the needs of the inmates housed in these units. The groups were facilitated by two mental health staff, and, depending on the situation, sometimes corrections officers were nearby. As is shown in the right column of Table 9, the inmates commented about the helpfulness of groups of which 70% of the comments were positive and 30% negative. Moreover, ninety percent of the inmates mentioned educational aspects of group therapy of which 65% of their comments were positive and 35% negative. Illustrated below are two positive comments

that represent the right column of Table 8. Both excerpts describe helpful and educational aspects of group therapy as explained by Kobe and J.T. To Kobe, group therapy shaped his perception about addiction and his ability to integrate that knowledge into his present situation. J.T. also credited changes in his more positive outlook to group therapy.

The facilitator helped us to understand about addiction. It helps me personally. To understand why we get high. I can talk about things afterwards.

Yeah...just.... I am a lot more patient. I think before I do things. I used to be impulsive. I got rid of the impulse. It was detrimental for my well-being.

According to Yalom (1995), group therapy members must reflect on and make sense of their emotional disclosures in order for increased awareness and growth to take place. This process, however, can create difficulties for inmates who may have never been in touch with their own feelings and experiences, to say nothing of the experiences and feelings of others. It was in this context that Grey reflected, in one sentence, the impact that group therapy had on him.

I am more conscious of other people's feelings now.

In regards to negative perceptions about group therapy, unhelpfulness was conceptualized as an expected active participation which meant communication. Many inmates thus remained reluctant to participate for those reasons. Fear of anticipated self-disclosure formed another barrier. L.D. expressed what the source of his anxiety about groups:

I told I didn't want to go to a group 'cause I don't like talking in front of guys about my problems.

Several inmates expressed their frustration over prison staff who failed to show up to facilitate groups and not being informed about their absences ahead of time. J. Todd, a group participant, stated angrily:

Half of the time X don't show up (to do group). You lose all type of respect here!

The same inmate also stated that the group in question “has been going on for seven months” and quipped “It is supposed to be 2 ½ months!” He cited the absence of prison staff for the prolonged extension of the group beyond its customary length.

In summary, group experiences were both supportive and threatening to inmates. Throughout the interviews, several inmates reported becoming more informed about their illnesses and associated symptoms which they contributed to the educational aspects of the group process. The negative comments were also reserved to groups that did not meet consistently, thus the inmates felt frustrated and lamented their diminished helpfulness to them as mentally ill inmates.

General Section Summary

Identical themes and complementary attitudes were described in both inmate groups. Sixty-five percent of Vantaa Prison inmates and 70% of Northern State Prison inmates found group therapy helpful because groups offered opportunities to share opinions, psycho-educational topics about mental illness and substance use, problem solving, and self-reflection. Also, access to groups was guaranteed in both prisons by virtue of inmates' residence in specialized housing. A smaller percentage of the inmates attributed concerns to anticipated participation in a setting where the inmates did not necessarily know each another.

VP Inmate Comments

Medications

The majority of the Vantaa Prison inmates reported that it was mandatory and expected that everyone would take prescribed psychiatric medications as part of their mental health treatment. Eight-five percent of Vantaa Prison inmates remarked about medications; 90% of the comments were positive and 10% percent negative. Most inmates reported that the medications helped them control negative symptoms associated with psychiatric disorders, helping them engage in their own treatment more effectively. The issue of “right” medication dosages was also mentioned in the context of their helpfulness.

Table 10. Medications and Medication Refusals

Themes	VP (n=40) %	NSP (n=40) %
1. Helpfulness	85	80
2. Consequences	60	80

Jukka saw that taking his medication had had an impact associated on his mental illness.

I hear other voices talking about me, bad about me. Trying to get me killed. The medication has reduced some of them.

To Jorma, ingesting psychiatric medications produced multiple positive outcomes. He had a lengthy history of prescription medication abuse and benzodiazepines in high dosages had served as a pain management strategy in the streets.

With right dosages, the medications reduce panic disorders and nervousness. They also help me sleep. The medication discharges the tension and lack of caring when the dosage is right.

To Alvo and Kim, medications were not something either enjoyed because they did not produce expected outcomes. They explained their reasons for not taking medications this way.

I hear things I really don't hear. The voice is inside my head. It feels as if I don't enjoy them (medications). Like I do from cutting myself.

Yeah when I stopped them (medications). Before them I saw nightmares. Woke up many times on that medication. Get all mixed up from it, or if I take sleeping medication, I expect to sleep the night through and not wake up from it because of nightmares. I noticed that the two days that I did not take these medications I laughed.

In conclusion, the majority of the inmates cited the medications positive impact in reducing negative symptoms associated with psychiatric disorders, and increasing their levels of functioning. In some instances, these positive effects were not reduced to lessening psychotic symptoms, but the medication also calmed them down and made them feel less restless.

NSP Inmate Responses

Northern State Prison inmate answers revealed that taking prescribed psychiatric medications was a major part of their mental health treatment plan. In fact, 80% of the interviewed inmates talked about medication; 70% of their comments were positive, and 30% were negative. Inmates cited reduced symptoms, changes in behaviors and mood, increased ability to function, and fewer auditory hallucinations after taking medications. The following three interview excerpts reveal a range of symptoms experienced by the inmates and the role of medications in managing them. They are from Ricky, Karl, and Jason.

They have had impact on my behavior. I am stable now. I don't have sicknesses.

Almost eliminated my depression. Calmed down. I don't snap out anymore.

They help with voices. They don't get worse and with depression.

Of the inmates who mentioned unhelpful aspects about taking medication, many cited the medications' inability to reduce negative symptoms they had expected to go away. The next remark is from Tuck, who complained that the medication prescribed to control his mood disorder was useless.

Prozac. It don't help. It doesn't stop me from being depressed.

Walter did not take his prescribed medication because he felt he did not need it, possibly because he was in denial about his psychiatric problems or because he felt better without them.

I eliminated the medication. I didn't feel it was doing any good. The medications made me sleepy, drowsy and sleep walking half a day.

Joe was taking Effexor to treat negative symptoms associated with his diagnosis

That's for my anxiety. He said, "I am not content with it. It ain't working. I have not noticed changes.

VP Inmate Comments

Medication Refusals

Regarding prescribed medication refusals, all Vantaa Prison inmates said that they were expected to sign an agreement with staff to comply with medication regimen that was started or continued in specialized housing. Refusal to sign could mean that the

inmate in question was not admitted to specialized housing at that time. As is illustrated in Table 9, 70% of Vantaa Prison inmates commented on medications; 60% of the comments mentioned that they were mandatory and that non-compliance led to negative consequences that included termination from specialized housing. Riddick and Janni confirm that refusing medications was not an option, although neither explicitly stated so. It was implied and understood, though. The first comment is Riddick's and the second from Janni.

The doctor decides. I must eat them.

I would not want to take them. I am required to take them.

The inapplicability of the involuntary medication protocol at Vantaa Prison made it possible for inmates to decline their medication if they wanted to, though some inmates may have found themselves subject to soft or subtler forms of coercion by treatment staff to encourage compliance.

NSP Inmate Comments

Medication Refusals

Seventy percent of Northern State Prison inmates talked about medication refusals, and 80% of the inmates mentioned consequences for medication refusals. The remaining 20% made no mention of what might happen as a result of non-compliance. Consequences, they said, ranged from therapeutic or disciplinary actions or both. The implicit understanding among inmates was that medication refusal was tantamount to violating Northern State Prison rules, which could lead to disciplinary charges. There was, however, some built-in flexibility in the process because inmates said they were allowed to refuse medications on three separate occasions. Jason for example, explained

that if an inmate stopped taking his medications for two to three days, “someone will come see you,” referring to mental health staff. This approach allowed mental health staff to intervene in order to evaluate an inmate’s presenting situation and perhaps avert institutional charges related to medication non-compliance. After the third refusal, Jason reported, mental health staff was authorized, depending on the inmate’s presenting symptoms, to initiate an involuntary medication hearing. The following comment by Rob discusses medication refusal from his point of view, including why he complies with his bipolar medication. It represents the right column of Table 10.

They might lock you in Crisis Stabilization Unit. There is no way around it. They don’t let you out until you take it!

Go-Go’s eventual decision to take his medications seemed to be influenced by NJ DOC policy on off-prison institutionalization at Ann Klein Forensic Center in Trenton, New Jersey.

They was gonna put you in the psychiatric hospital or they was gonna put me on medications. I picked medication because hospital would not count as jail time.

Dre, an inmate who was serving multiple life sentences, said that institutional tactics were used against inmates such as him to facilitate medication compliance.

You can’t refuse medications. You get a disciplinary charge. You have violated one of the institutional rules!

In conclusion, inmate answers indicated both positive and negative consequences to medication refusals. A risk of punishment existed which was integrated into medication management policy designed to deter inmates from being non-compliant with their treatment. For example, if mental health staff deemed inmates competent to refuse

medication, and aware of the consequences of doing so, the mental health staff were accorded the right to determine what was in the best interest of the inmates' mental health at that time. For this reason, actions taken by mental health staff could have therapeutic or disciplinary consequences attached to them, depending on the situations. The inmates also reported that medication refusals meant possible disciplinary action by Northern State Prison by filing charges against the inmate in question.

General Section Summary

The overriding goal of Vantaa and Northern State Prisons is to ensure the security and safety of inmates and staff alike. To this end, taking psychiatric medication formed an integral part of the management of inmate groups and their security and safety in specialized housing. It was in this context that the inmate answers were similar. Psychiatric medication was by far the most common psychiatric treatment modality at the two prisons' specialized housing units. Inmate answers differed regarding the consequences that were used for medication refusals in both prisons. Although taking medication was mandatory in both prisons, Northern State Prison inmates could face institutional disciplinary charges or increased therapeutic intervention as a result of their refusal. For Vantaa Prison inmates, medication refusals equated to potential discharge from specialized housing if no other staff intervention worked. No disciplinary charges followed as the termination was the disciplinary outcome. The protocols that each prison took to handle medication refusals were different, but in each prison there were elements of discipline associated with refusing medication.

VP Inmate Comments

Discharge from Specialized Housing/Release from Prison

At inmate discharge from specialized housing receiving prisons were alerted of inmate arrival dates so that treatment could continue. Vantaa Prison inmate feedback, however, conveyed the anxiety that a change in prison environment coupled with uncertain aftercare represented, even within Vantaa Prison confines. The following section focuses on inmate perceptions of this process and feelings connected with this procedure.

Table 11. Discharge from Specialized Housing

Themes	VP (n=40) %	NSP (n=40) %
1. Monitoring	70	50
2. Referrals	65	70

Eighty percent of the inmates commented about discharges; 70% mentioned monitoring, and 65% mentioned referrals by treatment staff as part of the process. When Jesuki was discharged from specialized housing, he said he returned directly to what he termed “isolation” in his home prison. He lamented the impending change.

“Depressive,” he said, adding that the conditions in his return prison magnified his feelings of depression. He also seemed ambivalent about continuing mental health treatment he started at specialized housing. His comment reflects the left column of Table 11.

I will probably tell their nurse or psychologists. There is a bunk bed, a table made of rock and there is nothing else there. One must just adjust.

The next passage is from Peter who summarized his feelings about returning to his home prison this way. His statement also reflects the left column of Table 11.

Little bad because I would like the rest of the time, because of this treatment, having to take medications, I would like to be around smaller

groups. But I don't have anything else. Having been there for years in that prison so you know how things work there. If I could choose I would rather be here.

Poika mentioned that he is scheduled to return to his home prison within ten days, meaning that his treatment is going to “interrupt.” He stated that this aspect bothers him and is why he would like to remain in specialized housing. Asked why he was being discharged from specialized housing, Poika replied that there are inmates waiting to be admitted, and he is “too healthy” according to treatment staff. Poika disagreed with this assessment and is leaving reluctantly.

In summary, Vantaa Prison inmates had to acquiesce to the reality that the rest of Vantaa Prison or their home prisons did not operate as specialized housing had, nor had it facilities comparable to specialized housing. Also, because the inmates returned to prisons that represented all security categories and a wide range of prison conditions, most inmates felt that transfer was not advantageous, nor did they want to be transferred back when scheduled.

NSP Inmate Comments

Discharge from Specialized Housing

Northern State Prison inmates had fewer comments about discharges from specialized housing to the general population because most inmates remained in specialized housing for the duration of their incarcerations. The next two comments are from two inmates who offered insight about their impending discharges to general population. Cornell reflected on his impending discharge this way:

Little strange. I feel different. Going from single cell back to sharing a cell takes some adjustment. Still take medications.

Herbert expressed some degree of skepticism about his impending transition:

They (inmates) will watch what I do. Sometimes the medications make me zone out. People are telling me (letting him know). I hope that my cellmate will understand my problem.

In conclusion, the inmates who were approaching their return to the general population were looking forward, for the most part, to this transition. None of the inmates conveyed obvious anxiety, although several mentioned having to get used to new routines and housing-specific practices while on medications.

VP Inmate Comments

Release from Prison

To understand how inmates who are mentally ill perceived their release from Vantaa Prison and Northern State Prison specialized housing, they were asked to discuss the pre-release process. For both inmate groups, impending release dates presented a critical junction in their lives. They were no longer to be under the supervision of the correctional system and would commence lives characterized by autonomy in treatment-related decisions. Their referrals to various community mental health treatment programs and community assistance agencies reflected this new beginning, and as such, involved personnel both inside and outside of corrections.

Table 12. Release from Prison

Themes	VP (n=40) %	NSP (n=40) %
1. Referrals	70	80

Leaving prison produced a range of responses from the inmates who were nearing their release dates. At this juncture, the inmates were accorded the opportunity to start making their own decisions to either opt out of mental health treatment in their release

communities or continue, which less than one-third of the inmates stated they would do.

As shows in Table 12 on referrals upon release from prison, 73% of the Vantaa Prison inmates commented about release planning; 80% mentioned community support agencies for the purposes of continuation of treatment and other transitional needs. The remaining 20% mentioned no referrals in place upon release. Heikki talked about his post-release goals while also acknowledging his impending homelessness. He was going to count on treatment staff to prepare his transitioning from an inmate to a free person.

Well...that is the just the case. I have plans but I need the social worker. I would be happy if the plan included or if I had a place to go to and not be without money when I leave. The prison officials should be in contact with the welfare officials. I myself cannot take care of it.

To Forrest, release meant he would need the help of the prison social worker for multiple referrals to different community resources.

And if you have no money, they point you to the county welfare office in your area. Arrange monetary things. I have a situation that I must find a place to stay although I am engaged. Apartment and stuff... that is why I have seen the social workers here.

To Janni, taking psychiatric medications upon release from prison was not an option he considered, although he would reconsider it should that need to arise.

When I am released I don't need any type of medications! I am so glad when the ports (prison) close behind me. It's a safety plan (the medications). So that it keeps me together.

Then there was Seppo who stated that he was not going to adhere to psychiatric treatment of any kind upon release. His comment below is short and succinct.

Amphetamine is my medicine.

In summary, inmate answers revealed wishes to continue treatment, receive multiple social services, and desired managing without medications, if possible. Because of inmates' sometimes counterproductive attitudes, limited built-in safeguards in the community made some of these very same inmates at risk to return to prison.

NSP Inmate Comments

Release from Prison

Fifty percent of Northern State Prison inmates commented about release planning, and 80% of the comments mentioned referrals to mental health and social service agencies as part of the process. The remaining 20% of inmates did not comment on release planning. Ricky talks about his release planning process. It reflects the right column of Table 12.

They are supposed to set me up two months before my release for outpatient. I've got a list of state mental health providers. I might continue taking meds but I'm not sure.

To Poet, the notion of leaving prison meant an unknown future as potentially a homeless person. Thus his plan was to sign himself into a psychiatric hospital.

I have no relatives, nobody out there. I am requesting to go back to hospital. I want to be committed. I cannot make it in the society. I cannot do no five years parole in Jersey City.

Adrian, who was diagnosed with affective disorder and impulse control disorder made his release plans known.

I'm not gonna be taking medication! I don't need it (mental health). I never needed it. They (mental health) started giving it to me!

As Fagan and Ax (2003) state, and some of the inmates in this research study confirmed, the psychiatric medication compliance pattern in prison can vary vastly in a post-release environment that is marked with less or no structure, minimal if any supervision and established linkages to persons or places that can supply drugs and alcohol.

General Section Summary

In conclusion, over two-thirds of the Northern State Prison inmates mentioned the community mental health and social service agencies referrals they would receive upon release. Sixty percent of the Vantaa Prison inmates mentioned the same issues. Also, some inmates identified various destinations while others pondered whether to continue mental health or substance abuse treatment in the community. This is where the inmate answers were found to be similar. The central theme in their comments collectively reflected the role of prison staff in facilitating linkages to outside agencies for the benefit of treatment continuation. Trepidation linked to reentry, scattered destinations, unsure treatment follow up, marginalized employment and housing prospects, and restoration of social capital was similar across both inmate groups.

STAFF

Prison research literature does not typically discover positive relationships between inmates and staff. Given that there is a role for prison staff in treatment of inmates who have psychiatric disorders, however, it is important to understand the perceptions that the inmates hold in relation to the staff that takes care of them. It was in this regard that the inmates were asked to characterize staff. The feedback that they provided most often centered on the nurses, mental health staff, and corrections officers.

Vantaa Prison inmate replies about nurses are presented first. Both positive and negative comments are included. As shown in Table 13, eighty percent of Vantaa Prison inmates commented about the nurses; 95% of the comments were positive, and 5% were negative. Positive comments characterized the nurses as respectful, professional and helpful in terms of how they interacted with the inmates.

Table 13. Nurses

Themes	VP (n=40) %	NSP (n=40) %
1. Respect	80	85
2. Professionalism	90	80
3. Helpfulness	80	85

VP Inmate Comments

The next two statements represent helpfulness and professionalism. Ossi for example, compared his pre-prison interactions with civilian treatment staff in a non-custodial setting to the nursing staff in specialized housing.

They are not like the civilian workers. They are helpful, do not talk to you rudely, and don't slam doors, treat us as people. In my opinion it is ten plus for them.

Poika in turn, compared the nursing staff in his home prison to the one in specialized housing by explaining what made the difference to him.

(home prison) They don't seem to be interested in listening and the interactions are short and superficial, unlike here, where discussions are more in-depth and personalized.

Of the negative or ambivalent comments about the nurses, Riddick made the following statement.

Some well and some not well. Depending on the nurse. If you ask for something and they refuse to give it or help to you.

In conclusion, the nurses were well liked at Vantaa Prison; the inmates attributed their high regard to the nurses' empathetic qualities, respectful demeanor, and general helpfulness. Only a small number of inmates reported negative encounters with nurses by citing unhappiness for not getting what they had asked for from nurses.

NSP Inmate Comments

As is illustrated in Table 13, Northern State Prison inmate commentaries about the nurses produced three themes and issues relating to nurses, and their comments were often specific negative opinions. Disrespect, unprofessionalism, and unhelpfulness were mentioned most frequently. For example, eighty-five percent of the inmates commented about respect, and 95% of those comments were negative. Likewise, eighty-five percent of the inmates commented about professionalism; 96% of the comments were negative and 4% were positive. Eighty-five percent of the inmates made remarks about the nurses' helpfulness, of which 95% of the comments were negative and 5% positive. Of those, only two inmates made positive remarks. Luis and C.J. stated:

The nurses do their jobs. They care.

They are alright.

Negative sentiments toward nurses were reportedly influenced by the inmates' daily interactions with nurses during medication distribution and visits to medical clinic. The first is from C.B who felt that the nurses exhibited unhelpful behavior toward inmates such as him. The second excerpt is from Walton who also felt similarly about the nurses.

Nurses here really don't care about special needs inmates. The nurses look at us like scum of the earth. They forget about you.

We are looked at as outcasts by the nurses.

General Section Summary

Vantaa Prison inmate comments about the nurses were overwhelmingly positive and they cited the nurses' caring, professionalism and respect as primary factors that influenced their opinions. In contrast, inmate comments about Northern State Prison nurses were in general more negative than positive. Lack of caring and unprofessionalism were cited most often by the inmates along with the nurses' general unhelpfulness. It was in this context that the inmate answers were different.

VP Inmate Comments

Mental Health Treatment Staff

Many of the inmate residents at Vantaa Prison specialized housing expressed appreciation for what they regarded as helpful and fair treatment extended to them by the mental health treatment staff.

Table 14. Mental Health Staff

Themes	VP (n=40) %	NSP (n=40) %
1. Respect	85	80
2. Professionalism	90	90
3. Helpfulness	90	90

As illustrated in Table 14, eighty-five percent of the inmates' commented about respect; 94% of the comments were positive and 6% negative. Ninety percent of the inmates also commented about professionalism; 90% of the comments were positive and 10% negative. Also, 90% of the inmate mentioned staff helpfulness; 95% were positive and 5% negative. Vantaa Prison inmate views conveyed the sentiment that the men felt

respected being “spoken to” rather than “spoken at” by the staff, the staff was helpful in working with inmates regarding treatment planning, and that their general demeanor was professional. Similarly, positive opinions were reported by many inmates about being fairly and equally treated (to other inmates) by staff, and their understanding of inmates’ mental health issues. Two statements are from Alvo and Jukka.

The staff want feedback, and ask what I think is the problem.

Here everyone is treated equally. Everyone is treated fair and without preference.

Puppet Master, who was receiving treatment for panic disorder, said the following about mental health staff. His comment was one of few that was not overtly positive.

Well....I don’t know. Some are very irritating. And some are just OK.

In conclusion, Vantaa Prison inmate answers expressed the sentiment that the mental health treatment staff was well liked because of their professionalism, helpfulness, and respect displayed toward inmates. These perceptions were shared by the overwhelming majority of the inmates.

NSP Inmate Comments

Mental Health Treatment Staff

Eighty percent of Northern State Prison inmates commented about respect for the mental health staff; 90% of comments were positive, and 10% were negative. Ninety percent of the inmates also commented about professionalism; 98% of those remarks were positive and 2% negative. Similarly, ninety percent of the inmates commented about helpfulness of the treatment staff; 95% were positive comments and 5% negative. The

majority of inmates valued the opportunity to meet with treatment staff, and that experience was almost always positive. Cee and J.R. both remark on what each found helpful about the treatment staff.

I would say excellent. Mental health has continuous therapy sessions. The staff makes an effort to do something.

They (mental health) treat us better than the officers. They are good. They are even here on Saturdays!

Of the inmates who reported negative experiences with treatment staff, two reactions, from J.R and Jason, are presented below. Neither was satisfied with the care provided by treatment staff.

They don't do their jobs. You have to take better care of inmates in the special needs housing. Guys have issues! They don't see anyone on a continuous basis!

They treat you good.... Not all of them. Some like to pick on you. To send you to a lock up. If they were the judge, we would never go home.

In summary, most inmate comments revealed that the mental health staff was well liked which they attributed to the staff's genuine caring, helpfulness, and respect toward them. A small group of inmates felt that the treatment staff was not helpful because they did not see inmates regularly.

VP Inmate Comments

Corrections Officers

Given that there is a role for corrections officers in the mental health treatment of inmates at Vantaa, it is imperative to understand the perceptions that inmates hold of officers and whether the inmates feel comfortable in interacting with them. The left column of Table 15 shows the key themes from Vantaa Prison inmate perceptions about corrections officers in their facility. Fifty percent of the inmates talked about respect;

70% of the comments were positive or ambivalent in tone. Similarly, forty-five percent of the inmates commented about professionalism; 55 % of their comments were either positive or ambivalent in tone.

Table 15. Correction Officers

Themes	VP (n=40) %	NSP (n=40) %
1. Respect	50	80
2. Professionalism	45	90

The next two inmate statements represent the left column of Table 15. Both Jorma and Metsä offered their opinion about the corrections officers.

Some are very irritating. And some are just OK.

Well, it is like..... in principal fine but then you have corrections officers who are arrogant. But there are good ones as well.

Well, most treat me well. Generally the older people who have worked here longer treat you better. But I don't have complaints about any of the corrections officers.

In conclusion, about half of the inmates reported both positive and neutral interactions with corrections officers, although none of the inmates mentioned explicitly that difficulties with corrections officers were their most challenging problem.

NSP Inmate Comments

Corrections Officers

Eighty percent of the inmates made comments about respect; 90% of those comments were negative, and 10% percent were positive or ambivalent in tone. Ninety percent of the inmates commented about professionalism; 95% of their comments were negative and 5% positive or ambivalent in tone. In that vein, inmates commented on

corrections officers' lack of respect and unprofessionalism most frequently. Wilson stated defiantly:

The corrections officers talk slick to you. I don't care if these COs kill me!

J.R. commented how some COs created barriers to mental health treatment delivery within special housing units.

Some officers do not want to open doors to mental health staff. They are harassing, not trained, screaming at inmates, yelling, raiding cells, calling people crazy!

The third inmate, C.J., stated that because some COs refused to open inmate cells to mental health staff, discussions took place through the cell trap opening. According to C.J., those encounters led some inmates to refuse to see treatment staff citing breach of confidentiality and the presence of COs in hearing range. C.J. also commented on the over-reliance on disciplinary sanctions toward special needs inmates by COs.

You get five days if you are too slow going into your cell. Q: What do you mean by five days? A: You are in lock down in your room. No rec, no nothing!

There was one inmate, José Luis, who characterized corrections officers in a more neutral tone. His tactic for dealing with corrections officers consisted of a global avoidance of them.

As long as you stay away from them, they don't give you problems.

In summary, the inmates reported a high degree of dissatisfaction with the corrections officers at Northern State Prison. Typically, inmates found corrections officers lacking respect and professionalism.

General Section Summary

Based on Vantaa Prison inmate comments about the prison nurses, they expressed satisfaction with the nurses because of their respect, professional behavior, and helpfulness. These themes were not globally shared by their Northern State Prison inmates as they cited opposing perspectives about the nurses in their facility. They characterized the nurses' general lack of respect, unprofessionalism, and unhelpfulness when interacting with the inmates. It was in this regard that the inmate comments were most different. Where the inmate answers were found to be similar was in their regard for the mental health staff. They were well liked in both prisons, and the inmates used similar language such as helpfulness, respect, and professionalism when talking about the treatment staff. Generally, the inmates reported that frequent contact and interpersonal discussion with mental health staff were fundamental to their interactions and in many ways contributed to positive feelings toward treatment staff. These were global themes across both inmate groups. Vantaa Prison inmates cited fair treatment, respect and being listened to by mental health staff. Northern State Prison inmates discussed their mental health staff in a similar fashion while citing that these factors influenced their perceptions. The inmate comments in both facilities universally conveyed that the treatment staff was dedicated to helping inmates with proper medications to treat their symptoms and provide therapy. Satisfaction was also expressed for staff's medication management skills and understanding of inmates' problems with mental illness. Vantaa

Prison inmate comments were more likely to be ambivalent or positive in tone than Northern State inmate comments, which were mostly negative. Inmates collectively perceived correction officers at Northern State as unprofessional and disrespectful. None of the Vantaa Prison inmates spoke about the corrections officers in similar terms. It was in this context that the inmate comments were most different between the two groups.

Chapter Conclusion

Vantaa and Northern State Prisons both provide in-house spaces in which inmates with mental illnesses are housed and in which individual and group therapy, medication monitoring, and discharge and release planning is provided. The length of stay in specialized housing varied significantly between the two prisons, however. Northern State Prison inmates with psychiatric disorders reside in specialized housing until stabilization or completion of their prison sentences. Specialized housing thus represents a long-term residency option at Northern State Prison, whereas at Vantaa Prison treatment episodes average thirty days or less, a short term stay, which staff attribute to structural and organizational characteristics such as relocation to the current site and the reassignment of staff. Only fourteen men were able to stay in specialized housing at any given time, and the transitioning to and from the general population was a constant occurrence.

Vantaa Prison inmates' diagnostic workup and psychiatric stabilization (excluding psychiatric emergencies) often result from self-initiated requests or staff observations rather than a systematic screening for inmate mental illnesses. This aspect emerges as a significant procedural difference between the two facilities. In addition, Vantaa Prison inmates choose specialized housing voluntarily and their feedback reveals that prison

staff play key roles in facilitating this process. At Northern State Prison, referrals to specialized housing originate in CRAF where psychiatric diagnoses and courses of treatment are first established.

Vantaa Prison inmate feedback attributed specialized housing's positive treatment milieu to several factors. First, it offers a pleasant atmosphere with fewer reminders of correctional life such as small cells, windows with bars, or small inmate assembly areas. Second, specialized housing provides multiple treatment options to stabilize the inmates' mental illnesses. For example, inmates mentioned enriched opportunities to learn about their mental illnesses, addictions, and psychiatric medications in the context of individual and group therapy. Third, small inmate-to-staff ratios permit more individually tailored intervention, which is unavailable to the same extent elsewhere in Vantaa Prison or in inmates' home prisons. Finally, inmates reported feeling varying degrees of safety, which helped build a semblance of trust with staff and other inmates. To inmates, safety was conceptualized as an open daytime cell door policy, less restricted movement (albeit controlled), and constant visibility of treatment staff. The specialized housing offered plenty of groups and no waiting lists which were appreciated by most inmates. In contrast, the majority of Northern State Prison inmates felt that specialized housing units were not helpful because of the practice of prolonged lockdowns, lack of structured activities, their similarity to general population housing units, poor living conditions, and safety issues precipitated by unstable inmates and antagonistic behavior from various prison staff. In terms of treatment, many in both inmate groups reported mental health treatment produced tangible benefits, manifested in self-reports of reduced psychotic symptoms. Tangible benefits were conceptualized as structured sessions with clear

therapeutic focus, the ability to talk, and the opportunity to learn about their disorders. Vantaa Prison inmate commented that nurses were respectful, helpful, and sensitive to inmates' mental health problems. In contrast, Northern State Prison inmate commentaries about nurses were mostly negative, citing their collective indifference and lack of professionalism toward inmates and their mental health needs. The mental health staff was well liked in both prisons as the inmates felt that they cared about them; they were respectful toward them and generally felt satisfied with the help they received from the mental health staff. Vantaa Prison inmate remarks about the corrections officers were neutral to positive compared to Northern State Prison inmates, who reported unprofessional behavior and displays of disrespect by corrections officers. The inmates cited the correction officers' uncaring attitude and insensitivity to their mental health issues as ongoing. Northern State inmates had a tactic of global avoidance of corrections officers to evade problems. The inmates' feedback also revealed an underlying theme of heightened stress level when interacting with the corrections officers in specialized housing. It was in this context, that the answers between the two inmate groups varied the most.

CHAPTER 8 STAFF INTERVIEWS

Introduction

Chapter 8 presents prison staff attitudes about and experiences with the mental health services at Vantaa Prison and Northern State Prison. Seven staff members at Vantaa Prison and four at Northern State Prison's psychology department were interviewed to explore staff perceptions of how each prison identified, treated, and planned for the discharge of inmates with mental illnesses. Of the seven staff interviewed at Vantaa Prison, all but one were stationed in the specialized housing unit. They included the medical director, who was also the chief psychiatrist, a psychologist, the nursing supervisor, a mental health clinician and two psychiatric nurses. A nurse who provided treatment to general population inmates but was not stationed in the specialized housing unit was also interviewed. Four Northern State Prison staff, two psychologists, a psychiatrist, and a clinical social worker, were interviewed.

The staff interviews in both facilities were conducted in person and every effort was made to preserve privacy and confidentiality. The questions to staff were semi-structured and open-ended, containing items that permitted staff to reflect on the mental health services available in their respective prisons, what each staff person provided, and more broadly their role within the prison mental health services. This chapter will present the results of these interviews in both prisons. Vantaa Prison staff comments are presented first followed by Northern State Prison staff comments. The content areas include: (1) screening and referral to psychiatric services; (2) admission to specialized housing; (3) treatment, i.e., therapy, medications, and case management; and (4)

discharge and release planning. The first question was about the role of prison staff in identifying and referring inmates who may be mentally ill to care.

Screening and Referral

VP Staff Comments

Lacking a system for screening incoming inmates for psychiatric disorders, Vantaa Prison inmates who expressed a need for mental health treatment or exhibited symptoms of mental illness had to submit a written request to staff that was then screened by nurses, who also relied on the observations of corrections officers and other staff who were not trained in psychiatry. This was the first step in inmate identification for mental illness and referral for care. Then, depending on a brief screening of inmate requests, appointments were scheduled for in-house psychiatric consultations. While nurses made the decisions to schedule these appointments, they received no training in recognizing the symptoms of mental illnesses. Thus they frequently relied on inmate self-reports for mental health history. A staff member who was stationed in the medical clinic shared the following about the protocol.

The inmate is taken to either the transportation cell or to the floors from the book-in area first. There is nurse present rarely. Mental health staff is not there, either. When a new patient (inmate) comes in, we ask for background information and generally ask about mental health. All our nurses ask.... I do ask about somatic illnesses, medications and about any psychiatric treatment, how is he feeling at the moment.

This staff member noted that no medical or mental health staff were stationed in the booking area because of a lack of adequate clinical space, the presence of Cos, and strict confidentiality rules:

I am thinking that because the correction officers' presence here and there is no peaceful or appropriate place to talk with patients there, for them to walk here to the clinic where you can talk with them.... It is a better

option rather than seeing them at the book-in area. The officers being present. And because we have different confidentiality rules. We cannot tell the correction officers about patient illnesses, and we do don't.

The staff member continued, explaining the medical department's responsibilities for inmates who exhibited unstable behavior and the role of COs in facilitating inmate transfer to specialized housing.

Sometimes the inmate is in such a bad shape that he cannot be processed and is sent to specialized housing right away. But that is quite rare. No, there is no nurse in reception. They (COs) call us and we prefer to see them (inmates) here because we document things by computers. And we have equipment like the blood pressure machine and the like here so we can use them here to check on them.

Because of an absence of mental health staff at the point of inmate entry to the prison, corrections officers stepped in as part of the mental health referral system. This medical service provider discusses how the corrections officers were utilized at Vantaa Prison by medical staff.

Here you can say that although he (CO) is not a nurse, he is the person who sees the inmate daily... that he can assess him. Quite often we ask the correction officers about their opinion, when they send patients down here.... why they sent them to us and what have they noticed?

While the medical staff played pivotal roles in referring inmates to the psychiatrist, referral forms still went through another round of elimination.

The main goal is to determine if the presenting symptoms exhibited by the patient are psychiatric or something else. This question is explored when the medical department sends their referrals for psychiatric consultation.

In summary, most referrals to mental health services were inmate initiated and screened by nursing staff for appropriateness and for psychiatric consultations. The inmates were not diagnosed at this juncture, rather, they were referred only for psychiatric consultation. Furthermore, corrections officers played a key part in this

process by observing inmates' behaviors at booking and on the floor and reporting to nurses when necessary. The mental health staff did not participate in this process. The exception was for the in-house psychiatrist's consultation that was held at a later date.

Screening and Referral

NSP Staff Comments

Northern State Prison mental health staff reported caseloads averaging 30-50 inmates each. With a constant flow of new inmate arrivals to Northern State Prison specialized housing, they commented on the challenge of keeping an accurate roster of their mentally ill inmate population. NJ DOC policies mandated that all inmates suspected of having mental illness be initially screened at CRAF, an NJ DOC facility. Aided by electronic mental health records that held information about inmate diagnoses and prescribed medications, arrivals to Northern State Prison's specialized housing unit appeared as a seamless process.

All four Northern State Prison staff commented on the inmate mental health treatment transfer process and each of the four mentioned that the inmates were, by policy, referred to their care. Staff members discussed how they felt the referral process worked. The primary idea to emerge was that Northern State Prison, under the Terhune decision, must respond to inmates' psychiatric needs.

The vast majority of inmates come to us already classified. We have a reception unit called CRAF. It is the classification unit. All inmates in the state system go through CRAF and are classified there. So, often they'll come to us classified as mentally ill.

Another staff member felt that the overall CRAF referral process should be improved or revamped and its diagnostic criteria tightened to keep out inappropriate referrals.

I think part of it is.... I don't mean to blast or criticize the X from other institutions but if CRAF could not put everyone with an adjustment disorder... nobody wants to come to prison. Everyone adjusts badly at first. Doesn't mean they have full blown mental illness. I am not sure if they are looking up the adjustment disorder criteria specifically ahh.... and that's a problem.

The staff also discussed the challenges associated with managing a roster of newly referred inmates who may or may not be mentally ill and may have reasons other than a mental health problem for desiring placement on the roster and in specialized housing and. The roster of mentally ill inmates was generated by NJ DOC, and Northern State Prison staff used it to identify every inmate who entered their specialized housing units. Inmate malingering was a constant concern that some staff attributed to the diagnostic threshold used at CRAF. It produced, as one staff member described it, mental health roster contamination and challenges in specialized housing.

One of our problems is that we have people on the roster who are not truly mentally ill. And they really contaminate the mental illness units because if they were put on the roster for an adjustment disorder and it's hard to get them off or if they are manipulative and act out so they can stay on the roster. I would say if we really get rid of those guys and wean the roster down to the inmates who are truly mentally ill it would be better for everybody.

Essentially, the treatment staff addressed this issue by deciphering whether the inmates' presenting symptoms listed on the referral forms were linked to malingering or if they were truly mentally ill.

And so when you are treating mentally ill people in the community you don't really have to worry too much about feigning symptoms. Here it is a constant battle. It is a...trying to figure out what the secondary gain is....trying to figure out why...who is telling the truth.

In conclusion, with a correctional philosophy rooted in legal decisions and related mental health practices, treatment staff saw transparency. Inmate identification for

mental illness and referral to care commenced early during incarceration so appropriate treatment and housing could be provided on entry to Northern State Prison specialized housing. The referral process, however, created challenges in terms of keeping inappropriately diagnosed inmates off the mental health rolls and from specialized housing.

Section Summary

Vantaa and Northern State Prisons had very different protocols for identifying and referring persons in need of psychiatric services. In Vantaa Prison, inmate requests and the direct observations of non-mental health staff acted as initial flags for mental health problems. In-house psychiatric consultations then formed the first step in formally identifying and diagnosing potentially mentally ill inmates. This protocol also utilized corrections officers as part of their mental health referral and warning system network. Vantaa Prison mental health staff, with the exception of the psychiatrist, did not participate in the referral process nor did they contact or see new inmates until their admission to specialized housing had been approved.

In contrast, the majority of Northern State Prison inmates who were mentally ill arrived with psychiatric diagnoses and were transferred directly to specialized housing. It was there that the mental health staff took over their treatment and follow up care. Corrections offices referred a small number of inmates to mental health services as well. These were the inmates who did not, for various reasons, follow the established routes to specialized housing at Northern State Prison. In comparison to Vantaa Prison corrections officers, Northern State corrections officers' played a more restricted role in referring and identifying persons in need of care. Lastly, both Vantaa Prison and Northern State Prison

staff engaged in ongoing inmate evaluations to remove inappropriate individuals from mental health rosters, or in the case of Vantaa Prison, to screen out unsuitable inmate requests for psychiatric consultation.

Admission to Specialized Housing

VP Staff Comments

Vantaa Prison staff reiterated the role of psychiatric consultation and subsequent referral to specialized housing depended on consultation findings. Furthermore, the decision to refuse or defer inmate admittance was a collective staff decision and prior knowledge of an inmate was factored in.

All seven Vantaa Prison staff commented about specialized housing and everyone mentioned referrals with psychiatric consultation and evaluation as the gateway to specialized housing. In the ensuing passage, a staff member discussed internal admission practices.

The psychiatrist initially decides who comes to specialized housing... although decisions are made democratically among the staff. For example, if there is a patient [inmate] who is known to staff but not to the psychiatrist, staff opinion is heard as to the suitability of the patient referral or acceptance to specialized housing.

In conclusion, Vantaa Prison staff remarks noted that inmate assessment was a continuing process that commenced at the point of arrival to psychiatric consultation and beyond. The treatment staff engaged in the diagnostic workup process, which started with a psychiatric consultation; the psychiatrist functioned, however, as the primary decision maker although treatment staff feedback influenced admission decisions.

Admission to Specialized Housing

NSP Staff Comments

Northern State Prison staff comments provide a contrast of policies and practices that guided inmate arrivals to specialized housing units. As was reiterated elsewhere, staff members reported that a majority of the inmates were referred to them and to specialized housing directly from CRAF.

Most of the time they come from other institution and they are already diagnosed. So we just catch them in specialized housing.

For a small number of inmates who did not follow the traditional path to care, the corrections officers, because of their frequent inmate interactions and observations, identified those who needed mental health services. In addition, inmate-initiated requests for mental health services were also possible at Northern State Prison.

The ones who don't but become patients on the roster are those, which either staff members' corrections officers will call us because they are acting bizarrely or seem to be in distress on the unit. Or inmates can drop what we call 'drop a slip'.

Section Summary

In summary, Vantaa Prison mental health staff took on roles as diagnosticians and gatekeepers in order to determine inmates' clinical appropriateness for admissions to specialized housing. The process commenced with a referral for consultation with a psychiatrist followed by a potential admission depending on staff feedback. In contrast, Northern State Prison inmates arrived through an established referral pipeline to specialized housing with psychiatric diagnoses already established. Both facilities, however, had systems in place that allowed inmate access to treatment staff and treatment by submitting written requests. Also, the corrections officers in both prisons functioned as part of the in-house mental health referral and inmate observation system. At Vantaa

Prison, their role was vital because the mental health staff did not see inmates beyond the boundaries of specialized housing.

Mental Health Services

Vantaa Prison specialized housing treatment staff consisted of a medical director who was also a psychiatrist, a clinical psychologist, nursing supervisor, three psychiatric nurses, four mental health workers, a secretary, and one on-site corrections officer. The medical director, the psychologist and the secretary all worked during regular business hours and were on call after-hours (except for the secretary). Specialized housing operated in two shifts (7 AM-3 PM; 3PM -9 PM) permitting the morning and evening treatment staff to meet and review inmate related clinical information in person. The nurses worked in pairs on evenings and weekends, and no overnight nursing or mental health coverage was provided anywhere in the prison. A member of the treatment staff and the psychiatrists were on call during off-hours and on weekends. An on-site corrections officer was also stationed in specialized housing from 7 AM -7:15 PM daily. Specialized housing is bounded by prison rules regarding inmate meals, visitations, and evening lockdown. Treatment related practices such as therapy, medication management, and treatment plan meetings were executed independent of the prison schedule, however. As specialized housing residents, inmates had access to a sauna, laundry facilities, and their own canteen. Psychiatric treatment in Vantaa Prison was voluntary which meant that the inmates could not be medicated involuntarily. In psychiatric emergencies, and if authorized by the psychiatrist, inmates could be transported to an off-site psychiatric facility where involuntary medications were administered. All inmates were expected to take prescribed medication, and refusal could lead to discharge from specialized housing.

According to staff, inmate admissions to specialized housing were driven by depression, suicide risks, anxiety disorders, psychotic symptoms, and substance use-induced symptoms. Treatment episodes, on average, varied from a few days to one month. Upon admission, each inmate was assigned either a nurse or mental health clinician whose primary role was to organize and manage inmate treatment needs for the duration of his treatment stay. The nurse/mental health clinician formulated treatment plans around individual and group therapy, distributed and monitored medication management, and conducted discharge and release planning. Psychosocial groups were available to all inmates, and all treatment staff members, with the exception of the psychiatrist, facilitated them. Group topics consisted of acupuncture, discussion, music therapy, recreation, relaxation and meditation, anger management, occupational, and art and activity therapy. Medication distribution by mental health staff took place three times a day, and during off hours and weekends, corrections officers distributed medication. At individual therapy at Vantaa Prison, the inmates were matched with treatment staff who specialized in domains connected to the inmates' presenting symptoms. For example, some staff specialized in chemical addiction, while others were trained in eating disorders, one in sexual violence, another in administering acupuncture treatment, and yet another in personality disorders. Duties that were specific to the psychiatrist and the psychologist included mental status examinations, competency evaluations, and dangerous offender assessments for court purposes. Besides these tasks, the psychologist saw inmates for individual therapy, participated in treatment plan meetings, facilitated group therapy, monitored medication compliance, and provided discharge and release planning.

VP Staff Comments

A treatment staff member described the primary goals of specialized housing and the need to factor in inmates' presenting symptoms as well as customize treatment intervention accordingly.

The most important and overarching treatment objective here is to engage the inmate to fully cooperate so that it can be determined whether his primary problem is mental illness or substance abuse or both. Treatment is then modified based on primary symptoms and clinical opinion of the psychiatrist.

Vantaa Prison staff discussed mental health services available to inmates in their facility, the role of staff in providing these services, and what the staff thought about the services. They commented on the services they provided and mentioned assessment, individual and group therapy, medication management, and discharge and release planning as the core services in specialized housing. The ensuing passage by a staff member discusses duties that were assigned to her. As a whole, clinical tasks were divided among the treatment team members based on their expertise and inmates' presenting symptoms.

The core of my job entails providing clinical and psychosocial support to assigned psychiatric patients, facilitation of discussion groups, and engaging patients in recreational activities. Also, I am specialized in providing acupuncture treatment. I manage psychiatric medication distribution and watch for any patient side effect problems.

A staff member summarized her clinical duties, which covered a range of treatment related services.

I run weekly patient discussion groups in specialized housing with another staff member, attend clinical treatment plan meetings where the patient is present along with the psychiatrist, and follow up on patients in general.

As a treatment approach to substance using inmates, treatment staff discussed how best to integrate substance use and mental health treatment into unified treatment goals. In this capacity, the treatment staff applied ideas about cognition and addiction and emphasized education by teaching inmates about themselves.

The inmates are given cognitive skills development exercises whereby he is involved and designs his own relapse prevention.

In brief, the staff comments revealed a multifaceted treatment approach to their inmate population in specialized housing. These services, albeit stationary, formed the core of basic mental health services that were available to selected Vantaa Prison inmates.

NSP Staff Comments

The psychological services at Northern State Prison offered in-house mental health services to inmates in specialized housing and the general population on an outpatient status. These services consist of individual assessment, therapy and group therapy, medication monitoring, crisis intervention, and discharge and release planning. Clinical tasks were divided by housing units rather than individual inmates. For example, a mental health clinician and one or more psychologists covered one part of specialized housing where they provided comprehensive care including group and individual therapy, medication management, and discharge and release planning. The CSU (Crisis Stabilization Unit) was covered by an on-site psychologist and a nurse for the rapid assessment, stabilization, and triage of inmates experiencing mental health crises. The RTU (Residential Treatment Unit) and the TCU (Transitional Care Unit) were covered by a mental health clinician and psychologists who provided care to more stable inmates during daily visits there. Both were structured environments that offered psychosocial

rehabilitation through individual and group therapy, medication management, and discharge and release planning. The inmates who were in outpatient status were monitored for one month by several psychologists and a mental health clinician to oversee their adjustment with reduced medication dosages. The prison social workers took over their care after thirty days if no adjustment problems were reported.

Northern State Prison staff spoke about the types of services that they offered inmates in specialized housing. All four staff members commented on individual and group therapy, medication monitoring, crisis intervention, discharge and release planning. One of the four members also mentioned the challenge of providing individual therapy in a facility that was not designed for that purpose.

I think the facilities here are difficult.... Ah...there are many therapists here but not enough space to do private therapy sometimes we have to do it in the hallway because the visitor area gets so jam packed ... and who wants to discuss personal information in the hallway?

The second excerpt reveals the comprehensiveness of mental health treatment that extended beyond specialized housing into discharge and release planning as well.

I do groups; I have anger management and relationship group. I do discharge planning when they are released and are transitioning back to society but are still under the NJ DOC.

With regard to addressing substance use among specialized housing residents, the passage below conveys the challenges associated with conducting group therapies in a large prison setting with multiple interests and philosophies.

The problem is...we don't do MICA program for instance where you combine the mental illness and chemical addiction treatment. It's very separate and compartmentalized. Dr. X and one of X do a substance abuse relapse program for patients on X Unit where they work. Other than that, we do nothing for that...for substance abuse. We let the other departments handle it. They have AA/NA here and they have TC program.

And they might have other relapse programs, I am not sure. But other than that one group, we don't really do too much.

The prison offered Narcotic Anonymous and Alcoholic Anonymous meetings to inmates with substance use histories; most residents in specialized housing, however, could not attend the meetings due to off-unit movement restrictions. To address this issue, the treatment staff began offering group therapy with the substance-using inmate population in mind.

The vast majority of the people who are on our special needs roster have some type of substance abuse problems. We do offer substance abuse groups. We started another kind of group (REBT) that integrates substance abuse and more of a general kind of cognitive behavioral approach to anti-social behavior thinking and incorporates substance abuse so we don't ...we are really interested in....ah... our primary focus is on treating mental illness but we certainly incorporate substance abuse treatment on individual and group level.

In brief, Northern State Prison mental health staff provided a range of treatment options that included counseling, group therapy, medication management, outpatient services, discharge and release planning. Mental health services were also made available to general population inmates on an outpatient basis.

General Section Summary

At Vantaa Prison, the frontline triage mechanism served as the primary filter to direct inmates toward or away from mental health treatment. In New Jersey, the frontline inmate triage mechanism began at CRAF, and the primary receiver of this group was Northern State Prison specialized housing units where treatment continued. Northern State mental health treatment services were non-stationary, extensive, and covered inmates in the general population in aftercare status. In stark contrast, Vantaa Prison mental health services were concentrated in a stationary location except for psychiatric

consultation for general population inmates who only saw mental health staff upon admission to specialized housing. Yet, despite such procedural and practical differences, the staff provided similar services to inmates in their care.

Discharge and Release Planning Practices

VP Staff Comments

Vantaa Prison staff were concerned with inmate monitoring and psychiatric medication management as inmates were to be discharged from specialized housing. Staff members felt that the current discharge practices were wanting because treatment staff ceased monitoring inmates when they were discharged, except for medication management if the inmates' remained at Vantaa Prison. Changes in the organizational and geographic context associated with Vantaa Prison's relocation to its present site in 2002 were mentioned as factors that affected current discharge practices. For example, the prison relocation led to more restricted general population access to mental health staff because the treatment staff no longer visited general housing units.

All seven Vantaa Prison staff mentioned monitoring and medication management as key duties in the discharge practices in place in specialized housing. The following staff comment underscores how the discharge practices operated rather than how they should operate.

The staff numbers are the same, but the way the work is divided is now different. When we were in our previous prison, the aftercare worked better. We had patients in outpatient treatment. They were followed once a week or biweekly. This is no longer done. Currently, a prison psychologist who is working as a temporary employee in closed housing units performs this function.

In terms of discharge planning at Vantaa Prison and why it had not worked as it did at the previous location, a staff member discusses it in the passage below.

For example, the X saw patients in the previous prison but now X's time is taken up more by administrative tasks, leading other treatment staff to take up the load. Moreover, what is also quite different is that in the old prison, the patients were able to mingle with general population inmates and be in the recreation yard with fifty or more inmates at the same time. Here this is not done and they cannot "air out" their issues.

The same staff member also noted positive aspects about the new location that the inmates also benefited from.

This space is physically very good compared to the previous location. Here, we are more of a private unit with our own patient store, recreation yard, and sauna. Treatment service delivery here is quite intensive and new for this place.

When inmates were transferred to other facilities, the staff at the inmates' next destinations reportedly took on the responsibility of inmate monitoring, adjustment, and psychiatric medication management. Treatment staff's clinical commitment to the inmates ended at this juncture.

Right now, follow-up care is left to each individual prison and it is not known how it works.

The ensuing passage discusses the discharge protocol rules for taking over inmate supervision and care for custodial and non-custodial staff outside the purview of specialized housing.

Now, regular medical department nurses follow them up. Also, the general population nurses are aware if patients are released from specialized housing back to general population. They also serve as screeners and report back if the inmate begins to exhibit psychiatric symptoms again. That patient has access to staff in general population that hopefully links him to services so that he is not forgotten.

In conclusion, nursing linkages, surveillance, observations, and corrections officers formed the post-discharge follow up system in Vantaa Prison wherever inmates were discharged from specialized housing.

NSP Staff Comments

By policy and legal decisions, Northern State Prison mental health service delivery was coordinated from the point of inmates' arrival to the facility until their discharge from specialized housing to general population or to other prisons. In particular, NJ DOC and CMS policies stipulated that discharges consisting of inmate monitoring and medication management by qualified treatment staff were to be implemented gradually. The four staff members commented that monitoring and psychiatric medication management was standard protocol. In the following excerpt, a staff member discusses several key phases in the inmates' discharge planning and transitioning process.

If they are taken off our roster, if they are on medication, they have to be taken off medication gradually. And then we still follow them up for about a month or so to see if any symptoms return. If they don't, then they can be completely off the roster and they would move to another unit, general population unit.

In summary, the mental health staff monitored inmates during their transitioning from specialized housing to the general population. This practice underscored the wide reach of mental health intervention to the general population that would not usually be under the purview of mental health treatment services. In their roles, the mental health staff assisted the inmates during their adjustment to new housing units, new floor routines, and new security levels.

Release Planning Practices

VP Staff Comments

Vantaa Prison staff member were asked how inmates were prepared for release and release planning from prison and what the staff felt about this process. All seven

staff members commented on the release practices, and nearly all of them mentioned contacting mental health treatment and social service agencies as part of release planning in order to continue prescribed treatment and medications. According to two staff members, no specific reentry services existed for released inmates in Finland which made linking them to community support services even more critical. Linking about to be released inmates to community support services was standard protocol and commenced prior to the inmates' prison release dates, if possible. It was at this juncture that the staff commitment to these inmates ceased, and these men essentially became the responsibility of their local social and mental health service providers. The following staff comment stresses the role of community treatment providers that received inmates and paid for and designed their post-release mental health care. The role of the prison social worker was also highlighted.

Released patients who want treatment in the community can get it and is paid for by the county of their residence. This type of aftercare is voluntary and arranged by the psychiatric nurses here on the unit. If the patient is homeless, the prison social worker is contacted for help and the patient is urged to meet with her to discuss various alternatives. This particular psychiatric unit does not have a social worker.

The next passage underscores the active participation that the inmates were expected to take in their release planning process. Learning about community resources and medication continuation loomed large.

He is given a prescription of his current medication. Also, if the patient knows his exact release date, it is suggested he contact various treatment providers in the community with the help of his nurse or mental health worker in order to make appointment.

Sometimes when attempting to link inmates to community resources the treatment staff members faced resistance from the community at large.

Another issue is the difficulty of placing a multi-problem offender in a treatment program because they are not wanted. They are not desired patients. Why the reluctance to admit such patients? One thing is fear, prejudice, personality disorders and threatening behaviors if they don't get what they want. It is easy for staff in such situations to say "we cannot treat this here" or we don't tolerate this here.

In short, the mental health staff focused on mentally ill inmates engaged in active, boundary spanning roles as part of the Vantaa Prison release planning practices. The inmates were encouraged to participate by actively contacting treatment agencies while still incarcerated. In essence, the goal was to make the inmates' transitioning to freedom easier so that linkages to suitable resources, including psychiatric treatment, would be successful. Thus, these agencies served as potential reentry safety nets.

Release Planning Practices

NSP Staff Comments

The Northern State Prison release planning process was part of basic mental health services. It consisted of making phone calls to community mental health and social service providers and securing appointments, if possible, two months before actual release dates. For many inmates, this transition can be both arduous and replete with barriers, both regulatory and legal. To offset some of the barriers, the mental health staff is mandated to meet with all soon-to-be released inmates to map out their release plans. Alerted to inmates' release dates by the classification department, the date, which was six months before release, activated the initial release planning process.

The four staff members indicated that release planning was standard protocol and stipulated in the CMS policies and protocols. The staff also reported contacting various community agencies at the inmates' release for addresses for appointments and

availability. The next two passages reflect release planning and the role of the inmates and other prison staff in this process.

We provide discharge planning. Where we start doing this, we are alerted to the tentative max date or parole date ahead of time by classification. We discuss with inmates what their plans are and when the time comes we offer to make appointments for them at community mental health centers near where they want to live. In terms of housing, that is handled by the state social workers and increasingly we are working closely with them integrating services.

The ensuing passage illustrates that inmates who are mentally ill received no preferential treatment when linkages to different community services providers were made. Thus, the lack of preferential treatment could create barriers to their reentry transitioning. In this passage, a staff member pondered moral and ethical issues that could be driving such practices among community treatment providers.

They are not given any preference. But at the same time is one's mental illness any worse than somebody else's who didn't commit a crime? There is such a demand especially in Essex County. There is such a demand for services from other people that there is a waiting list sometimes. Certain hospitals have waiting lists. So....sometimes the hospital doesn't call back and you just I keep a list in front of me and just keep going down that list and whoever calls back first is whoever I get.

On release from Northern State Prison, CMS policy authorized inmates receive a fourteen-day supply of medication. Inmates, however, have a right to refuse their prescribed medications. A staff member worried inmates could sabotage future treatment gains.

They are released with a two-week supply of whatever psychotropic they are on. At that point they need to be followed by a psychiatrist in the community. But again they have a right to refuse that. I mean they can tell us no and that's it!

In summary, specialized housing inmates who were nearing their release dates, met with mental health staff to review their release plans and to make appointments with

service agencies in their communities. Inmates were not given preference regarding appointments, however; placing them on waiting lists was, at times, the only option. Inmates were also provided a two-week supply of psychiatric medication during which they were expected to follow up with a psychiatrist in the community. Inmates were not mandated to take medications and could refuse all services offered to them.

General Section Summary

As a group, both Vantaa Prison and Northern State Prison treatment staff expressed concerns that focused on several key issues. First, when inmates were released from prison, structural and regulatory barriers let some inevitably fall through the community social welfare safety net. Second, for discharged inmates, fragmented community mental health and substance abuse delivery networks were a challenge to negotiate because of their separate client criteria, location and waiting lists. Third, inmate non-compliance with mental health and substance use treatment emerged as global themes particularly when compliance was not mandated. The last issue was the perceived reluctance by some community treatment providers to accept and work with people with mental illnesses, co-occurring substance use, and criminal backgrounds. Vantaa Prison and Northern State Prison treatment staff commentary, however, underscored the significance of maintaining positive agency and in-house collaboration across multiple disciplines and domains.

General Chapter Summary

Vantaa Prison and Northern State Prison staff comments revealed that the work they engaged in could be divided into three overlapping areas: mental health assessment, treatment, and discharge and release planning. Within these three areas, clinical services

included assessment, acute crisis intervention, individual and group therapy, medication management, and discharge and release planning. There were several notable differences between the treatment staff roles in both prisons. For example, referrals to mental health services and to specialized housing were not automatic at Vantaa Prison. Rather, the inmates almost always initiated this process by a written request instead of staff request. The Northern State Prison referral process was markedly different because inmates arrived with psychiatric diagnoses and were transferred directly to specialized housing. The treatment staff played no part in this process, and it was not until the inmates' arrival at special housing that the staff took over their care. This procedure, as the Northern State Prison staff comments indicated, was a reflection of a larger managerial approach to mentally ill inmate management in which psychiatric diagnoses and psychotropic medications were initiated elsewhere within NJ DOC. Some Northern State Prison staff, however, felt that this protocol led to mental health roster contamination due to CRAF's lower diagnostic threshold used to identify mentally ill inmates. These concerns were not expressed by Vantaa Prison treatment staff as they screened all inmate requests for treatment before admission to specialized housing was considered. Also, Vantaa Prison treatment staff had the discretion to turn down inmate requests for treatment and consideration for specialized housing whereas Northern State Prison staff could not do so as freely due to existing referral practices and procedures in place there. Also, the corrections officers formed a more important part of the mental health referral network at Vantaa Prison than at Northern State Prison, where their roles were more restricted to custody and control.

Vantaa Prison treatment staff acknowledged curtailing mental health services to general population inmates was an emerging quandary that resulted from the prison's relocation to its present site. Vantaa Prison staff acknowledged that outpatient treatment services reached only a small fraction of the total inmate population, and treatment parity emerged as an issue. Treatment services were stationary consisting of limited post-discharge follow up even if the inmates remained in Vantaa Prison. In contrast, Northern State Prison treatment staff circulated in all specialized housing units thus being able to provide services to a much wider inmate population. They also had built-in graduated specialized housing areas – the CSU, RTU and TCU – for acute care and transitional programming. Vantaa Prison did not have a similar structure in place for their mentally ill inmates. Instead, their specialized housing functioned as though it were a combined version of Northern State's graduated housing, but this all-in-one set-up favored the treatment of the most acutely ill inmates.

Mental health treatment staff provided discharge planning in both prisons as part of their mental health services, though Northern State Prison staff followed up on inmates for a certain period of time after the inmates' discharge from specialized housing to the general population. Comparable protocols, which the staff recognized could be improved, did not exist at Vantaa Prison. Not having a post-release aftercare program in place to monitor discharged inmates was a serious limitation of Vantaa Prison's mental health services. In addition, Vantaa Prison staff did not offer outpatient treatment services to general population inmates which their Northern State Prison counterparts did. This, too, was a negative aspect associated with Vantaa Prison mental health services. Vantaa Prison and Northern State Prison staff both highlighted issues related to release

practices. First, systemic regulatory and structural barriers made it more likely that inmates who were nearing release in both facilities could fall through the community social and mental health treatment provider safety net. Northern State Prison staff mentioned agency waiting lists and inmates' right to refuse participation in their own release planning. Second, Northern State Prison staff lamented that community-based treatment providers were, at times, difficult to negotiate with, and that discharged inmates had no preference over other community residents. Yet, these very agencies, according to staff in both prisons, were used extensively to connect inmates to existing resources. Lastly, staff feedback in both prisons indicated that despite these shortcomings, specialized housing were places where inmates with mental illnesses could get clinical and practical assistance and where they could be referred to various community resources. They were thus a unique resource for both prisons.

CHAPTER 9 – CONCLUSION AND POLICY IMPLICATIONS

Introduction

This study investigated the management and treatment of prison inmates who are mentally ill at Vantaa Prison in Finland and Northern State Prison in the United States. It compared their differences in law and policy and philosophies and practices. This study asked whether differences in correctional philosophies regarding the management, housing, and supervision of inmates who are mentally ill at Vantaa Prison in Finland and Northern State Prison in New Jersey were observable at the individual facility level and, specifically, whether those philosophies influenced mental health programs. Policies and procedures were reviewed, site visits conducted, and inmates and mental health staff interviewed to discover how these inmates were identified, their treatment and housing needs met, and each prison prepared them for discharge from specialized housing and release from prison.

A sample of forty male Vantaa Prison inmates who met the criteria for mental illness and seven of their staff members were interviewed during calendar year 2003. The Northern State Prison sample was comprised of forty male inmates who met the criteria for mental illness and four staff members. They provided a comparison sample from calendar year 2004. Their responses were analyzed and summarized to provide a better understanding of their experiences and prison services. This chapter will summarize the findings from this research. Included are sections on: (1) inmate characteristics, (2) detailed discussions of each of the four research questions, (3) study limitations, and (4) policy implications.

Inmate Characteristics

Notable similarities and differences emerged in the two inmate samples. The Northern State Prison sample was racially more diverse than the sample of Vantaa Prison inmates, who were primarily ethnic Finns. Northern State Prison inmates were also better educated and older than Vantaa Prison inmates. Both inmate samples came from lower socio-economic backgrounds, and the majority in both groups had never married.

At the time of this study, Northern State Prison inmates were serving much longer sentences and had been incarcerated, on average, much longer than Vantaa Prison inmates. In addition, fewer than half of Northern State Prison inmates were in prison for violent crimes, whereas most Vantaa Prison inmates were incarcerated for violent offenses. When violent crimes were committed, Northern State Prison inmates were more likely to have used guns in the commission of their crimes. Vantaa Prison inmates used their hands and sharps objects such as knives and axes in their assaults. Vantaa Prison inmates' crimes were mainly directed at family and intimate partners, but those targets were not as common among Northern State Prison inmates. Although some of their crimes were targeted toward family and intimate partners, many crimes were also committed against strangers.

In terms of psychiatric disorders, the sample of Northern State Prison and Vantaa Prison inmates had similar rates of serious mental illnesses, including psychotic disorders (schizophrenia), affective disorders, adjustment disorders, and secondary substance use diagnoses. The majority of inmates in both facilities had secondary substance use and dependency disorders.

Research Questions and Summaries

The four research questions that guided this dissertation are:

1. Are persons with mental illness in Vantaa Prison in Finland and the Northern State Prison in New Jersey different?
2. Are persons with mental illness at Vantaa Prison and Northern State Prison treated in different ways? (i.e., are perceived quality, access, usefulness, and helpfulness of mental health services different in the two institutions?).
3. How do Vantaa Prison and Northern State Prison mental health staff perceive the ways in which their prisons identify, treat, and discharge persons with mental illness?
4. How do policies and practices differ between the two countries and prisons?

Are persons with mental illness in Vantaa Prison in Finland and the Northern State Prison in New Jersey different?

This research started with the assumption that the inmates in Northern State Prison's specialized housing were more likely to be diagnosed with more severe psychiatric disorders than the inmates at Vantaa Prison's specialized housing. Limited support was found for this assumption. As a group, Northern State Prison inmates and Vantaa Prison inmates presented similar percentages of severe psychiatric disorders, including psychotic disorders. Vantaa Prison inmates had slightly higher diagnoses of mood disorders, while more Northern State Prison inmates were diagnosed with personality disorders. It is beyond the scope of this dissertation, however, to ascertain whether this phenomenon is linked to the practice of a more severe correctional philosophy at Northern State Prison. Regarding inmate ages and education levels, Northern State Prison inmates were older and more educated than Vantaa Prison inmates. In addition, most of the inmates in both facilities had never married, nor had they graduated from high school. Northern State Prison inmates were more likely to be

incarcerated for violent crimes than Vantaa Prison inmates. In addition, Northern State Prison inmates committed crimes with firearms more frequently than Vantaa Prison inmates, who mostly employed hands, axes, and knives as weapons. Vantaa Prison's sentenced inmates were serving 3.1 years on average compared to 9.8 years among the sentenced inmates at Northern State Prison. Eighteen of the 40 inmates at Vantaa were awaiting sentencing, however, thus influencing average sentence lengths in this study. Finally, none of the inmates at Vantaa Prison or Northern State Prison qualified as single-diagnosis psychiatric inmates. Instead, as multi-problematic individuals they required multi-focused psychiatric and substance use intervention. In regard to substance use, close to 95% of Vantaa Prison and Northern State Prison inmates received secondary substance use diagnoses and most of them self-reported extensive substance use in the past. According to self-reports both inmate groups had histories of alcohol, cannabis, prescription medication, cocaine, crack, heroin, and amphetamine use.

Are persons with mental illness at Vantaa Prison and Northern State Prison treated in different ways?

The second question was based on the hypothesis that Vantaa Prison inmates would be treated better than Northern State Prison inmates because of Vantaa's more treatment-oriented philosophy toward mental illness. This research assumed that the two prisons were examples of contrasting correctional philosophies that influenced the management, housing and treatment of inmates with mental illnesses observable at the individual prison level. Only limited support was found for the hypothesis.

Vantaa Prison was affected by the broader social values of Nordic countries that emphasize respect for human dignity and recognize the purpose of incarceration is

restricted to the deprivation of freedom. The focal point of Finnish correctional philosophy is the idea that inmates have the right to receive mental health treatment equivalent to that provided to the general public in terms of standards, quality, and range of services. This philosophy was observable in the prison's specialized housing more so than anywhere else at Vantaa Prison. The inmates who were in specialized housing were permitted to mingle in the hallway, in treatment areas, and in the multipurpose room, and most of them spent their daytime hours outside of their cells in structured treatment activities. Vantaa Prison specialized housing inmates expressed overall approval of their care. Their appreciation was influenced by comfortable surroundings which included cells equipped with showers and private toilets, bathrobes and slippers, a canteen, sauna, on-site laundry, optimal care, and fair and respectful treatment by staff. Outside the boundaries of specialized housing, however, the physical surroundings changed along with policies that guided Vantaa Prison's day-to-day operations.

Northern State Prison inmate feedback also noted that treatment was helpful, the treatment staff were well liked, and the inmates felt fairly treated. This support did not extend, however, to specialized housing, which the majority of inmates, who felt little incentive to be there, perceived to be structurally similar to general population areas. Their support also did not extend to the nurses and corrections officers with whom they felt they experienced adversarial interactions. According to Northern State inmates, this adversarial relationship resulted from staff members' disrespectful behavior and general unhelpfulness. Similar statements were directed at nurses, whom the inmates found uncaring and unprofessional in their tone and behavior. This resulted in the inmates expressing their interactions with nurses and corrections officers' in more forceful

language, whereas Vantaa Prison inmates tended to describe their interactions with corrections officers and nurses in softer language and more neutral tones. According to the Vantaa Prison inmates, the nurses were sincere and helpful and treated them fairly and respectfully. For corrections officers, feedback varied between affirmation and ambivalence. Inmates reported encounters with COs different than their Northern State Prison counterparts did.

Nonetheless, the risk of punishment, however mild the punishment might be, was embedded in the treatment practices and treatment staff discourse in Vantaa Prison specialized housing. Inmates, whose behavior did not conform to treatment staff expectations, faced disciplinary action that, at its severest, led to their discharge from specialized housing. Inmates who refused to submit to urine analysis faced denial of admission or potential discharge from specialized housing.

In both prisons, an assessment of inmate participation in treatment was an ongoing practice for monitoring progress and behavior. As a matter of policy, therapeutic and disciplinary, treatment staff in both facilities addressed deviations from specialized housing regulations. Behavior that was considered a departure from established treatment-related norms was addressed through therapeutic (soft coercion) or disciplinary (forced coercion) means. For example, treatment planning meetings, medication adjustments, and individual and group therapy involved influence, a soft form of coercion, while termination of treatment was an example of forced coercion. At Northern State Prison the practice of the involuntary medication protocol was utilized as a method of forced coercion whereas Vantaa Prison's medication distribution was seen as

a softer form of coercion because inmates could assert a degree of autonomy under the shroud of due process, supported by legal decisions.

How do Vantaa Prison and Northern State Prison mental health staff perceive the ways in which their prisons identify, treat, and discharge persons with mental illness?

Similar to the second question, the third question was based upon the theory that Vantaa Prison staff would discuss (in observable ways) the way in which their facility identifies, treats, discharges and releases inmates with mental illnesses differently than Northern State Prison treatment staff. Limited support was found for this statement. While a correctional philosophy that is embedded in a rehabilitative posture existed at Vantaa Prison, the staff communicated that specialized housing residents benefitted from this ideal because the staff and the resources were primarily concentrated there. Hence, a placement at Vantaa Prison specialized housing appeared to reinforce the concept of privilege and created disparity in access and participation in mental health services by general population inmates. At the time of this research, Vantaa Prison's specialized housing had been in operation for a year. As such, the new site presented an organizational culture with new treatment staff patterns and new methods of functioning that were beginning to evolve. Integration of specialized housing into the overall Vantaa Prison administrative culture was also ongoing. This integration meant new surroundings for both inmates within specialized housing and the treatment staff stationed there. Hence, it was conceivable to anticipate that barriers to mental health treatment would take place. Noted barriers included absence of treatment staff at book-in areas and a classification system that did not do a systematic screening of incoming inmates for

psychiatric symptoms. In other words, intensive psychiatric interventions were reserved for high-risk inmates, and low risk inmates were assigned less intensive services. For example, general population inmates had access to psychiatric consultation on designated days but could not generally participate in mental health treatment without being admitted to inpatient care. Also, the Vantaa Prison mental health treatment program is not transitional in nature; thus, it led to the treatment of a mixture of inmates in a small treatment setting meant to be less restrictive than general population housing units. The treatment staff also reported that the outpatient treatment program that was in place before the recent relocation significantly curtailed inmate access to mental health services. These factors influenced somewhat negatively staff perceptions about the mental health treatment program in operation at Vantaa Prison.

The findings also produced rich data about the mental health treatment programs in operation in both facilities. Both prisons offered similar mental health services but on a varying scale. They included crisis stabilization, (involuntary medication at Northern State Prison), individual and group therapy (both facilities), medication distribution and management (both facilities), discharge and release planning (both facilities), and social and recreational programs (both facilities). Northern State Prison treatment staff reported that their treatment program utilized a hierarchical approach to the provision of psychiatric treatment based on the inmates' level of psychiatric needs and capacity to function in prison. Thus, specialized housing functioned transitionally, positioned between the Crisis Stabilization Unit, the Residential Treatment Unit, the Transitional Care Unit, and the outpatient program. Collectively, these units offered inmates housed in them "a progressive therapeutic career," whereby the residents were expected to

advance through three distinct therapeutic modes (adapted from Grendon, 1995). To facilitate the inmate movement through these stages, treatment staff were there to help through observations, medication management, and individual and group therapy. Lastly, these units were created in reaction to the Terhune decision; Correctional Medical Services, the contracted treatment provider, put in place policies and procedures that solidified and guided their management, housing practices, and unit specific treatment operations and staffing levels. A point of contention, however, emerged for some staff members who felt that CRAF tended to set a lower threshold for mental illnesses when diagnosing and sending new inmates to Northern State Prison, thus compromising the integrity of the mentally ill inmate roster there.

Unlike their counterparts at Vantaa Prison, Northern State Prison treatment staff felt that structural factors hindered optimal mental health service delivery to inmates in specialized housing. Adequate space and privacy were compromised due to NJ DOC mandated security goals such as inmate counts, lockdowns, inmate movements, and programming needs and schedules. Confidentiality was never absolute. Nonetheless, sufficient staffing levels were reported and were considered a factor associated with few antagonistic interactions between treatment staff and the inmates in their care.

Confidentiality was not absolute in Vantaa Prison specialized housing either, although the treatment staff felt that the existing space and associated privacy supported a therapeutically conducive environment. Moreover, a low inmate census, a high staff to inmate ratio, and structured treatment occurring on multiple levels were cited as factors that contributed to fewer antagonistic interactions between the inmates and treatment staff.

How do policies and practices differ between the two countries and prisons?

The fourth question investigated whether correctional treatment policies and practices were more severe toward inmates with serious mental illnesses in either of the prisons. It was expected that that the Northern State Prison structure would be more punitive and more likely to impede rehabilitation of inmates who suffer from various psychiatric disorders. Review of CMS policies and practices at Northern State Prison lends very limited support for this hypothesis. While the policies and practices in place at Northern State Prison were found to be oriented toward imposition of order and discipline and they stressed regulation and control of inmate routines, there was also, the establishment of mental health treatment-related responsibilities.

Northern State's correctional philosophy obligated, and ratified in writing, a different strategy that was more therapeutic in nature (e.g., graded disciplinary practices, disciplinary charges and hearings) toward mentally ill inmates. Thus, the policies and practices were not totally centered on control by disciplinary methods as the presence of specialized housing and concomitant treatment staff indicates. Many therapeutic objectives, however, were found to contain disciplinary outcomes such as the loss of privileges, extended lockdown time, the use of Ad Seg, or loss of time off for good behavior. The CMS policies also spelled out in detail the use of restraints in the management of mentally ill inmates including a detailed protocol for administering involuntary psychiatric medications.

Similarly, Vantaa Prison correctional policies and practices also presented security and inmate discipline as important objectives. Those concerns, though, were in keeping with the prison's therapeutic orientation and aligned with international decrees

and local legislative frameworks. The existence of disciplinary sanctions governing inmate conduct was found to be consistent with UN treaties and European Union prison rules. These frameworks collectively stipulated when, how, and under what circumstances inmate disciplinary action can be taken. In stark contrast to Northern State Prison, no Vantaa Prison policies were located that specifically mandated screening inmates for psychiatric disorders and related conditions.

The policies and procedures in place at Northern State Prison were more extensive; they outlined levels of mental health care to inmates with varying degrees of functionality and needs. In addition, they permitted treatment staff intervention and utilization of discretion by recommending alternative or less severe sanctions. In contrast to Vantaa, Northern State Prison policies and procedures were also more specific and detailed and their discourse more formal and rule-bound, underscoring inmate security and supervision first and foremost.

Limitations

There are several limitations to this dissertation study. One is this study's narrow scope in that it focuses on two prisons only; one in Vantaa, Finland and the other in Newark, New Jersey. Neither prison is representative of their respective countries' prison systems, and not all prisons in either country have in-house specialized housing or mental health treatment programs on the premises. Secondly, this study cannot be generalized to larger inmate populations due to the narrow sampling method and gender specificity, 100 percent male. Furthermore, the small inmate sample size ($n=40$) from each prison limits the generalizability of these findings even within the narrow sampling

frame. Should this study be replicated, it ought to be conducted with more prisons and a larger sample size.

Recommendations

This dissertation has several important and far-reaching recommendations for mental health treatment program providers at Vantaa Prison and Northern State Prison. First, because the Vantaa Prison general inmate population does not receive nearly the same type or range of mental health treatment services as they would if housed in the prison's specialized housing, a strong argument exists for expanding these services for the general population inmates. Because of this gap in mental health services, at this time, Vantaa Prison mental health treatment is reserved for high-risk inmates rather than more psychiatrically stable ones.

Second, establishing an outpatient mental health treatment program should be a top priority for Vantaa Prison depending on fiscal and staff resources. The outpatient program, if implemented, should extend beyond the purview of specialized housing to target inmates during their post-discharge adjustment including others who may need mental health treatment services. Unquestionably, the most problematic aspect of Vantaa Prison specialized housing involves aftercare. It is of great concern that discharged inmates return to other prisons without appropriate treatment plans. Third, it is not known to what extent Vantaa Prison informs new inmates of in-house mental health services and how the inmates can access them. Therefore, an orientation procedure should be a top priority and include how to access mental health treatment services, length of treatment, and the various focuses of treatment.

Inmate Orientation

One recommendation is presented here that is relevant to Vantaa Prison. This recommendation calls for new inmate orientation sessions to be implemented at Vantaa Prison. The orientation sessions should be implemented and conducted weekly by representatives from the medical, mental health and custodial staff. In these orientations, information about the in-house programs to address inmate needs, including access to mental health and other services, should be stressed.

Inmate Classification

Two recommendations are presented here that are pertinent to both Vantaa Prison and Northern State Prison. The first recommendation is that both prisons mandate their mental health staff to communicate with classification department within 24 hours of the inmates' arrival to determine the most suitable housing and treatment options for inmates with pending and established psychiatric diagnoses. The basis for this recommendation is that it is of sound policy that mental health treatment staff is present at key treatment decision points to advocate for these inmates. The second recommendation calls for the custodial staff to be made aware of the mental health needs and associated housing decisions linked to making inmate classification decisions in both prisons. Collaboration between custodial and treatment staff helps both to be aware of inmate movements and treatment related decisions regarding such inmates. In addition, collaboration is critical as the inmates' psychiatric needs may complicate decisions about housing, treatment program, classification, disciplinary issues, or transfers to other prisons. For these reasons, the custodial and treatment staff can assign and, if needed, change inmate custody levels during incarceration.

Staff Training

Two recommendations are presented here that are applicable to both Vantaa Prison and Northern State Prison regarding prison staff. The first recommendation calls for cross-training of custodial staff on the signs and symptoms of major mental illnesses and how they may manifest in prison settings. Techniques of basic counseling should be incorporated into corrections officer training with the intention of providing them with the basic skills and knowledge, incorporating behavior and cognitive modification approaches. The outcome could be beneficial for inmates and custodial staff alike as more knowledgeable and trained corrections officers may lead to fewer situations where the safety and the security of inmates and staff are compromised. To the knowledge of this writer, neither prison provided this type of training to custodial staff. The second recommendation calls for collaborative meetings between custodial, administrative and mental health staff at Vantaa Prison and Northern State Prison. Collaborative meetings can serve as framework upon which to share in house knowledge on the different skills sets that are required when managing and supervising inmates who suffer from mental illnesses. The meetings may also increase non-judgmental milieus as well among administrative, custodial and treatment staff. This writer believes and as Steadman (1991) indicated, prisons ought to be a 'community service responsibility.' To facilitate internally drive prison 'community transformation,' whether in Finland or in New Jersey, it is imperative that the initial changes for this type of change emerge from within the prisons in question. Therefore it is urgent to establish collaboration and training grounds to find methods in which to best manage, treat and supervise inmates who are mentally ill, for the safety of everyone concerned. These recommendations are suggested pending availability of fiscal and personnel resources in each of these prisons.

Conclusion

The uniqueness of this dissertation lies in its cross-national approach comparing two different prison systems and their correctional philosophies and practices regarding inmates with mental illnesses. More specifically, this dissertation sought to establish whether different facets of correctional philosophies may affect inmate experiences in specialized housing and whether an overview of cross-national changes in specialized housing targeted for inmates who are mentally ill is warranted. Additionally, there are a number of benefits for international prison research that facilitates qualitative research. Primary among these benefits is the opportunity to gather rich data that may otherwise be hidden from correctional staff, mental health staff, and policy makers.

This study can also provide relevant information for criminal justice and public health policy makers, legislators, correctional staff, and medical personnel, as well as designers of correctional facilities. At the practical level, these findings offer correctional administrators and staff insight into how inmate and staff provided information can be utilized for the overall improvement of policies and practices, as measures of mental health treatment success or failure (adapted from Patenaude, 2002). Also, as Conover (2000) and Marquart (1986) have added to our penological *verstehen*, so, too, can other international qualitative researchers if they are permitted entry and access to the prison and its residents.

In conclusion, this study and its methodology provides an intriguing and distinctive framework which can be utilized to better understand the problems of persons who are mentally ill and incarcerated in places other than New Jersey and Finland. Using this methodology together with the cross-national cultural perspectives of those inmates

with mental illnesses who live outside of U.S. and Finnish borders will allow greater exploration of comparative international policies and practices. It has the potential for increasing understanding, enhancing prison treatment, and improving the lives of inmates with mental illnesses.

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APPENDIX A**INMATE INTERVIEW GUIDE**

Date:
Interview#:
Name:
Nickname:
Interview Site:
Time:
Housing Unit:
Special Needs:
Age:
Marital Status:
Education:
Employment:
Military Veteran:
Children:
Psychiatric History:
Previous Psychiatric Hospitalizations:
Family Psychiatric History:
Mental Status Examinations:
Previous Arrests:
Previous Incarcerations:
Current Conviction:
Substance Use History/Treatment:
Current Psychiatric Diagnosis:
Current Psychiatric Medications:

1. How long have you been in this prison?
2. Can you tell me why you are in prison?
3. Do you have prior mental health treatment in the community or in other prisons?
4. How did the prison staff notice that you needed or wanted mental health treatment?
5. Are you receiving mental health treatment at this time?
6. Tell me about the type of treatment you are receiving, how often and why?
7. What are your thoughts about the staff in this prison?
8. Do you participate in planning your mental health treatment plan? If so, how?
9. Do you have a mental health diagnosis?

10. Are you receiving treatment for something else other than mental health?
11. Tell me about the mental health medications you are taking currently?
12. What happens if you refuse your mental health medications?
13. How are you getting used to/adapting to your medications?
14. Are you informed of any side effects of your mental health medications?
15. How are you coping now?
16. Is there anything in your opinion that this prison could do to make things easier for you?
17. Do you have a substance use background?
18. Tell me about your plans after release from prison.

APPENDIX B

STAFF INTERVIEW GUIDE

These structured open-ended questions contain items that permit staff to reflect on the services they provide and more broadly their role within the prison mental health services.

1. What is your educational background? (optional)
2. How long have you worked in this prison?(optional)
3. How did you get involved in working with inmates who are mentally ill?
4. What role do you play in this prison?
5. What is the process by which inmates who need mental health services come to you or contact you?
6. What do you think about this process?
7. Is it adequate or appropriate in your opinion?
8. Does your role in this prison include identification of inmates who may be mentally ill?
9. What kinds to services do you provide to inmates who come to you or are referred to you?
10. What is the average inmate length of stay in specialized housing?
11. How do you manage inmates who refuse psychiatric medication?
12. How does this program manage inmates who may be dually diagnosed (i.e. mental illness and substance use, etc.)?
13. Is there anything in your opinion that could improve the overall level of wellbeing of inmates who are mentally ill in this prison?
14. Tell me about the post-discharge follow up on inmates who return to general population in this prison? What is your opinion about it?
15. How does the mental health staff in this prison prepare inmates for release from prison?

APPENDIX C

Inmate Informed Consent Form

Contains:

- 1) Written informed consent form
- 2) Interview questions (protocol)
- 3) Contact information statement

Part 1:

Introduction and informed consent:

I would like to invite you to participate in dissertation research being conducted with persons like yourself who are incarcerated and receiving mental health treatment. I want to learn how prison services address your mental health needs.

I am doing this study for dissertation research purposes only. I have no connection with police or law enforcement or treatment providers in prison or in the community. Information obtained in this research could make it easier to get help for mental health problems but I cannot promise that you can derive any direct or immediate benefits from participating in this interview.

What I would like to know is how do you receive mental health treatment and what is your satisfaction level with mental health services provided at Northern State Prison?

The only risk to you would be if I told someone the things you told me, but I won't do that. Your real name will never be associated with your interview; you can pick a nickname for yourself that I will use in any write-up of your interview. I am not going to tell other people that you told me anything, and I am not going to tell you what other people tell me. This protection is not absolute, however. If you indicate that you may harm yourself or others or if you report intent to escape, I must notify the prison authorities.

The interviews will be audio taped for the purpose of transcription. Your name will not be identified or attached to the transcription, but be replaced by a code. This is to ensure that what you and others tell me cannot be used to harm you or others in prison. I hope this will allow you to be as open as possible with your answers.

I would like to interview you for about one hour. Your refusal to participate or stop the interview will have no effect on any benefits you are receiving or are entitled to in prison. Your participation in this interview is voluntary. If any questions make you uncomfortable, you do not have to answer them. You may stop the interview at any time.

Your participation in this study is not going to affect any prison decisions; nothing is given or taken away from you because of your participation. Your participation will

have no bearing on any parole, or other release decision. Consent or no consent will have no bearing on the way you are treated in this institution and after release.

Please tell me if you agree to participate after hearing this.

Documentation of informed consent:

If you have any questions about this research study, you may contact Rose Marie Äikäs at (973) 353-3115. The sponsored programs administrator of the Rutgers University Institutional Review Board at (732) 932-0150 ext. 2104 can answer any questions about your rights as a research participant.

I am going to ask you to sign a consent form. This is done only to help me to demonstrate that I obtained consent from you. Also, the consent form states that I will not provide this information to anyone in a way that could be connected to any particular thing you want to discuss with me.

By signing this consent form, you indicate that you have read the information above; the research study has been explained to you, your questions have been answered.

Signatures:

(1) Authorization for participation

_____	_____	_____
Name (please print)	Signature	Date

_____	_____	_____
(2) I agree to be audio taped	Signature	Date

_____	_____	_____
(3) Person Obtaining Consent	Signature	Date

(4) Receipt: I have received a copy of this document.	_____
	Initials

(5) Subject agrees to allow the interviewer to see/get name of his psychiatric diagnosis and names of any psychiatric medication.

_____	_____
Name	Date

APPENDIX D

Professional Staff Informed Consent

Contains:

- 1) Informed consent form
- 2) Interview questions (protocol)
- 3) Contact information statement

Part 1:

Informed consent:

I would like to invite you to participate in a dissertation research study being conducted to learn about your observations and interactions with persons diagnosed with mental illness and those in need of mental health care in this prison. I want to hear your description of the mental health services here in prison. I want to learn how well you think this prison is accomplishing its goals in terms of treatment, supervision and management of inmates with a diagnosis of mental illness. I am especially interested in how do you think intervention provided by you affects inmates with mental illness.

My interviews with you and others are for dissertation research purposes only. I have no connection with police or law enforcement or any treatment agency in the United States. Information obtained in this research could improve prison mental health services in the United States and in Finland.

I am not a social service provider, so I need the help of experts like you to explain how things are done and why. I am hoping you will agree to be one of the experts who can help me understand how things work in your facility.

Identifying information will not be used in any of my research reports. I will also make sure not to ask your work title, your department, or the city in which you work in my write-ups. Your real name will never be associated with your interview; you can pick a nickname for yourself that I will use in any write-up of your interview. The interview will be audio taped for the purposes of transcription only. Any identifying information will be coded and kept in a locked file separate from the research data. The information will only be presented in the aggregate and anonymously. There are no anticipated risks from your participation in this study. I hope this will allow you to be as open as possible with your answers.

I would like to interview you for about one to two hours the first time. I may ask you for a second follow-up interview.

Your participation in this interview is voluntary. If any questions make you uncomfortable, you do not have to answer them. You may stop the interview at any time.

Please tell me if you agree to participate after hearing this.

Documentation of informed consent:

If you have any questions about this research study, you may contact Rose-Marie Äikäs at (973) 353-3115 or by email: suomi46@hotmail.com Any questions about your rights as a research participant can be answered by the sponsored programs administrator of the Rutgers University Institutional Review Board at (732) 932-0150 ext. 2104.

I am going to ask you to sign a consent form. This is done only to help me to demonstrate that I obtained consent from you. Also, the consent form states that I will not provide this information to anyone in a way that could be connected to any particular thing you want to discuss with me.

By signing this consent form, you indicate that you have read the information above; the research study has been explained to you, your questions have been answered.

Signatures:

(1) Authorization for participation

_____	_____	_____
Name (please print)	Signature	Date

(2) I agree to be audio taped

_____	_____	_____
Name (please print)	Signature	Date

(3) Person Obtaining Consent Signature

_____	_____	_____
Name (please print)	Signature	Date

(4) Receipt: I have received a copy of this document.	_____
	Initials

VITA

Rose Marie Äikäs

Born: Helsinki, Finland

Graduated: GED, Chicago, Illinois

B.A., Criminal Justice, University of Illinois-Chicago, 1986

M.S.W., Social Work, University of Illinois-Chicago, 1990

M.A., Criminal Justice, School of Criminal Justice, Rutgers University,
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ACADEMIC AWARDS AND HONORS

Who is Who Among America's Teachers (9th Edition)

Who is Who Among America's Teachers (8th Edition)

Recipient, Research Award - Rutgers University - School of Criminal Justice, 2003

Recipient, Graduate Merit Award - Executive Women of New Jersey, 2003

Recipient, Research Award - Scandinavian Council on Criminology, 2003

PROFESSIONAL WORK EXPERIENCE

Instructor, CUNY/Queensborough Community College, 2008 to Present

Lecturer, School of Criminal Justice, Rutgers University, 2001 to 2008

Visiting Scholar - University of Helsinki- School of Law, 2003

PROFESSIONAL AFFILIATIONS

Academy of Criminal Justice Sciences

International Sociological Association

American Association of University Professors

American Society of Criminology