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Public Vs. Private:
The Effect of Profit Seeking in Caring for America’s Mentally Ill Incarcerated Youth

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ABSTRACT

The U.S. criminal justice system has become the largest caretaker for the mentally ill population, and the prevalence of mental illness in the juvenile justice population is particularly high. Due to a shortage of available community-based mental health services, many youth rely on the juvenile justice system to provide them with necessary care. Although they have a constitutional right to adequate treatment while they are incarcerated, they are met with severe inadequacies in the system. The dramatic increase in the prison population emerging as a result of the stricter sentencing policies introduced in the final decades of the last century, created a high demand for private services in the field. This thesis is exploring the intersection of the use of private health care contractors with the comprehensive mental health needs of a young prison population, all in the perspective of the human rights violations suffered by this vulnerable group of individuals. By examining Department of Justice investigations from the inside of these facilities, as well as collecting opinions from advocates and experts in the criminal justice field, the thesis argues that privatization in the criminal justice system as it stands today, surrounded by a lack of transparency and accountability, reduces the likelihood for the human and constitutional rights of mentally ill youth to be fulfilled.
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i. Introduction

The mentally ill population in America’s prisons and jails is vast; in fact, the criminal justice system has become the largest caretaker of mentally ill individuals. As for the juvenile justice population, the prevalence of mental illness is particularly high. Imprisoned individuals with a mental illness have a constitutional right to mental health care that meets minimum standards, and is equal to care for physical illness.¹ As will be demonstrated in this thesis, mentally ill youth still risk being subjected to severely inadequate treatment once incarcerated. Moreover, they risk receiving meager treatment in their community prior to detention.

The deinstitutionalization phase that took place in the 1950s and 60s resulted in a shortage of services for mentally ill individuals. The authors of the book The Rights of People with Mental Disabilities point to three main driving forces behind the phase: the introduction of psychotropic drugs (reducing patients’ psychotic symptoms and thus enabling them to be released into the communities), the horrific revelations of the conditions of some state mental institutions, and the passage of the Community Mental Health Act in 1963.² The law, encouraging community based mental health care, initially galvanized newfound enthusiasm in the mental health field, but significant challenges followed.³ The system never gained the resources and staffing necessary to tend to the mentally ill population in community-based settings. The issues of underfunding and understaffing remain to this day, increasing the risks of homelessness and incarceration among all age groups.⁴

¹ Bowring v. Godwin, 551 F. 2d 44 (Court of Appeals, 4th Circuit 1976).
⁴ Ibid.
Over 600,000 youth are taken in by juvenile detention centers in the U.S. every year, and nearly 70,000 youth live in these centers on any given day. As will be discussed further, the majority of these individuals have a mental illness, yet many of them will go untreated – despite the fact that their recovery is typically strongly impacted by the quality of care they receive within the walls of detention. The United States has seen a growing use of private service providers in the criminal justice system in the last decades in order to meet the demands of a high prison population. The overall objective of the study is to explore this intersection, and answer the question: How does the use of private vs. public health care providers in the U.S. juvenile justice system affect the adequacy of the treatment given to mentally ill youth? For this purpose, I will analyze investigations of juvenile justice facilities and collect opinions from experts and advocates in the criminal justice field to explore the impact on mental health care provision of using private versus public providers. Throughout the study, I will highlight how profit seeking potentially affects specific constitutional and human rights of mentally ill children and youth in the juvenile justice system. This includes individuals who were below the age of 18 when they committed a crime (states in the country operate with different upper and lower ages for trying juveniles; whether it regards a status offense or juvenile court delinquency, the majority of states use the upper age of 17, and do not specify a lower age).

I am looking at this issue through the lens of Paul Farmer and his text On Suffering and Structural Violence: A View from Below. Farmer analyzes the root causes

of suffering, and points to poverty and lower social class being the common denominators of victims of suffering. The issue of race in the U.S. criminal justice system could not be more evident, considering the fact that African-Americans are overrepresented at every stage of the process. While Farmer recognizes the deep-rooted issues connected to i.e. race and gender, he encourages us to move away from a one-dimensional interpretation of the suffering involved, and embrace “multiaxial models of suffering”.

For instance, when it comes to race, he highlights that it is the underprivileged part of the African-American population who are ignored and left to suffer, quoting sociologist William Julius Wilson: “Trained and educated blacks, like trained and educated whites, will continue to enjoy the advantages and privileges of their class status.”

Farmer emphasizes that victims of structural violence are, from the outset, and not by accident, at risk of that very fate. “For many, including most of my patients and informants, life choices are structured by racism, sexism, political violence, and grinding poverty,” he says. He points out that what victims of suffering in various parts of the world share, today and throughout history, is “the experience of occupying the bottom rung of the social ladder in inegalitarian societies.” He argues that part of the reason why this remains true, is that the poor are “more likely to have their suffering silenced.” He quotes the Chilean theologian Pablo Richard, who says: “(…) A wall between the rich and poor is being built, so that poverty does not annoy the powerful

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8 Ibid., 276.
9 Ibid., 263.
10 Ibid.
11 Ibid., 280.
and the poor are obliged to die in the silence of history."\(^{12}\) For change to happen, Farmer argues, we need to break the silence by identifying “the forces conspiring to promote suffering.”\(^{13}\)

The U.S. society is one with significant levels of inequality. Many are brought up in generational poverty, with little opportunity to establish new patterns. As will be reviewed later in the paper, mental illness in the juvenile justice system is an issue of race and poverty; it is the underprivileged African-American youth who have the highest levels of being uninsured, and struggle to get access to proper mental health treatment in their community. They are the ones who end up enduring the horrendous ramifications of being mentally ill and incarcerated. When these individuals enter the corrections system, their problems are often made worse by the conditions and the lack of treatment. Upon exiting the corrections system, they are again facing difficulties with accessing the necessary health services, contributing to high rates of recidivism and poor odds of escaping the cycle. Because they have been stripped of their liberty, the government has a greater duty to ensure that their rights are being fulfilled. Even in this circumstance of greater responsibility, structural violence is allowed to exist. As will be discussed in this thesis, the government further distances itself from its responsibility through privatization, due to the lack of transparency and accountability that follows. The privatization industry itself has a financial interest in maintaining high incarceration levels, lobbying to enforce stricter criminal codes to maintain a steady flow of people coming into their facilities. This creates additional opportunities for social structures to inflict further suffering on these individuals, by preventing them

\(^{12}\) Ibid.
\(^{13}\) Ibid.
from having their basic needs met. The ones who are enduring the pain, in silence behind the high walls of privacy, are underprivileged youth, the majority being African-American, who did not receive the help they needed in their community, and who are not receiving the help they need behind bars.

The next sections consider the scope of mental illness among the juvenile justice population, details about how race and poverty play a role in access to mental health care, developments in prison privatization, a description of the relevant provisions in place to protect this population, as well as an account of the existing literature on the issue.

ii. Background

a. Mental Illness in the Juvenile Justice population

One in every five youth between 13 and 18 years old live with a mental health condition, and around half of those who have a serious mental health condition during their lifetime, report that the onset of the problem took place by age 14.\(^{14}\) Nearly half of all students over the age of 14 who suffer from a mental illness will drop out of school, representing the highest dropout rate of any disability group.\(^{15}\) As many as 65-70 percent within the juvenile justice system meet criteria for a mental disorder, and over sixty percent of youth who have a mental illness, also have a substance use disorder.\(^{16}\) Close to 30 percent among those with co-occurring mental and substance use disorder


\(^{16}\) National Center for Mental Health and Juvenile Justice, “Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System,” 2.
had their ability to function impaired.\textsuperscript{17} Disruptive disorders are the most common among incarcerated youth, followed by substance use disorders, anxiety disorders, and mood disorders.\textsuperscript{18} According to one study, more than 90 percent of individuals in the juvenile justice system reported being exposed to some form of “adverse childhood experience.”\textsuperscript{19}

\textbf{b. The Role of Poverty and Race}

The demand for mental health treatment in the community has proven vast and difficult to meet. As pointed out by Cocozza, Skowyra and Shufelt: “The reality for most system of care sites is that the need for mental health services far outstrips the capacity of the community to provide services, because of a lack of qualified providers, inadequate funding, or other barriers.”\textsuperscript{20} Thus, the authors hold, communities are forced to prioritize certain youth populations, which often means that youth involved with the juvenile justice system fall behind due to “challenges associated with collaboration” and “limited political and public support.”\textsuperscript{21}

When mental health services are not universally accessible, individuals from poor and low income families are most at risk of suffering from it. The child welfare and juvenile justice departments estimated that over 12,000 children and youth entered

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\textsuperscript{21} Ibid.
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the child welfare or juvenile justice system solely to receive mental health services in 2001 (this study has not been followed up since).\textsuperscript{22} In the report \textit{Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System}, Skowyra and Cocozza point to the transfer of responsibility of treatment from the community to the criminal justice system, holding that many of the mentally ill youth who are detained or in the juvenile justice system for “relatively minor, nonviolent offenses,” have ended up there due to a shortage of available community-based treatment options.\textsuperscript{23} A 1999 study conducted by researchers at Virginia Commonwealth University revealed that twenty percent of the parents who participated in the study reported that they relinquished custody of their children in order for them to receive treatment, and over one third of the parents held that their children were in the juvenile justice system due to the unavailability of mental health services.\textsuperscript{24} Moreover, a 2004 study showed that \textit{two thirds} of juvenile detention facilities “hold youth who are waiting for community mental health treatment”\textsuperscript{25}; youth in 33 states are detained in juvenile justice facilities without any charges against them; and children as young as seven years old are “incarcerated unnecessarily” as they await treatment.\textsuperscript{26} Among the facilities housing youth waiting for


\textsuperscript{24} Stephanie Vitanza, Robert Cohen, and Laura Lee Hall, “Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness Results of a National Survey of Parents and Other Caregivers” (Department of Psychiatry, Virginia Commonwealth University, July 1999), http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.554.4268&rep=rep1&type=pdf.

\textsuperscript{25} United States House of Representatives Committee on Government Reform - Minority Staff Special Investigations Division, “Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States,” July 2004, 4.

\textsuperscript{26} Ibid., 6.
mental health services in the community, over a quarter reported that youth received “poor, very poor or no mental health treatment,”\textsuperscript{27} over half reported that staff received “poor, very poor, or no mental health training,”\textsuperscript{28} and close to half of the facilities reported suicide attempts among the youth waiting for treatment.\textsuperscript{29}

There are ample reasons why receiving mental health treatment inside the U.S. juvenile justice system is less than ideal. An array of U.S. Department of Justice investigations continue to reveal stark inadequacies in the mental health treatment offered in the juvenile justice system.\textsuperscript{30,31} Correspondingly, as held by Mahoney et al., being involved with the juvenile justice system can have “profound and devastating”\textsuperscript{32} effects for youth with serious mental health needs, can exacerbate symptoms, and trigger responses to previous traumatic experiences.\textsuperscript{33} African-American youth are significantly over-represented at every stage of the juvenile and criminal justice systems.\textsuperscript{34} According to a report by the Youth Reentry Task Force of the Juvenile Justice and Delinquency Prevention Coalition, over 80 percent of youth in the juvenile justice system serving sentences of four to six months (which is the most typical sentence duration) were male, and 60 percent were youth of color.\textsuperscript{35} Minority youth have the

\textsuperscript{27} Ibid., 9.
\textsuperscript{28} Ibid., 10.
\textsuperscript{29} Ibid., 8.
\textsuperscript{32} Cocozza, Skowyra, and Shufelt, “Addressing the Mental Health Needs of Youth in Contact With the Juvenile Justice System in System of Care: An Overview and Summary of Key Issues,” 2.
highest rates of being uninsured.\textsuperscript{36} This is not only a relevant problem in the time leading up to incarceration, but also in the time after, when the need for treatment, including the proper medication, is critical in order for recidivism not to occur.\textsuperscript{37} What happens for any young individual in the first months after release from the juvenile justice system is crucial in determining how the transition back to the community progresses.\textsuperscript{38} The authors of the report \textit{Back on Track: Supporting Youth Reentry from Out-of-Home Placement to the Community} underscore:

“(…) because of the overlap between mental illness, substance abuse, and criminality, the period of transition from secure custody to the community is a critical time where necessary support should be in place to provide appropriate medical attention. This is especially true for young people coping with mental illness, a history of substance abuse, or other disorders that may make reintegration difficult.”\textsuperscript{39}

Minority youth have a particularly hard time accessing mental health services; the percentage of African-Americans who receive sufficient care is half that of non-minorities.\textsuperscript{40} They are more likely to have their mental illness identified through the juvenile justice system than non-minority youth, and are thus “less likely to undergo a thorough psychological assessment and less likely to receive therapeutic treatment.”\textsuperscript{41} When African-American adolescents do receive treatment outside of detention, their diagnoses tend to be of a more severe kind, and they have significantly higher rates of

\textsuperscript{36} Lynsen, “Criminal and Juvenile Justice.”
\textsuperscript{38} Ibid.
\textsuperscript{39} Nellis and Wayman, “Back on Track: Supporting Youth Reentry from Out-of-Home Placement to the Community.”
psychiatric hospitalizations, indicating that “prevention and early intervention services may be less available to African-American youth.”

Research indicates that individuals in the juvenile justice system who received treatment have around 25 percent lower recidivism rates than those who did not receive treatment, irrespective of the type of program they enrolled in or their background. Every year, around 100,000 individuals leave the juvenile justice system. The authors of the study An Empirical Portrait of Community Reentry Among Serious Juvenile Offenders in Two Metropolitan Cities point to an estimate of around a 50 percent recidivism rate among children and youth in contact with the juvenile justice system, and underscore that certain studies show even higher rates of recidivism. In addition to medical care, education is crucial for a young individual’s successful return to the community. About two thirds of the individuals leaving formal custody, however, do not go back to school. The Coalition for Juvenile Justice found that high school dropouts are three and a half times more likely to be arrested than those who complete high school, and that the likelihood of youth from low-income families dropping out of high school is 2.4 times higher than for children from middle-income families, and 10.5 times higher than for high-income families.

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42 Ibid.
43 Ibid., 1.
c. Privatization Developments

On a world basis, the U.S. has the highest total number of privately held incarcerated individuals, largely due to elevated incarceration rates, while countries like Australia, England, and New Zealand hold a larger proportion of their incarcerated population in private facilities.\(^{48}\) A range of countries, however, oppose the use of private prisons. For instance, the plan to build a fully private prison in Israel was struck down by a 2009 Israeli Supreme Court ruling, which held that relying on for-profit companies to take on the responsibility of the state for correctional services would lead to: “harsh and grave damage to the basic human rights of prisoners and to their personal freedom and human dignity.”\(^{49}\)

There are three levels of privatization in correctional facilities: a private company can fully own and operate a facility; fully manage a facility owned by the state; or be involved in part of the operations at a facility.\(^{50}\) Privatization has only in recent decades extended to the U.S. criminal justice system. The dramatic increase in the prison population emerging as a result of the so-called “War on Drugs” and the stricter sentencing policies of the 1970s and 1980s, created a high demand for private services in the field.\(^{51}\) According to a report issued by the Office of Juvenile Justice and Delinquency Prevention in 2015, 49 percent of U.S. juvenile justice facilities were privately operated in 2012,\(^{52}\) while a similar report issued in 2011 showed that 53


\(^{49}\) Ibid., 3.


\(^{51}\) Ibid., 2.

percent were privately operated in 2008.\textsuperscript{53} However, when it comes to the percentage of individuals of juvenile age serving time in privately versus publicly operated facilities, the number is lower; roughly 30 percent are incarcerated in private facilities.\textsuperscript{54} This is due to the fact that most private juvenile justice facilities are of smaller size. As an illustration, close to 80 percent of group homes are private, and the majority of these have room for less than ten residents.\textsuperscript{55}

As pointed out in the report \textit{Oversight of Private Juvenile Facilities}, the increasing number of states working to deinstitutionalize youth contributes to an environment encouraging privatization of "programs around the edge of juvenile corrections," such as group homes, stating: "Policy-makers may find it difficult to reconcile your desire for small, community-based group homes with opposition to privatization, since they appear to be complementary."\textsuperscript{56} The same report underscores that small private facilities can "ride under the radar screen for long periods of time, with little oversight or regulation from government officials, and little scrutiny from concerned citizens, advocates, or the media. Abuses or lack of services can go undetected for years."\textsuperscript{57} Prisons that are entirely privately owned are not subject to the Freedom of Information Act (FOIA), and usually not subject to state open records laws.\textsuperscript{58}

Corrections Corporation of America (CCA) and GEO Group, Inc. are today the two leading private prison companies, with combined total revenues of $2.9 billion in

\begin{itemize}
\item \textsuperscript{54} Michele Deitch, "Oversight of Private Juvenile Facilities," July 28, 2011, 2.
\item \textsuperscript{55} Ibid.
\item \textsuperscript{56} Ibid., 3.
\item \textsuperscript{57} Ibid.
\end{itemize}
Lobbying has become an important tool for private corporations to maintain a high incarceration and privatization rate. CCA and GEO Group have both previously been involved with the American Legislative Exchange Council (ALEC), an organization advocating for privatization, and with “past model policies” contributing to higher rates of incarceration, such as three strikes laws and mandatory minimum sentences. In CCA’s 2010 Annual Report, the three following quotes can be found (one of them also quoted in The Sentencing Project’s report Too Good to be True. Private Prisons in America), underscoring the financial interest the company has in maintaining a large number of incarcerated individuals:

“As of December 31, 2010, we had approximately 11,700 unoccupied beds in inventory at facilities that had availability of 100 or more beds, and an additional 1,124 beds under development. Of those, 1,200 beds are under guaranteed contracts with existing customers, leaving us with 11,600 beds available. We have staff throughout the organization actively engaged in marketing this available capacity to existing and prospective customers. Historically, we have been successful in substantially filling our inventory of available beds and the beds that we have constructed. Filling these available beds would provide substantial growth in revenues, cash flow, and earnings per share. However, we can provide no assurance that we will be able to fill our available beds.”

“The demand for our facilities and services could be adversely affected by the relaxation of enforcement efforts, leniency in conviction or parole standards and sentencing practices or through the decriminalization of certain activities that are currently proscribed by our criminal laws.”

“A decrease in occupancy levels could cause a decrease in revenues and profitability (...) We are dependent upon the governmental agencies with which we have contracts to provide inmates for our managed facilities. We cannot control occupancy levels at our managed facilities. Under a per diem rate structure, a decrease in our occupancy rates could cause a decrease in revenues and profitability. When combined with relatively

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60 Ibid., 12.
61 Ibid., 13.
63 Ibid., 19.
fixed costs for operating each facility, regardless of the occupancy level, a decrease in occupancy levels could have a material adverse effect on our profitability.”  

iii. Healthcare Provision: Legislative Overview

a. Domestic Law

In the book *The Rights of People with Mental Disabilities*, the authors underscore that because access to basic health care is not considered a legal right in the U.S., and the right to treatment for mentally ill individuals is not found in the Constitution, the rights that they do have today have required justification. When discussing the debate in the U.S. around the right to treatment for individuals with mental illness who are institutionalized, they hold that: “At its root the right to treatment is an assertion that the government has an obligation not just to protect institutionalized individuals or leave them alone, but to provide services that will improve their lives.”  

This principle also applies to individuals in confinement.

In the U.S. Fourth Circuit Court of Appeals case *Bowring v. Godwin*, the court held that there can be no “underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.”  

The U.S. District Court Case *Ruiz v. Estelle* established the constitutional right of mentally ill individuals to receive a minimum standard of mental health care while in prison, including the following requirements: 1) “There must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment”, 2) “Treatment must entail more than segregation and close supervision of the inmate

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64 Ibid., 22.
patients”, 3) “Treatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders”, 4) “Accurate, complete, and confidential records of the mental health treatment process must be maintained”, 5) “Prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluation, is an unacceptable method of treatment”, and 6) “A basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program”. 67 The U.S. Supreme Court Case Youngberg v. Romeo ruled that mentally ill individuals who are under the state’s custody have, under the 14th amendment, the right to “reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably may be required by these interests.” 68

Another Supreme Court Case, Farmer v. Brennan, held that a prison official’s “deliberate indifference” to a “substantial risk of serious harm to an inmate” violates their rights under the Eight Amendment, protecting individuals against cruel and unusual punishment by the government, and includes the deliberate indifference to an individual’s serious medical needs. 69 70 Although it is underscored in Estelle v. Gamble that not every claim of inadequate medical treatment violates a prisoner’s rights under the Eight Amendment, the Supreme Court held that “(…) deliberate indifference to

68 Youngberg v. Romeo, 457 US (Supreme Court 1982).
69 Farmer v. Brennan, 511 US (Supreme Court 1994).
serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ (…) proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.” In the case of Brown v. Plata, the Supreme Court ruled that the services provided to prisoners with severe mental illness did not meet the level of care required under the Eighth Amendment, and ordered the state of California to release over 40,000 prisoners due to a lack of mental and physical health services.

Although there is debate about whether privately-owned prisons can be sued under the Americans with Disabilities Act from 1990, the Act represents an important effort to protect disabled individuals against discrimination. In its Title II, the Act professes the right of disabled individuals not to be discriminated from access to programs and services: “[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” The ADA defines the term disability as “(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.”

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72 Brown v. Plata, 131 S. Ct. 1910 (Supreme Court 2010).
76 Ibid., 12102 (1).
concentrating, thinking, and communicating. The U.S. Supreme Court held in *Pennsylvania DOC v. Yeskey* that the ADA does apply to individuals in prison. The provision referred to above has been brought up in various contexts, such as a DOJ investigation in 2013 of the State Correctional Institution at Cresson in Cambria County, Pennsylvania, and its use of solitary confinement of prisoners with serious mental illnesses. The investigation concluded that the use of solitary confinement, placing individuals with serious mental illnesses in their cells for the majority of the day and denying them basic services, violated their rights both under the ADA and the Eight Amendment.

b. **International Law**

The U.S. has yet to ratify foundational human rights conventions applying to this topic. Nevertheless, the standards that the international community has set for states to move towards, are decidedly relevant. In that sense, regardless of signatures and ratifications of the country one is discussing, it is highly important to bring up violations of these internationally recognized standards for how human beings should be treated.

The right to health is perhaps the most prevailing right applying to the subject matter of the thesis. The right is enshrined in a number of international human rights declarations and conventions, which will be outlined in the sections below, including

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77 Ibid., 12102 (2).
78 Pennsylvania Dept. of Corrections v. Yeskey, 524 US 206 (Supreme Court 1998).
81 Ibid.
the Universal Declaration of Human Rights (UDHR); the International Covenant on Economic, Social, and Cultural Rights (ICESCR); the Convention on the Rights of Persons with Disabilities (CRPD); the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), and the Convention on the Rights of the Child (CRC). The U.S. has only ratified one of these conventions: the ICERD. It is, however, a signatory to the remaining conventions. According to Article 18 of the Vienna Convention on the Law of Treaties, a signatory state is “obliged to refrain from acts which would defeat the object and purpose of a treaty.”

There is a strong interdependence between the right to health and other human rights. For instance, the right to education represents a human right that may be violated for someone who is mentally ill and without access to adequate health services, and thus unable to attend school. Being deprived of the right to education can play a role in your ability to lead a functional and productive life, which again may lead down the path to incarceration. The interdependence between the right to health and the right to freedom from discrimination is another example. The right to freedom from discrimination is considered customary international law, and is a principle emphasized in countless human rights treaties, declarations, and judicial decisions. As

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we have seen, minority youth experience higher levels of insufficient mental health treatment in their community. They are significantly overrepresented in the juvenile justice system, and are thus more prone to yet again having to endure poor levels of treatment while incarcerated compared to non-minority youth.

The ICESCR, signed by the U.S. in 1977,\textsuperscript{90} provides the most extensive coverage of the right to health in international human rights law,\textsuperscript{91} professing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” in its Article 12.1.\textsuperscript{92} The foundational, yet not legally binding UDHR states in Article 2 that “everyone is entitled to all the rights” of the declaration “without distinction of any kind”, i.e. race, color, or national or social origin.\textsuperscript{93} In its Article 25, it is underscored that a child is entitled to special care and assistance, and that all children shall enjoy the same social protection.\textsuperscript{94} The ICERD was ratified by the U.S. in 1994,\textsuperscript{95} and is thus legally binding. Article 5(iv) states “the right of everyone, without distinction as to race, colour, or national or ethnic origin” to “the right to public health, medical care, social security and social services.”\textsuperscript{96} The International Covenant on Civil and Political Rights (1976), ratified by the U.S. in 1992,\textsuperscript{97} states in its Article 7, similarly to the Eight Amendment of the U.S. Constitution, that: “No one shall be subjected to

\textsuperscript{92}UN General Assembly, International Covenant on Economic, Social and Cultural Rights.
\textsuperscript{93}UN General Assembly, The Universal Declaration of Human Rights.
\textsuperscript{94}Ibid.
\textsuperscript{97}“Status of Ratification Interactive Dashboard.”
torture or to cruel, inhuman or degrading treatment or punishment (…)"98 As we have seen in the domestic law section above, this can include depriving individuals of necessary mental health care.

The Convention on the Rights of the Child, which was signed by the U.S. in 1995,99 states the following in its preamble: "The child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth."100 Article 3.1 states: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration," and in 3.3: "States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision."101 In article 23.1, it is stated that: "a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community."102 Article 24.1 of the CRC affirms, similarly to Article 12.1 of the ICESCR, every child’s right to “the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.”103 Article 37 (b) states that “no child shall be deprived of his or her liberty unlawfully or arbitrarily,” and (c): “Every child deprived of liberty shall be

99 “Status of Ratification Interactive Dashboard.”
100 Ibid.
101 Ibid.
102 Ibid.
103 Ibid.
treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.”

The Convention on the Rights of Persons with Disabilities, signed by the U.S. in 2009, was created with the purpose of giving special protection to individuals with disabilities, termed “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” Article 7.1 proclaims “the full enjoyment by children with disabilities to all human rights and fundamental freedoms on an equal basis with other children,” Article 5(2) holds that “States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds,” and Article 24.1(b) states the right to “the development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential.” Certainly, jails by nature do not foster an environment where mentally ill youth can develop to their fullest potential, and they thus constitute barriers for the realization of this group’s rights under the CRPD.

The authors of the article Out of the Shadows: Using Human Rights Approaches to Secure Dignity and Well-Being for People with Mental Disabilities, bring up the elaborations of the Committee on the Rights of Persons with Disabilities, and underscore its call for a ban of disability-based detention, including confinement. The

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104 Ibid.
105 “Status of Ratification Interactive Dashboard.”
107 UN General Assembly, Convention on the Rights of Persons with Disabilities.
piece brings up the Committee’s position on community living as an “internationally recognized right,” not simply a “favorable policy development,” and points to article 14.1(b) of the Convention stating that “the existence of a disability shall in no case justify a deprivation of liberty.”\textsuperscript{109}\textsuperscript{110} This stance is pointed directly to individuals who are involuntarily detained due to a disability. As previously discussed, however, mentally ill individuals who would benefit from community-based treatment may instead end up in jail due to a lack of available treatment options. In that sense, the principle of being deprived of one’s liberty due to a disability remains relevant for this context, and represents a violation of the internationally recognized principle of community living as a key component in the life of individuals with a disability. Maya Sabatello points out in the article \textit{Where Have the Rights of Forensic Patients Gone?}\footnote{Maya Sabatello, “Where Have the Rights of Forensic Patients Gone?” (The Convention on the Rights of Persons with Disabilities and the Treatment of Institutionalized forensic patients, Washington D.C.: American Society of International Law, 2015), 78.} regarding the limited focus of the CRPD on mentally ill individuals in confinement following a crime: “(…) forensic patients—i.e., individuals with psychiatric conditions who committed a crime – have remained largely invisible throughout the drafting process, and its aftermath.”\textsuperscript{111} She holds, however, that article 14, considering “liberty and security of the person”\textsuperscript{112} indeed includes and holds value for forensic patients.\textsuperscript{113} This article, as elaborated on in the Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities, also addresses the right to medical access for detained individuals:

“The Committee has recalled that States parties must take all relevant measures to ensure that persons with disabilities who are detained may live independently and participate fully in all aspects of daily life in

\begin{footnotesize}
\textsuperscript{109} Ibid.
\textsuperscript{110} UN General Assembly, \textit{Convention on the Rights of Persons with Disabilities}.
\textsuperscript{112} UN General Assembly, \textit{Convention on the Rights of Persons with Disabilities}.
\textsuperscript{113} Sabatello, “Where Have the Rights of Forensic Patients Gone?,” 78.
\end{footnotesize}
their place of detention, including ensuring their access, on an equal basis with others, to the various areas and services, such as bathrooms, yards, libraries, study areas, workshops and medical, psychological, social and legal services.”

Several international guidelines address the treatment of prisoners, i.e. the Basic Principles for the Treatment of Prisoners,\footnote{Committee on the Rights of Persons with Disabilities, Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities. The Right to Liberty and Security of Persons with Disabilities, 2015, Art. 18.} the Standard Minimum Rules for the Treatment of Prisoners,\footnote{UN General Assembly, Basic Principles for the Treatment of Prisoners, A/RES/45/111, 1991, http://www.ohchr.org/EN/ProfessionalInterest/Pages/BasicPrinciplesTreatmentOfPrisoners.aspx.} and the Standard Minimum Rules for the Administration of Juvenile Justice.\footnote{UN General Assembly, Standard Minimum Rules for the Administration of Juvenile Justice, A/RES/40/33, 1985, http://www.ohchr.org/Documents/ProfessionalInterest/beijingrules.pdf.} The ladder states in Article 19 (1): “The placement of a juvenile in an institution shall always be a disposition of last resort and for the minimum necessary period.”\footnote{Ibid.} Furthermore, it is stated in the Commentary: “(...) the negative effects, not only of loss of liberty but also of separation from the usual social environment, are certainly more acute for juveniles than for adults because of their early stage of development.”\footnote{Ibid., Art. 19 Commentary.} In the Basic Principles for the Treatment of Prisoners, it is stated in Article 9: “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”\footnote{UN General Assembly, Basic Principles for the Treatment of Prisoners.} The Standard Minimum Rules for the Treatment of Prisoners states in Article 24: “The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures,” and in Article 62: “The medical services of the institution shall seek to detect and shall treat any physical or mental
illnesses or defects which may hamper a prisoner’s rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.”\textsuperscript{121} Moreover, Article 35 (1) states the following:

“Every prisoner on admission shall be provided with written information about the regulations governing the treatment of prisoners of his category, the disciplinary requirements of the institution, the authorized methods of seeking information and making complaints, and all such other matters as are necessary to enable him to understand both his rights and his obligations and to adapt himself to the life of the institution.”\textsuperscript{122}

The Standard Minimum Rules for the Treatment of Prisoners states regarding prison staffing in Article 46 (3):

“(…) personnel shall be appointed on a full-time basis as professional prison officers and have civil service status with security of tenure subject only to good conduct, efficiency and physical fitness. Salaries shall be adequate to attract and retain suitable men and women; employment benefits and conditions of service shall be favourable in view of the exacting nature of the work.”\textsuperscript{123}

The document also holds regarding staffing in Article 47 (2): “Before entering on duty, the personnel shall be given a course of training in their general and specific duties and be required to pass theoretical and practical tests,” and 47 (3): “After entering on duty and during their career, the personnel shall maintain and improve their knowledge and professional capacity by attending courses of in-service training to be organized at suitable intervals.”\textsuperscript{124} As will be elaborated on, one of the ways private facilities cut costs is by offering staff fewer training hours and lower wages, contributing to higher costs.

\textsuperscript{121} United Nations, \textit{Standard Minimum Rules for the Treatment of Prisoners}.
\textsuperscript{122} Ibid.
\textsuperscript{123} Ibid.
\textsuperscript{124} Ibid.
turnover rates. This practice opposes the principles pertaining to prison staffing described above.

There is a wide discussion about how much responsibility governments should have for the conduct of private actors providing public services and its effect on human rights. Nevertheless, international guidelines do express clear positions on the issue. The Draft Articles on Responsibility of States for Internationally Wrongful Acts (the ILC Articles)\(^{125}\) represents an effort to “codify existing case law and state practice,” and therefore arguably constitutes customary international law.\(^{126}\) Article 5 on *Conduct of Persons or Entities Exercising Elements of Governmental Authority*, states the following:

“The conduct of a person or entity which is not an organ of the State under article 4 but which is empowered by the law of that State to exercise elements of the governmental authority shall be considered an act of the State under international law, provided the person or entity is acting in that capacity in the particular instance.”\(^{127}\)

Further, in its Commentary to Article 5 (2), it is specified:

“The generic term ‘entity’ reflects the wide variety of bodies which, though not organs, may be empowered by the law of a State to exercise elements of governmental authority. They may include public corporations, semi-public entities, public agencies of various kinds and even, in special cases, private companies, provided that in each case the entity is empowered by the law of the State to exercise functions of a public character normally exercised by State organs, and the conduct of the entity relates to the exercise of the governmental authority concerned.”\(^{128}\)


\(^{127}\) International Law Commission, *Draft Articles on Responsibility of States for Internationally Wrongful Acts, with Commentaries*.

\(^{128}\) Ibid.
The Commentary points to the example of countries using private security firms to work as prison guards, and holds that the private contractors in this event “may exercise public powers such as powers of detention and discipline pursuant to a judicial sentence or to prison regulations.”

Furthermore, the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights states in Article 2 regarding the growing practice of privatizing government services:

“It is no longer taken for granted that the realization of economic, social and cultural rights depends significantly on action by the state, although, as a matter of international law, the state remains ultimately responsible for guaranteeing the realization of these rights. While the challenge of addressing violations of economic, social and cultural rights is rendered more complicated by these trends, it is more urgent than ever to take these rights seriously and, therefore, to deal with the accountability of governments for failure to meet their obligations in this area.”

In Article 18, the Guidelines hold:

“The obligation to protect includes the State's responsibility to ensure that private entities or individuals, including transnational corporations over which they exercise jurisdiction, do not deprive individuals of their economic, social and cultural rights. States are responsible for violations of economic, social and cultural rights that result from their failure to exercise due diligence in controlling the behaviour of such non-state actors.”

The European Court of Human Rights Case Costello-Roberts v. United Kingdom is relevant to look at in the context of government accountability for the actions of private entities. The Court case, addressing a seven year-old boy who was subjected to corporal punishment at the private boarding school he attended, held that the

129 Ibid., Art. 5 (2).
131 Ibid.
132 Ibid.
punishment did not violate his right to freedom from degrading punishment, or any other human right. Nevertheless, the Court stated that it “agrees with the applicant that the State cannot absolve itself from responsibility by delegating its obligations to private bodies or individuals,” and further:

“Accordingly, in the present case, which relates to the particular domain of school discipline, the treatment complained of although it was the act of a headmaster of an independent school, is none the less such as may engage the responsibility of the United Kingdom under the Convention if it proves to be incompatible with Article 3 or Article 8 or both (art. 3, art. 8).”

In his article Privatization of Corrections: A Violation of U.S. Domestic Law, International Human Rights, and Good Sense, American University Professor of Law and Justice, Ira P. Robbins, describes the case as “an important reiteration of the view that private action can engage state responsibility,” and argues:

“If this proposition is true in the context of private education – where private companies may control many, but not all, aspects of the students’ lives – it is even more compelling in the context of private incarceration – where private companies may control all aspects of their charges’ lives.”

What this selection of human rights provisions demonstrates, is that the protection of disabled children and incarcerated individuals is categorically strong. The ultimate responsibility for fulfilling their rights lies with the state, regardless of the entity providing the services. As we have seen, international human rights law recognizes that every child is in need of special protection due to the fact that they are not yet fully developed as independent individuals, neither mentally nor physically. Mentally ill

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134 Ibid.
children and youth constitute an especially vulnerable group, whose healthy
development depend heavily on a system ready to care for and treat them. Treatment in
the community should always be the principal route to recovery, and imprisonment
should never serve as a means to receive treatment. As for those youth who are
mentally ill and incarcerated, they are in urgent need of support such as qualified
personnel to treat their illness, appropriate supervision to monitor their safety and
medication, and a nonviolent and predictable environment. These are all elements that
need to be in place in order to protect their comprehensive human right to health.
When children and youth are deprived of their right to health, it can have severe
repercussions for other areas of their life, and other human rights that they are bearers
of, such as their right to enjoy a full life in dignity, to education, to the development of
their personality to their fullest potential, to active participation in the community, and
to not be arbitrarily deprived of their liberty. Furthermore, as demonstrated, it is poor
minority youth who are most prone to having these rights violated. Thus, the ever
important principle of non-discrimination in human rights law is undoubtedly at stake
for this exposed group of individuals.

iv. Literature Review

Although the issue of privatization of prison services has been, and continues to be,
thoroughly discussed from an economic as well as moral standpoint, and an array of
news stories has reported on significant violations of incarcerated individuals’ human
rights under the care of private companies, several researchers point out the need for
more studies on the effect of for-profit companies’ involvement in the health care
provided to incarcerated individuals. In Care of the Mentally Ill in Prisons: Challenges
and Solutions, Anasseril E. Daniel highlights the lack of studies on what the most adequate model for health care delivery in correctional facilities is. Similarly, in From Public to Private Care: the Historical Trajectory of Medical Services in a New York City Jail, Noga Shalev points to the scarcity of studies on the effect of the “for-profit correctional industry,” and states that “there is a notable paucity of data on the extent and quality of private care in the nation’s jails and prisons.”

It seems to be recurring in the literature that does exist on various effects of prison privatization that findings are varied and sometimes inconclusive. This is reiterated in the 2007 University of Utah study Prison Privatization: A Meta-Analysis of Cost Effectiveness and Quality of Confinement Indicators, comparing numeric findings from reports on the “relative effectiveness” of privately and publicly operated adult prisons, including indicators of cost effectiveness and quality of confinement. The study held regarding cost effectiveness that: “Cost savings from privatizing prisons are not guaranteed and appear minimal.” As for quality of confinement, their comparison found that it is “similar across privately and publicly managed systems, with publicly managed prisons delivering slightly better skills training and having slightly fewer inmate grievances,” and regarding health care delivery in particular, their comparison suggested: “no real advantage or disadvantage from private management.”

139 Ibid.
140 Ibid., 19.
Nevertheless, the study *Private and Public Sector Prisons: A Comparison of Select Characteristics*, provides more conclusive results. The study compared various aspects of private and public prison operations. It held that the private sector “is a more dangerous place to be incarcerated,” and “despite the fact that more dangerous offenders were housed in public prisons, private prisons had higher incidents of violence and a greater proportion of drug-involved inmates.” The study suggested that private sector prisons had twice as many individuals in drug treatment compared to the public sector. However, the researchers pointed out that this may be related to the tendency of the private sector to house “the less hardened offender” who may be “more willing to participate in rehabilitative endeavors.” The study found major differences in staff pay and training: the private sector paid new officers around $5,000 less and provided 58 fewer training hours than the public counterparts, leading the researchers to suggest that this explains the higher turnover rates and ultimately higher levels of violence found in private facilities. Similarly, the study *Growth and Quality of U.S. Private Prisons: Evidence from a National Survey* found a higher turnover rate in private facilities, and held that “privately operated prisons appear to have systemic problems in maintaining secure facilities.”

Regarding the juvenile justice system in particular, Katy Hancock underscores in her dissertation *Privatization of Florida Juvenile Residential Facilities*: “(…) despite the ubiquity of private juvenile residential facilities, research comparing public and private

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142 Blakely and Bumphus, “Private and Public Sector Prisons: A Comparison of Select Characteristics.”
143 Ibid., 47.
144 Ibid., 48.
145 Ibid., 46.
juveniles residential facilities is rare. This is especially disturbing given that, nationally in 2008, private juvenile residential facilities had higher rates of suicide, accidental death, and homicide than public facilities (...) Hancock warns of the dangers of the vast use of private services “without a foundation of research.” She also holds that the limited theory and empirical research that does exist on the impact of public vs. private ownership on operations, has mixed findings.

Towards the end of writing the thesis, the Department of Justice (DOJ) announced that they are starting the process of reducing, and finally ending, their use of privately operated prisons. This, however, only applies to federal prisons, which means it does not affect the vast majority of incarcerated individuals in this country, let alone the juvenile population, who is mostly incarcerated in state and county facilities. Nevertheless, the decision by the DOJ was partly based on a recent relevant report by the Office of the Inspector General titled Review of the Federal Bureau of Prisons’ Monitoring of Contract Prisons, comparing certain aspects of privately and publicly run prisons, or, more specifically, of: “the 14 contract prisons that were operational during the period of our review and from a select group of 14 BOP institutions with comparable inmate populations.” The analysis looked at the following eight indicators: contraband, reports of incidents, lockdowns, inmate discipline, telephone monitoring, selected grievances, urinalysis drug testing, and sexual misconduct, and concluded that the private prisons had a higher number of incidents in every category

148 Ibid., 154.
except for incidents of positive drug tests and sexual misconduct. They also concluded that private prisons had a higher number of assaults "both by inmates on other inmates and by inmates on staff." Although health services were not included in the eight categories mentioned above, the study noted that the Federal Bureau of Prisons (BOP) needs to improve its monitoring of health services provided in private facilities to ensure contract compliance.

The fact that research overall is fairly limited when it comes to the level of health care provided to mentally ill youth in private juvenile justice facilities is concerning for this particularly vulnerable population. There is a clear need for further examination of the ramifications for the mentally ill of privatizing services in correctional facilities, let alone through the lens of human rights. The Civil Rights of Institutionalized Persons Act (CRIPA), from which reports will be analyzed in the Findings section, represents an important tool in exposing civil and human rights violations occurring in juvenile justice facilities. By analyzing these investigations, as well as collecting opinions from experts and advocates in the criminal justice field, I seek to shed necessary light on the intricacy of profit seeking in the care for human beings.

v. Methodology

a. General Information

The methodology of this thesis is two-fold. It consists of an analysis of investigations conducted under the Civil Rights of Institutionalized Persons Act (CRIPA) in juvenile

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151 Ibid., 2.
152 Ibid.
153 Ibid., 3.
justice facilities, which will be described under the Findings section Quality of Care: Distinct Areas of Concern. Furthermore, it includes qualitative interviews with experts and advocates in the criminal justice field, from which excerpts are incorporated throughout the Findings sections. The sources who ended up participating in the study were found through independent research, and have all, in one way or another, spoken out on the issue of privatization, contributed to the wider societal debate, and published relevant pieces on the topic. I wanted the mix of respondents to reflect a range of approaches to the subject matter, including perspectives founded in academic work, activist efforts, and legal familiarity. After reviewing a number of potential candidates, seven individuals were carefully selected, and four of these ultimately followed through on their intent to participate. The sources were given the option of participating in the study via a phone interview or, if deemed more feasible for the source, an email interview. Three of the four sources chose to do so via phone, while one source preferred to participate via email. The Columbia University Human Research Protection Office of Institutional Review Boards approved the study, and determined it to be exempt from regulations for the protection of human research subjects. In order to meet the request of my sources for discretion regarding the unedited interview transcripts, they have not been included in the Appendix section.

b. Assumptions and Limitations

I have applied the CRIPA reports in the Findings section through pointing to information regarding specific failures within private facilities. Examples of similar failures exist in public institutions. This is evident in the CRIPA reports, and it is pointed out by the sources in the study in response to my questions about both systems.
However, due to the lack of transparency in privately run facilities discussed in this thesis, these reports act as a rare source of insight into the challenges that are hidden behind their high walls. I have used the reports in this context to build on the expert opinions given in the interviews, with detailed examples of facility challenges, as well as to highlight the experiences of specific incarcerated individuals whilst under the care of private contractors. Nevertheless, the Findings section as a whole represents a broader discussion of how the two systems compare.

As an interviewer, I made the assumption that the interviewees answered the questions honestly and to the best of their individual abilities. As this is a thesis written in the human rights framework, emphasizing the suffering of the individual above all else, I found it valuable to bring in the voices of individuals who have had personal experience with the topic. As expanded on below, study participant Alex Friedmann was himself incarcerated when he was younger, partly at a privately operated prison. Additionally, the son of participant Grace Bauer-Lubow was incarcerated at a privately run prison. These backgrounds add distinct insight to the discussion. Simultaneously, they can create biased viewpoints. When it comes to the non-partisan organization ACLU, where participant Margaret Winter worked for more than two decades, it is in the nature of the organization to look at issues from the perspective of the individual and to strive to protect their rights. It is an outspoken goal of the organization to create more transparency among the private actors in the U.S. criminal justice system, stating on their website: “The increasing privatization of detention, which creates financial incentives for both increased incarceration and harsher conditions of confinement, has
made public accountability even more important.”

**c. CRIPA Investigations**

CRIPA investigations are administered by The Civil Rights Division of the U.S. Department of Justice. CRIPA is a method of safeguarding that the rights of incarcerated youth are not violated, and investigations are initiated after information from various actors is received by the Division about “unlawful conditions” at a correctional facility.\(^{155}\) In addition to visits to the correctional facility, the work of the Civil Rights Division may be based on an extensive number of records from i.e. the Department of Corrections and the Department of Health, including medical records of incarcerated individuals, policies and procedures, disciplinary records, and use of force investigative files, among other data.\(^ {156}\)

CRIPA reports give information about what aspects of mental health treatment the facility failed to provide, such as screening of the mentally ill, proper administration of drugs, as well as access to general mental health treatment services. Juvenile justice facilities are a high priority for the Civil Rights Division, and constitute about 25 percent of the total CRIPA investigations.\(^ {157}\) All of the reports are public record, available from the Special Litigation Section of the Department of Justice (DOJ) website, and on the websites of applicable U.S. Attorney’s Offices (USAOs). For a CRIPA investigation to take place in the first place, the facility must qualify as a public


\(^{157}\) “Civil Rights of Institutionalized Persons Act in Juvenile Correctional Facilities.”
institutions.\footnote{158}{Ibid.} However, this requirement can be fulfilled if the facility is "owned, operated, or managed by, or provides services on behalf of any State or political subdivision of a State."\footnote{159}{Ibid.} For instance, a private facility can be subject to a CRIPA investigation when it is under some form of contract with a “State, city, or county.”\footnote{160}{Ibid.}

d. Participant Backgrounds

Margaret Winter worked as the Associate Director of the ACLU National Prison Project from 1992-2016, and is a former Professor of Law at Georgetown University Law Center, where she taught classes on prisoner’s rights, among others. Her work at the ACLU has given her extensive insight into the criminal justice system in the state of Mississippi. From 1999 to 2016 she served as lead counsel in challenges to conditions of confinement, including mental health care, at some of the worst prisons in the state, both state-run and privately operated.

Michele Deitch is a Senior Lecturer at the Lyndon B. Johnson School of Public Affairs at The University of Texas at Austin. She is an attorney with criminal justice policy experience, who has spoken out a number of times on the issue of privatization in the criminal justice field. One of her reports, which is referred to in a previous section of the thesis, regards issues related to privatization of juvenile justice facilities specifically, including transparency issues, safety concerns, and profit incentives. Her statements in this study regard medical care as a whole.

\footnote{158}{Ibid.} \footnote{159}{Ibid.} \footnote{160}{Ibid.}
Grace Bauer-Lubow is the Executive Director and Co-Founder of Justice for Families, a national alliance of organizations that work to limit youth incarceration. Bauer-Lubow's son was incarcerated at Tallulah Youth Correctional Center in Louisiana. The privately run facility, which was subject to a CRIPA investigation that will be addressed below, is now closed down. Bauer-Lubow has spoken out and written about the problems her son encountered at the facility, the gravity of the issues that emerged as a consequence of private actors running the services, as well as the importance of reducing the number of youth in the criminal justice system.

Alex Friedmann works as the Associate Director of the Human Rights Defense Center, as well as the managing editor of Prison Legal News. He has written extensively about the issue of prison privatization, and has spoken in numerous fora on this very issue. The main focus of his work has been on the adult criminal justice system, but he has also researched the juvenile justice field. Friedmann was himself incarcerated for ten years, six of which were served at a privately operated facility. During this time, he litigated his own cases, worked with spreading information through multiple publications, and founded the Pledge Program, a non-profit organization for prisoners. ¹⁶¹

vi. Findings

a. Healthcare Delivery: Obligation and Accountability

International guidelines make it clear that actions performed by entities providing services on behalf of the state, are ultimately the responsibility of the state. The fact that

a private entity runs the operations, does not in any way take away the obligation of the state to fulfill an individual’s human rights. This stance is brought up in several international Articles and Guidelines, including the Maastricht Guidelines, holding that although privatization of government services may be seen as a complicating factor in addressing human rights violations, the government is equally accountable for meeting their obligations to the individual regardless of the vendor they use to perform services for them.162 The primary concern, as stated in the Convention on the Rights of the Child, should always, and regardless of the service provider, be the “best interests of the child.”163 The mentally ill population has a right to adequate care that the U.S. government bears the duty of fulfilling; when the government deprives these individuals of their freedom and thus their options for care, the responsibility falls on them to provide services of high quality that again can improve their mental condition. Michele Deitch points to this foundational obligation, saying: “The ability to deprive someone of their liberty and control the condition in which they are held, goes to the heart of what human rights is all about. Whether it goes on in public prisons or private prisons, those are human rights issues.”164 Alex Friedmann makes the same argument, underscoring that incarcerated individuals only have the option of the medical care provided at the facility; they do not have the opportunity to see another doctor, call 911, or take charge of their own health in other ways: “If you’re going to deprive people of their civil liberty – their freedom – then you become responsible for ensuring their safety while you’ve

163 UN General Assembly, Convention on the Rights of the Child, Art. 3.1.
incarcerated them. If you prevent people from getting any other medical care than from your prison, then you have to provide them with adequate medical care,” he says. This adequate level of care can theoretically be provided by private contractors. However, as argued by Margaret Winter, state prison officials have a tendency to abdicate their responsibility to ensure adequate care when they turn the job over to private vendors:

“When a state privatizes health care, it’s easy for state prison officials to turn a blind eye to private contractors’ corner-cutting (...) But under the Eighth Amendment, the state doesn’t have the authority to pass the buck. Private contractors come and go, but the state always remains responsible for assuring prisoners’ basic human needs are provided for – including care for serious mental health needs,” she says.166

According to the former Associate Director of the ACLU National Prison Project, grossly substandard mental health care is commonplace in state prison systems, whether or not the state contracts out mental health care to a for-profit corporation. Nevertheless, she holds that contracting out to a private vendor often makes a bad situation worse, saying: “When the state hires a for-profit vendor to deliver mental health care to prisoners, it’s adding another layer of opacity and non-accountability to a system that’s already closed to public view.”167

b. Administering Care: Oversight, Transparency, and Contracting

As previously illustrated, a private facility or vendor is by law not subject to the same level of scrutiny as public counterparts. Thus, while the government obligation to provide adequate mental health services remains, privatization makes it more difficult to monitor

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165 Alex Friedmann, Interview via phone, August 18, 2016.
166 Margaret Winter, Interview via phone, August 18, 2016.
167 Ibid.
whether these services are indeed provided, and at what level. This is a major problem according to Margaret Winter, who holds that although the problem in theory could be solved if state prison systems were to adequately monitor their contractors, she has never seen prison systems provide adequate, sustained oversight during her decades of experience in the field. A recent example of government failure to oversee operations by a private contractor is described in a 2015 report by the New York City Department of Investigation on the health care provided in the city’s jails by the private corporation Corizon Health Inc.\textsuperscript{168} Serious operational failures took place at Rikers Island Jail Complex under Corizon’s care, like the hiring of multiple mental health staff with previous criminal convictions, including second degree murder and drug possession.\textsuperscript{169} Notably, the report stated that The Department of Health and Mental Hygiene (DOHMH) and the Department of Correction (DOC) failed their responsibility to supervise Corizon and properly vet the employees the corporation hired.\textsuperscript{170} Ultimately, the city ended the contract with Corizon, and placed a public provider in charge of the jail’s health care services.\textsuperscript{171}

From her role working with families of incarcerated individuals at Justice for Families, Grace Bauer-Lubow argues that there is a lack of “neutral observers” in the system. Moreover, in a piece she has written for an upcoming report that she included with her study response, she writes that when services are contracted out, the contracts

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\textsuperscript{168} New York City Department of Investigation, “Investigation Finds Significant Breakdowns by Corizon Health Inc., the City-Contracted Health Care Provider in the City’s Jails, and a Lack of Oversight by the City Correction and Health Departments,” June 2015, https://assets.documentcloud.org/documents/2095597/corizon-report.pdf.
\textsuperscript{169} Ibid., 1.
\textsuperscript{170} Ibid., 2.
\end{flushleft}
often include non-disclosure agreements that are not serving the best interest of the incarcerated youth, saying:

“If something isn’t handled correctly, is there a workable and accessible mechanism/process in place to report a problem and seek redress? If a child reports something that is wrong to a family member, do the family members know where to seek relief or solutions? In talking with thousands of families over the years, the majority report problems in this area.”

According to Michele Deitch, the lack of transparency in private facilities can act as a hindrance for the realization of human rights: “They [private prisons] have got an extra barrier, and they are not required to, for example, report a lot of information publicly,” she says. “They don’t have to go through administrative procedures that are required for public facilities or public agencies. So the public basically has very little information about what is going on inside. That is a barrier to protection of human rights, just because you need to be more open and transparent if you want to protect the rights of the people inside.” Alex Friedmann also holds that there is a severe lack of transparency in private facilities, and argues that the same abuses that have taken place in the past, continue to occur because of the lack of available monitoring, saying: “(…) the monitoring does happen, but when you get into more detail about why monitoring is not done adequately, the fact remains that all contracts currently have monitoring of some sort, and yet we still see systemic problems.”

Vendors are, naturally, in compliance with the contract when they are meeting the terms that are written out. Services like mental health treatment and care, however,
are complex items to contract out because quality is hard to measure. A private corporation will have a financial incentive to meet the bare minimum of what it is contractually obligated to do. In this way, the system lends itself to providing less services. Friedmann says the following about the challenge of addressing rehabilitative services in contracts: “They [private corporations] are supposed to provide the services the contracts specify they have to provide. The bigger question is the quality of that. They typically provide the services that are in the contract, but that doesn’t mean the services are adequate.”175 Deitch echoes this argument, stating that the way contracts are designed and monitored plays a significant role when private companies provide the services:

“Private facilities, vendors or agencies are not required to do anything that is not in the contract, so the degree to which they are going to be responsible for doing the things we want them to be doing; it all goes back to what is in the contract,”176 she says.

c. Quality of Care: Distinct Areas of Concern

The issues surrounding accountability and transparency raised in the above sections, fueled by the primary objective of creating profit, can act as barriers for private facilities to fulfill the rights of the mentally ill individuals residing in them. The following subsections illustrate key areas in which the effects are manifested.

i. Staffing

All juvenile justice facilities are faced with the expectation of providing an array of services, ranging from security, physical and mental healthcare, education, youth

175 Ibid.
176 Deitch, interview.
development, and many more. For a private contractor, the requirement of doing so in a profitable and efficient manner comes in addition to the services in and of themselves. Reconciling the two; providing quality services whilst following demands to be profitable, can pose significant challenges. As pointed to in existing research, the consequence is often to reduce staff salary and training, leading to higher turnover rates. The Standard Minimum Rules for the Treatment of Prisoners emphasizes both the importance of stable work conditions fostering long-term employment, as well as wages high enough to “attract and retain” skilled staff.177 In the article Privatization of Corrections: A Violation of U.S. Domestic Law, International Human Rights, and Good Sense, Ira P. Robbins points to this particular article and holds that: “None of these conditions are regularly met in the private prison industry, and the low wages and poor working conditions in private prisons do not allow personnel managers to be selective in their hiring.”178

The CRIPA reports detail serious issues with understaffing, as well as clear examples of underqualified and undertrained staff being utilized. At Walnut Grove Youth Correctional Facility in Mississippi, where GEO Group, Inc. was in charge of operations and Health Assurance LLC employed mental health staff at the time of the CRIPA investigation, it was found that the facility failed to provide “adequate suicide prevention training to all corrections, medical, and mental health staff to ensure the safety of self-harming youth.”179 A horrific example described in the report demonstrating the facility’s failure to meet its obligations, is the story of an individual with a reported history of depression and “suicidal ideation” who, according to a correctional officer noting the

incident in his log, was found in his cell with a rope tied around his neck, saying he was going to kill himself. Days later the youth told another staff that he had cut himself, and said: “I want out of here. If I have to do this again, I will.” The staff member reportedly told the individual that they would bring him to the medical unit after “pill call” (typically lasting 5-6 hours). At the end of the pill call, and after the staff member had notified another staff member of the incident, the individual was found “cold to the touch, with rigor mortis, eyes dilated.” The report adds that the staff member “did not initiate CPR or call paramedics.” Farmer v. Brennan held that a prison official’s “deliberate indifference” to a “substantial risk of serious harm” and/or “serious medical needs,” violates their rights under the Eight Amendment.

Tallulah Correctional Center for Youth in Louisiana, operated by Trans-American Development Associates at the time of the CRIPA investigation, did not employ any psychiatrists, and did not provide any mental health care to its “many youth with serious mental illness.” The findings letter states: “At most, counselors who are not trained in mental health care and not supervised by mental health professionals, speak to juveniles. This complete denial of necessary care is causing great harm at Tallulah.” Furthermore, youth with “extensive psychiatric histories who self-mutilate and/or threaten suicide” had never been referred to a psychiatrist.

180 Ibid., 22.
181 Ibid.
182 Ibid.
183 Ibid.
186 Ibid. Grace
Bauer-Lubow, whose son was incarcerated at Tallulah, echoes some of the findings from the CRIPA report regarding inadequate staffing:

“Guards were not hired based upon training or educational experience in mental health or youth development,” she says. “Facility staff operated solely on adult corrections models based on control and punishment. Even when individuals may have cared about the situations of the young people in their care, they lacked appropriate skills to offer any help and basic understanding of trauma and mental health care to make good judgment calls.”

The CRIPA Investigation of W.J. Maxey Training School in Michigan, where medical services were provided through Secure Care, Inc. at the time of the investigation, found that non-medical staff were used to dispense medications, stating:

“Given that the staff have no training in pharmacology, side effect recognition, psychological aspects of medication compliance, or symptom management, this practice places both the youth and the facility at great risk. Furthermore, several of Maxey’s medical providers expressed concern with this policy.”

At Charles H. Hickey, Jr. School in Maryland, operated by Youth Services International at the time of the CRIPA investigation, it was found that group treatment sessions needed to be cancelled at the facility due to an insufficient number of security staff present to provide the necessary supervision. At Alexander Youth Services Center in Arkansas, operated by Cornell Companies, Inc. at the time of the CRIPA investigation, it was found that staff were stretched thin, stating that the counselors had “many

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188 Bauer-Lubow, interview.
competing demands on their time.”\textsuperscript{191} Furthermore, it was stated about the counselors at the facility that they:

\begin{quote}
“(…) are only required to have a Bachelor’s Degree and need not be qualified mental health professionals. Moreover, many of the counselors we interviewed during our visit stated that they did not believe they had the knowledge or experience to provide individual mental health treatment to residents.”\textsuperscript{192}
\end{quote}

These findings demonstrate violations of several provisions relating to prison staff. \textit{Ruiz v. Estelle} requires treatment by “trained mental health professionals” and a program in place for identifying, treating and supervising individuals with suicidal tendencies.\textsuperscript{193} The Convention on the Rights of the Child requires, specifically for the areas of health and safety, “competent supervision” and suitable staff in sufficient numbers.\textsuperscript{194} The Standard Minimum Rules for the Treatment of Prisoners requires that staff passes theoretical and practical tests, and receives continuous training specific to their duties.\textsuperscript{195} Furthermore, the prompt examination of “every prisoner as soon as possible” by a medical officer is called for.\textsuperscript{196}

\textbf{ii. Medicalization and Treatment}

Although research is inconclusive and scarce when it comes to the levels of health care delivery in public and private facilities, it is undisputable that skilled and sufficient staff is crucial both in treatment programs and in the supervision and administration of

\textsuperscript{191} “CRIPA Investigation of Alexander Youth Services Center, Alexander, Arkansas” (U.S. Department of Justice Civil Rights Division, 2002), \textit{*Page numbers not provided due to online format, https://www.justice.gov/crt/1-background-0.}
\textsuperscript{192} “CRIPA Investigation of Alexander Youth Services Center, Alexander, Arkansas.”
\textsuperscript{194} UN General Assembly, \textit{Convention on the Rights of the Child}, Art. 3.3.
\textsuperscript{196} Ibid., Art. 24.
medication. Mentally ill individuals have a constitutional and human right to proper treatment and medicalization, far beyond simply being prescribed behavior-altering drugs. As demonstrated in *Ruiz v. Estelle*, facilities have an obligation to provide a “systematic program” for screening individuals and provide medication with “appropriate supervision” and “periodic evaluation.” Additionally, as described in the above section, the case established the obligation to provide a program for “identification, treatment, and supervision” of individuals with suicidal tendencies.

The Standard Minimum Rules for the Treatment of Prisoners requires that individuals with an illness be provided “all necessary” medical and psychiatric services.

Further addressing components of what adequate care entails, the following is stated in the CRIPA Investigation of Charles H. Hickey, Jr. School regarding the level of mental health counselling that facilities are required to provide:

> “Generally accepted professional standards require that mental health counseling be provided frequently and consistently enough to provide meaningful interventions for youth. Treatment should utilize approaches that are generally accepted as effective. Youth with mental illness should receive treatment in settings appropriate to their needs.”

In the CRIPA Investigation of the Walnut Grove Youth Correctional Facility, it is highlighted that an integral part of rehabilitation of incarcerated youth is “a mental health program for chronic conditions.” Additionally, “specialized programs” for those with “schizophrenia, bipolar disorder and other major mental health disorders” are required by the National Commission on Correctional Health Care’s standards for

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198 Ibid.
201 “Investigation of the Walnut Grove Youth Correctional Facility,” 27.
mental health services in correctional facilities, and endorsed by the American Psychiatric Association.\textsuperscript{202}

Margaret Winter argues that for-profit prison corporations are especially unlikely to provide adequate care for serious mental illness because such treatment, to be adequate, is necessarily \textit{resource-intensive}, saying:

“The place where the for-profit contractors can squeeze out maximum profit is by reducing hours of programming, supervision and interaction with patients by clinicians, teachers, social workers, and the other staff who are trained to interact with patients on a personal, human level. That kind of attention is essential for people who are seriously ill. If the contractor is just throwing drugs at prisoners with mental illness in order to sedate them, that saves the contractor a heap of money, but the patients predictably deteriorate.”\textsuperscript{203}

The Investigation of the Walnut Grove Youth Correctional Facility found a range of concerning issues regarding medicalization and treatment. According to the report, the facility was not providing adequate mental health care to youth who displayed “symptoms of suicidal behavior or serious mental illness,” stating:

“Instead, the Facility fails to adequately assess and treat youth at risk of suicide. Medication management or ‘therapeutic lockdown’ are the only treatments available, and those are plagued with errors. In addition, youth experience inordinate delays before receiving the basic mental health services that WGYCF [Walnut Grove Youth Correctional Facility] does provide, and mental health staffing levels are grossly deficient.”\textsuperscript{204}

It was found that Walnut Grove did not perform its own mental health screening, and they put youth at risk of new cases of ‘depression, psychosis, and bipolar disorder’ whilst they were waiting to be seen by mental health staff (after initially having been screened by the state).\textsuperscript{205} The report points out that the facility housed youth with

\textsuperscript{202} Ibid.
\textsuperscript{203} Winter, interview.
\textsuperscript{204} “Investigation of the Walnut Grove Youth Correctional Facility,” 21.
\textsuperscript{205} Ibid., 22.
“serious mental health needs” even if it was not supposed to.\(^{206}\) The facility failed to provide group therapy, psychotherapy, individual and group counseling, psychosocial programs, treatment documentation and follow-up,\(^{207}\) had a “shockingly low” level of psychiatric staffing,\(^{208}\) and showed a pattern of taking months to evaluate youth who were admitted with a history of psychiatric treatment and/or substance abuse issues, who subsequently developed bizarre behaviors and “sometimes became suicidal.”\(^{209}\)

The issue of inappropriate use of medication is referenced in several of the CRIPA reports. As mentioned above, Walnut Grove Youth Correctional Facility was found to provide “medication management” or “therapeutic lockdown” as the only available treatments for youth at risk of suicide. In the CRIPA Investigation of Tallulah Correctional Center for Youth, it was found that psychotropic medications were managed “inadequately”; the facility failed to “monitor for medication efficacy or side effects adequately,” with no psychiatrist present to monitor the medications.\(^{210}\) In the CRIPA Investigation of W.J. Maxey Training School, the facility was found to have “seriously deficient” administration of psychotropic medications and management of youth that were on psychotropic medications.\(^{211}\) The CRIPA Investigation of Alexander Youth Services Center found that several children with “serious mental illnesses, including psychosis and bipolar disorder” were provided with medication, but without receiving any other mental health services.\(^{212}\) Similarly, the CRIPA Investigation of Charles H. Hickey, Jr. School found that psychotropic medications were frequently

\(^{206}\) Ibid.
\(^{207}\) Ibid., 27.
\(^{208}\) Ibid., 26.
\(^{209}\) Ibid.
\(^{210}\) “Findings of Investigation of Secure Correctional Facilities for Juveniles in Louisiana.”
\(^{212}\) “CRIPA Investigation of Alexander Youth Services Center, Alexander, Arkansas.”
prescribed “without the benefit of appropriate evaluations or systematic physiological monitoring.”

As held in Farmer v. Brennan and Estelle v. Gamble, the deliberate indifference to an individual’s medical needs violates their rights under the Eight Amendment. In the CRIPA report from Charles H. Hickey, Jr. School, it was found that decisions around medications “appear to be directed at behavior control rather than improved functioning.” Furthermore, the report held that youth often were “prescribed sleep medications with little justification,” and that these medications were “often administered late in the afternoon, thus unnecessarily sedating youth early, making them less able to participate in evening programs.” Another example of what the report refers to as “questionable medication practices,” includes:

“Several youth at Hickey were treated with Neurontin, an anticonvulsant medication, for the purpose of controlling impulsive-aggressive behavior or bipolar disorder. This medication is not designed to treat these disorders. Furthermore, research has not supported its effectiveness for these purposes.”

Moreover, the report states that youth on medications to treat psychotic disorders did not receive sufficient information about “common and serious” side effects, including the potentially irreversible movement disorder tardive dyskinesia, exemplifying a violation of the Standard Minimum Rules for the Treatment of Prisoners, stating the right of incarcerated individuals to receive written information about “the regulations

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214 Ibid.
215 Ibid.
216 Ibid., 28.
217 Ibid.
218 Ibid., 29.
governing the treatment of prisoners of his category.”

iii. Safety

As illustrated in the thesis, research suggests that private corrections facilities are less safe than their public counterparts, and have higher levels of violence. Indeed, providing mentally ill youth with a safe and predictable environment is an important factor in ensuring their healing and rehabilitation. Failures to keep youth safe were manifested in various ways in the facilities subject to CRIPA investigations. At Walnut Grove Youth Correctional Facility, the investigation revealed that staff were “deliberately indifferent” to violence amongst the youth, constituting a violation of Farmer v. Brennan. The report provides the following example:

“An overwhelming number of youth reported that possession of shanks is common among youth for self-protection from other youth. During our investigation, a youth alerted the DOJ team that there was a piece of a razor blade on the dayroom floor. We located the razor blade and brought this issue to the attention of one of the high ranking Facility officials. In response, the official merely picked up the blade and disposed of it. We were told by many youth that they are allowed to keep razors in their possession for up to a week.”

At Charles H. Hickey, Jr. School, the DOJ found that the staff did not sufficiently monitor youth who “were on the highest suicide precautions,” in violation of Ruiz v. Estelle, requiring supervision of those with suicidal tendencies, and Youngberg v. Romeo, stating the right of individuals under the custody of the state to “reasonably safe

220 “Investigation of the Walnut Grove Youth Correctional Facility,” 15.
221 Ibid., 16.
conditions of confinement.”224 The report states that: “Psychiatric backup is not provided when the staff psychiatrist is unavailable, despite a commitment by the facility to have 24-hour psychiatric on-call coverage.”225 It is further elaborated in the report that, despite of the fact that the first 48 hours of being detained in an institution present “especially dangerous risks for attempted suicide,” particularly for youth, staff were not able to adequately supervise the young individuals in the intake areas due to a multitude of other tasks they needed to perform.226

The same report brings up the importance of “timely specialized clinical assessment”227 for those with mental health needs, and refers to an example of inadequate clinical assessment of a youth with the following diagnoses: psychotic symptoms, ADHD, behavioral problems, substance abuse, and “destructive behaviors to himself and others.”228 Without performing a psychiatric assessment determining the individual’s actual needs, and in this way adjusting the treatment specifically to him, the psychiatrist treated him with a “complex combination of medications.”229 The report states that the youth continued to struggle with hallucinations, and was unable to control his aggressive behavior.230 Not only does this example demonstrate an isolated case of inadequate treatment and medicalization; it shows how the failure to properly treat mental illness can exacerbate violent behavior and threaten an individual’s own safety, as well as the safety of others.

224 Youngberg v. Romeo, 457 US (Supreme Court 1982).
226 Ibid.
227 Ibid., 21.
228 Ibid., 24.
229 Ibid.
230 Ibid.
As referenced above, it was found that Walnut Grove Youth Correctional Facility housed youth with serious mental health needs, despite the fact that they were not supposed to let this population reside there. Similarly, at W.J. Maxey Training School, the CRIPA investigation found at least two young individuals with mental illness conditions that were “too severe to be adequately treated or safely housed” at the facility, exposing them to “heightened degrees of danger.” The report also states:

“Furthermore, because of the manifestations of their mental illnesses, the two individuals in question were regularly isolated in the Life Safety Unit and subjected to all of that Unit’s restrictions. In effect, they were punished for their disability. This is not a proper method of treatment. Maxey must either transfer such youths to a more appropriate facility, or provide the higher level of care that they require.”

This treatment violates the youth’s rights under the ADA not to be excluded from participation of services and programs due to their disability, as well the rights in the Convention on the Rights of Persons with Disabilities not to be discriminated against on the basis of a disability and the right not to be deprived of their liberty due to a disability.

d. Recommendations

The government has an obligation to provide proper health care to incarcerated individuals, regardless of the economics of doing so. Nevertheless, they have limited resources, which necessarily must be divided between the needs, wants, and demands

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232 Ibid.
of many stakeholders. As discussed, however, individuals who receive adequate treatment inside the walls of detention are less likely to reoffend, which again will generate substantial savings for the government that ultimately can be spent elsewhere. Mental illness negatively impacts an individual’s ability to stay in school. Thus, providing adequate treatment is crucial in obtaining higher graduation rates. Although the U.S. spends just over $12,000 annually on education per student, states spend an average of over $28,000 per year for each incarcerated individual in their care. The Alliance for Excellent Education reported that an increase in the male high school graduation rate of five percent could result in annual crime savings of approximately $18.5 billion. The group also pointed to an estimate that these individuals would generate additional earnings of nearly $1.2 billion per year. This illustrates that limited resources do not have to be a barrier to providing treatment. Focusing more in the short-term on improving outcomes for mentally ill youth will reduce long-term costs, and provide opportunities for them to contribute more to society.

A red line in the responses of the study participants to the question of how the current system of public and private providers can be improved, is that there are major systemic issues that need to be tended to before real change can happen. A key issue raised is reducing the prison population. If fewer individuals are incarcerated, providing adequate care to those who remain behind bars would be more feasible. Margaret Winter holds that the incarcerated population should be a small fraction of what it is today, saying:

236 Ibid., 5.
237 Ibid.
“The same politicians who boast about the draconian sentencing laws they pass, have no interest in paying for mental health care for the prisoners who need it. Ultimately, there shouldn’t be any people with serious mental illness in prison. And especially not mentally ill youth.”

She believes the focus needs to be on providing adequate mental health care in the community, a view we have seen emphasized in the Convention on the Rights of Persons with Disabilities and its position against deprivation of liberty based on a disability. The illustrated failures of jails to properly care for the mentally ill, along with previously discussed research on the perilous ramifications of incarcerating youth with mental illness, reinforces this view. Winter holds that communities and families shattered by drugs, poverty, and mass-incarceration can fuel mental illness. She argues that dramatically reducing the prison population will enable a redirection of resources into mental health programs and education in the community, and thus put an end to the vicious cycle of placing people with mental illness behind bars, often leading to a worsening of their illness.

As long as private contractors remain a significant supplier of health services in the juvenile justice system, there are measures that should be taken in order to improve some of the destructive patterns illustrated in this thesis, for the benefit of society as a whole, as well as the individual. Better monitoring and contracting are the two main solutions brought up by the study participants. Michele Deitch holds that contracts need to be highly specific in order to generate good outcomes for the individuals receiving care, stipulating everything from the treatment programs that need to be provided, to the number of square feet an individual’s prison cell must be. In addition

238 Winter, interview.
to better contracting, the University of Texas at Austin Lecturer wants to see more emphasis on the systems that are in place to monitor compliance with the contract. Winter stresses that if the state decides to contract out core services like health care, it must accept its fundamental obligation to closely monitor those operators. “But the for-profit prison industry strongly resists transparency and accountability,” she says, “and state prison officials are not strongly motivated to hold their feet to the fire unless people on the outside are watching. For that reason, it is essential that outside independent advocates, litigators, and monitors (...) have meaningful access to the prisons. Ultimately, meaningful prison reform has never come about without outside, intensive, independent monitoring.”

vii. Conclusion

Mentally ill incarcerated youth in the U.S. have a constitutional right to receive adequate mental health care, to be protected from harm, and not to be discriminated against whilst under the care of the government. When it comes to international human rights law, children are recognized as especially vulnerable and in need of extra protection, and those with a disability even more so. Children and youth not only have a right to health, but a right to a life in dignity and security, to not be arbitrarily deprived of their liberty, and to conditions that foster the development of their personality to their fullest potential. Moreover, the principle of non-discrimination is foundational in international human rights law.

Throughout the thesis, we have seen that mentally ill youth who reside in correctional facilities around the country are deprived of these rights. Individuals who are the least able to provide for themselves are the ones who are most dependent on the availability of health services in the community. When these services are scarce
and not offered on a universal basis, the suffering of the underprivileged population is exacerbated. The African-American population, being overrepresented at every stage of the criminal justice system, have the highest levels of being uninsured and the hardest time accessing mental health services. Individuals who should be in treatment instead end up in jail, where their mental illness is not sufficiently tended to – in an environment of neglect and unpredictability, without adequate professional help and safety provided.

Both the public and private systems are failing to provide the adequate level of care and safety that they are legally bound to. However, research suggests that private facilities foster a more violent environment than public institutions, with higher turnover rates and less trained staff. This study points out limitations that are unique to the private system, creating barriers to meeting the government obligation of ensuring sufficient care is provided for. While the motive for bringing private actors into the corrections industry was to meet a high demand and increase service efficiency, there are fundamental challenges in reconciling their business model with protecting the human rights of disabled individuals who are deprived of their liberty. Thus, privatization in the criminal justice system as it stands today, surrounded by a lack of transparency and accountability, reduces the likelihood for the human and constitutional rights of mentally ill youth to be fulfilled. As the private prison industry profits on maintaining high incarceration levels, the individuals residing in their facilities are paying the price. Reducing the prison population will both create savings for the government, and be of tremendous value for the health of mentally ill youth. Moreover, it will lessen the structural violence inflicted on this utmost vulnerable population.
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Interview Questions

Margaret Winter:

- How do you view the trend of using private health care contractors in the criminal justice system in general, and in the juvenile justice system in particular?

- What are possible consequences of privatization of prison health care services for mentally ill individuals? In what ways are mentally ill youth especially vulnerable in this setting?

- When correctional facilities lack the resources to meet the mental health care needs of the mentally ill population, what are the major services they typically fail to provide first? What do you see as the most pertinent services to be provided to a mentally ill incarcerated adolescent?

- In an article from 2012 titled “Private Prisons Are the Problem, Not the Solution,” you write that profit incentives are so important to private contractors that a facility serving their prisoners poorly will not improve simply by switching to a new private contractor. Could you please elaborate on the experiences you have had leading you to this conclusion? What are some examples you have encountered in your work of failures by private facilities to uphold the level of care that mentally ill individuals have a constitutional and human right to? How do you see them differing in nature - if at all - from issues encountered at public institutions?

- What are possible alternatives to using private health care contractors? How can we improve the current system, and what does it require?

Michele Deitch:

- In your presentation "Oversight of Private Juvenile Facilities" you speak about barriers for private facilities to protect prisoners' human rights. Could you please expand on these?

- You mention human rights multiple times throughout your presentation. Could you speak to how privatization of prison services is a human rights issue to you?

- How has the idea of deinstitutionalization impacted the scope of privatization in the juvenile justice field?

- What are possible consequences of privatization of prison health care services for mentally ill individuals? In what ways are mentally ill youth especially vulnerable in this setting?
When correctional facilities lack the resources to meet mental health care needs, what are the major services they typically fail to provide first? What do you see as the most pertinent services to be provided to a mentally ill incarcerated adolescent?

How does the lack of oversight in private facilities impact mentally ill incarcerated youth?

How do you see the failures of private facilities differing in nature - if at all - from those of public institutions (or is it, in your opinion, the same type of issues but to a different extent?) Do you see clear trends across institutions or does it manifest itself in specific examples?

Since public facilities also face some issues with the quality of care they provide, what do you see as solutions going forward? In other words, how can we improve the current system, and what does it require?

Alex Friedmann:

How do you view the trend of using private health care contractors in the criminal justice system in general, and in the juvenile justice system in particular? In what way is this a human rights issue to you?

What are possible consequences of privatization of prison health care services for mentally ill individuals? In what ways are mentally ill youth especially vulnerable in this setting?

In the article "Juvenile Crime Still Pays - But at What Cost?" you wrote that there are major issues facing public correctional facilities, but that "some of the worst forms of abuse and neglect however, can be found among the growing number of privately-operated juvenile facilities that are accountable to corporate stockholders and not to the tax-paying public." In the same article you point to privately operated facilities accepting mentally ill individuals because they can charge a higher fee for them. Could you please elaborate on these issues? How do you see the failures of private facilities differing in nature - if at all - from those of public institutions (or is it, in your opinion, the same type of issues but to a different extent?) Do you see clear trends across institutions or does it manifest itself in specific examples?

When correctional facilities lack the resources to meet mental health care needs, what are the major services they typically fail to provide first? What do you see as the most pertinent services to be provided to a mentally ill incarcerated adolescent?

Since public facilities also face some issues with the quality of care they provide, what do you see as solutions going forward? In other words, how can we improve the current system, and what does it require?
Grace Bauer-Lubow:

- How do you view the trend of using private health care contractors in the criminal justice system in general, and in the juvenile justice system in particular?

- In your experience working with issues encountering youth in the criminal justice system, what are the consequences for them of being in a facility with private contractors versus a publicly run facility? In what ways are mentally ill youth especially vulnerable in this setting?

- You were a leader figure in the drive to shut down Tallulah Correctional Center for Youth, where your son was incarcerated. Briefly tell me about the concerns you had about the facility. How did the Louisiana Department of Corrections respond to your inquiries? How did the DOJ investigation change the trajectory of this process?

- In an interview with Inequality.org, you discuss how the private contractors running Tallulah did not have the proper background in youth development and mental health treatment, among other areas, to properly care for the incarcerated youth. Could you please elaborate on this? With regards to operations at Tallulah, you mentioned profit motive, lack of oversight, incentives to keep youth in a cycle of incarceration, and violence at the facility. How do you tie these issues together?

- How can we improve the current system, and what does it require?