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An Updated Look at Mental Health Services in American Public and Private Prisons

A Thesis Presented in Partial Fulfillment of the Requirements for the Degree of
Master of Arts in Forensic Psychology

John Jay College of Criminal Justice
City University of New York

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An updated look at mental health services in American public and private prisons

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This Thesis has been presented to and accepted by the Office of Graduate Studies, John Jay College of Criminal Justice in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Forensic Psychology.

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Abstract

People residing in American prisons have the legal right to mental health care while incarcerated (Justia, 2021). This is important, as the prevalence of mental disorders is high in this population (Prins, 2014), and incarceration is a psychologically damaging experience, which hinders a person's success at rehabilitation. Numerous of issues related to the mental health services (MHSs) in both public and private prison facilities have been reported in recent years, which warrants systematic exploration. The little existing research comparing the presence of MHSs in these facilities has produced mixed results, it uses out-of-date datasets, and none has explored MHSs in detail. This thesis aimed to expand upon previous research by observing the present-day policies and procedures of 57 American facilities via publicly available online materials: 29 public and 28 private prisons randomly selected from states that contained a private prison. It explored what kinds of services were available, what factors may be associated with their availability, how transparent the facilities were with this information, and the *questionable media* associated with a facility's health or mental health services. It was hypothesized that facilities that were private, in less wealthy states, and/or in rural communities would host fewer MHSs, and that private facilities would be less transparent with their information than public facilities. The results indicated that the private and public facilities, regardless of additional characteristics, generally had similar types and amounts of services available to their residents. Private facilities were associated with greater *questionable media* than were their public counterparts, however. While the MHSs in prison facilities appear to be comprehensive, there may still be deeper issues that require further exploration for the good of those residing within them.

Keywords: private prisons, public prisons, availability, mental health, health, services, treatment, policy, procedure, transparency

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An Updated Look at Mental Health Services in American Public and Private Prisons

Mental Health of People in Correctional Facilities and their Rights

The U.S. Supreme Court has held since 2001 that a lack of reasonably adequate health care, including mental health care, is a violation of prison residents' Eighth Amendment rights (Justia, 2021). A lack of care constitutes the Amendment's "cruel and unusual punishment" aspect. This ruling relates to both human rights and the fact that those housed in correctional facilities in the United States face an abundance of mental illness (MI) and associated symptoms. Current estimates show that for almost every common diagnosable MI, rates in the prison population are higher than in the general population (Prins, 2014). Disorders with the highest prevalence in prisons are attention deficit hyperactivity disorder (~10-26% compared to ~4%), major depression (~1-29% compared to ~3-13%), posttraumatic stress disorder (~0-48% compared to ~2-5%), generalized anxiety disorder (~1-23% compared to ~1-4%), and bipolar disorder (~1-16% compared to ~1-3%) (Prins, 2014).

Substance use disorders are also highly prevalent in prison populations (Smith & Strashny, 2016; Ring & Gill, 2017). The results of a survey of 2,000+ federal prison inmates by FAMM found about a 66% prevalence rate of drug or alcohol addiction upon entry to prison in its sample (Ring & Gill, 2017). The Bureau of Justice Statistics has found a rate of about 50% (Ring & Gill, 2017). Recovery from substance abuse can produce many positive outcomes, such as helping the individual cope with incarceration in healthier ways, and reducing the chances of reliance on drugs when they leave prison. The same FAMM report described the substance abuse programs available in federal facilities, the Residential Drug Abuse Program, the Non-Residential Drug Abuse Treatment, and Drug Abuse Education (Ring & Gill, 2017). Those with qualifying nonviolent crimes are eligible to have some time removed from their sentence for

completing the Residential Drug Abuse Program, and fortunately, 76.5% of those in the study who completed the program found it to be helpful (Ring & Gill, 2017).

Why is mental illness so prevalent in this population? It could be due to different reasons, such as genetic inheritance of a disposition to MI symptoms, or that many incarcerated individuals have extensive histories of prior victimization (Brav, 2021; Willison et al., 2021). Prior victimization is a term generally used to indicate that a person has been the victim of a crime or otherwise traumatic event at some point in their past. Oftentimes, trauma symptomatology is a consequence of prior victimization (Boney-McCoy & Finkelhor, 1995; Brav, 2021; Griffing, 2005). Prior victimization also has been found to lead to re-victimization (Piper & Berle, 2019), thus perpetuating the development and occurrence of victimization-related trauma. Mass incarceration in America also disproportionately affects low-income communities, communities which are significantly impacted by traumatic loss and violence (Harris & Kearney, 2014).

Scholars and professionals have concluded previously that correctional facilities are not ideal for mental health treatment (Mills & Kendall 2016). However, even if someone who is incarcerated does not come into a correctional facility with a severe mental illness, it is important that they have access to treatment. For one, there are certain types of “potentially traumatic events” that people who are incarcerated are highly likely to experience, especially those related to interpersonal violence (physical and sexual assault, coercion) (Piper & Berle, 2019). Solitary confinement is also psychologically traumatic (Piper & Berle, 2019). This compounds with other aspects of incarceration that are psychologically harmful, such as isolation from the community, loss of autonomy and privacy, loss of income, processing of one’s sentencing, and anticipation of what the future will look like, along with the general stresses of incarceration. The option to

utilize support when it is needed is something that everyone who endures incarceration should be able to access.

Overview of Mental Health Care Services in U.S. Prisons

This study will specifically examine the mental health services (MHSs) offered in public prisons and privately owned/operated prisons. Private prisons began to emerge during the early 1980s, as the newly implemented “tough on crime”-related laws took place and caused a dramatic increase in the number of people incarcerated throughout the country (Khey, 2015). Overcrowding in prisons, and the government’s reluctance to spend money on building new prisons, became a business opportunity. It became a for-profit industry after the Corrections Corporation of America was the first to obtain a contract with a Tennessee county government (Khey, 2015). Private facilities have been accused of being incentivized to incarcerate as many people as possible because they are typically paid based on their respective number of residents (Khey, 2015; Matthews, 2013). This contrasts with publicly-run prisons, which are not-for-profit (paid for with taxes) and operated by the government, where rules and regulations are set by government policies (Criminal Justice Programs, n.d.). Because of this, information regarding said rules and regulations are much easier to access, and we have a much better idea of how public prisons are run than we do private prisons (Criminal Justice Programs, n.d.).

Public Prisons

The most recent Program Statement by the Federal Bureau of Prisons (BOP) regarding correctional MHSs was issued in 2014. It provides an outline of the policies that are to be implemented within federal facilities (BOP, 2014). First, it lays out the responsibilities of the key players in managing MHSs. The Psychology Services Branch, Reentry Services Division, and Health Services Division are tasked with using the BOP’s Psychology Data System to oversee

facility conduct, and also with developing training programs for facility staff (BOP, 2014). Others on this list include Wardens, Chief Psychologists, Mental Health Treatment Coordinators, Social Workers, Psychiatrists, Health Services Administrators, Clinical Directors, Community Treatment Services, Residential Reentry Management Branches, Care Coordination and Reentry Teams, and all other staff. The combined efforts of these roles should produce a system that ensures 1) implementation of Program Statement policies, 2) continuity of treatment for facility residents, 3) appropriateness of treatment and resident placement, 4) dissemination of educational materials and training for staff and residents, 5) coordination amongst these entities, and 6) identification of residents who display behaviors that are indicative of an MI and may require treatment (BOP, 2014).

The next two sections of the Program Statement address its program model and means of meeting the model's goals. Its program model identifies recovery, or "the process by which people are able to live, work, learn, and participate fully in their communities" (p. 5), as its primary objective, as per recommendations set by the President's New Freedom Commission on Mental Health (BOP, 2014). It also specifies that recovery does not look the same for every individual; some may focus on alleviating symptoms, while others essentially learn to live with them (BOP, 2014). Congruent with contemporary literature on best practices for MHSs, the Program Statement recognizes evidence-based practices (EBPs) as its priority treatment methods. EBP-based cognitive-behavioral therapy, group treatments, Priority Practices ("EBPs delivered in group format that address core needs of the inmate population" (p. 7)), skills training (enhancing skills that support "responsibility, empowerment, and independence upon reentry" (p. 7)), criminal thinking and risk (treatment of risk factors associated with recidivism), and peer support are the main methods of working towards recovery (BOP, 2014). MHSs are delivered on

different levels; no significant care, routine outpatient/crisis oriented care, enhanced outpatient/residential care, and inpatient psychiatric care are options for residents depending on their determined levels of need (BOP, 2014). These determinations are typically, but not exclusively, made by the Mental Health Treatment Coordinator (BOP, 2014).

The rest of the Program Statement dictates: screening procedures, Care Coordination and Reentry Team approaches to care, criteria for the placement of individuals with serious MI in Special Housing Units and Special Management Units, mental health training of staff, the Mental Health Companion Program (peer support from trained residents), incentives (achievement awards) for participating in Psychology Treatment Programs, transference guidelines, reentry guidelines, and other resources for facility staff.

Private Prisons

To reiterate, it is much more difficult to glean information about the standards by which private prisons operate. This information is not readily available, as most of it is set by contracts between the entity which owns a given facility and the jurisdiction in which it resides.

Approximately 8,871 federal inmates reside in private facilities, which is about 5.7% of all federal inmates (BOP, 2021), down from 18% in 2016 (Criminal Justice Programs, n.d.). This number has probably lessened since President Biden's executive order ending federal contracts with private prisons in January 2021, which was done with the purpose of decarceration by "reducing profit-based incentives" (Biden, 2021). In 2019, however, around 88,500 state prisoners were residing in private facilities, compared to 19,600 federal prisoners (Minton et al., 2021).

One way to paint the picture of MHSs in private prisons is by looking at their populations. Private prisons tend to select those who have committed nonviolent crimes, and

whose medical records contain fewer conditions, because they require fewer services and security and thus, less money to support (Criminal Justice Programs, n.d.). In addition, the average length of stay for those in private prisons is over a year shorter than that for public prisons (Blakely & Bumphus, 2004). This suggests that the available intensities and/or services of care provided in private facilities may be different from that in their public counterparts.

Another way to look at this is by examining the information provided by the companies that own these facilities. CoreCivic (2021), the largest corporation running private prisons, stated in their 2020 Environmental, Social, & Governance (ESG) report that: “licensed staff conduct mental health evaluations for new residents within two weeks,” “we renew current psychiatric medications upon arrival with follow-up by licensed mental health professionals within 30 days,” and “qualified mental health professionals provide counseling and medication for diagnosed psychiatric conditions” (p. 13). Their Code of Ethics stated that residents in their facilities receive services via in-facility clinics that are run either by themselves or a third party contracted by the government (CoreCivic, n.d.). They explain that the MHSs are “at levels consistent with accreditation and practice standards in correctional health care,” and that “health care services are provided by credentialed and licensed professionals who perform services to standards of care comparable to those applicable in the wider community” (CoreCivic, n.d., p. 65). These explanations give an idea about how these services function in CoreCivic facilities, but understanding the organizational setup of them, and the actual programming available to residents, requires investigation beyond publicly-available information.

Issues with Mental Health Services in Correctional Facilities

It is the hope that all residents who need treatment within correctional facilities are receiving it; however, over the years, there has been considerable criticism of MHSs. Why?

There are guidelines that dictate how these services are to be provided, such as the Program Statement, but effective implementation depends on many factors outside of the law.

Organizational capacity, available resources, finances, and levels of cooperation amongst the entities responsible for managing MHSs can all negatively impact their availability and effectiveness. In 2014, for example, there was a documented shortage of mental health professionals and shrinkage of correctional budgets, which would have decreased the availability of services (Reingle Gonzalez & Connell, 2014). It may also simply be related to priorities; because prisons are seen as facilities of retribution, and because of a pervasive “custodial and masculinist” culture, staff could view residents’ mental-health-condition-related behaviors as problems to be punished rather than treated (Mills & Kendall, 2016, p. 194). Some of the issues associated with MHS availability have been documented, which is important to note, as it is more so to ensure that they do not continue unchecked.

Public Prisons

Using data from the 2004 Survey of Inmates in State and Federal Correctional Facilities and the 2004 Survey of Inmates in Federal Correctional Facilities, Reingle Gonzalez and Connell (2014) examined the demonstrated need for, and continuity of, mental health medications. They examined 18,185 incarcerated individuals and results showed a significantly large prevalence of mental health conditions, congruent with the prevalence rates summarized prior. Approximately half of respondents reported receiving medication while incarcerated, but 40-50% of them did not continue to receive medication after they were given it upon admission (Reingle Gonzalez & Connell, 2014). Also, most respondents were initially screened for mental health conditions, but only 40.95-46.33% of those who had ever seen a counselor saw one while incarcerated (Reingle

Gonzalez & Connell, 2014). These data show an apparent discrepancy between needs and needs being met.

The aforementioned 2017 FAMM survey also addressed mental health services. Ring and Gill (2017) asked their respondents whether they had received mental or behavioral health counseling while incarcerated. Approximately 69% of the respondents said they had not, and over half of those who did receive the counseling described it as unhelpful, citing a lack of confidence in the boundaries of confidentiality and in the counselors (Ring & Gill, 2017). The author of this study recalled a similar sentiment among the residents of a juvenile detention center at which she worked in 2019. While anecdotal, it could be that this sentiment is truly widespread among incarcerated populations.

In the wake of the 2014 Program Statement, The Marshall Project obtained data from the BOP that helped paint the picture of how things had changed since its implementation four years prior. The data showed that the total number of federal prisoners receiving consistent MHSs was reduced by 35%, and which varies widely based on location. For instance, for one prison in West Virginia, this amount was reduced by 86% (Thompson & Eldridge, 2018). This is concerning, because only 3% of people at federal facilities had been classified as requiring MHSs, in contrast with the 23% who have been diagnosed with an MI (Thompson & Eldridge, 2018). Staffing shortages exacerbated by a hiring freeze initiated by the Trump administration was cited as the main reason for these issues. As such, facilities were not provided with the organizational capacity or resources necessary to satisfy the Program Statement guidelines. Thus, psychologists were allegedly lowering care levels for individuals, leaving the few resources for sufficient levels of care for those with the most severe conditions (Thompson & Eldridge, 2018). It was noted that not only do these designations affect levels of care while incarcerated, but also the planning and

support involved with reentry. A lower care level designation equates to worse outcomes in terms of mental health care continuity, disability benefits, and housing options (Thompson & Eldridge, 2018).

Private Prisons

There is a decent understanding of the issues associated with public facilities. It is even more difficult to understand those within private facilities, however. Yet, there is some information about the issues associated with health care services in general. Part of it is rooted in the general business model of private facilities. Because it is for-profit, much of their finances are managed with the goal of reducing costs where possible (e.g. housing people with fewer health and security needs, outsourcing healthcare providers) (Singh, 2017). In some cases, it is speculated that this has resulted in fewer available services, and has thus led to further harm caused by the lack of medical attention (Singh, 2017).

In particular, there is evidence of wrongful practices by Corizon Medical Group Companies, the most prominent medical service provider in private prisons. The company has been sued 1,300+ times for reasons such as wrongful deaths and sexual misconduct (Singh, 2017). An extensive article published in Prison Legal News which investigated Corizon's financial picture and accounts of misconduct mentioned a court-ordered review of its MHSs. The review described Corizon as being significantly deficient in terms of its treatment programs, treatment records, staffing, recordkeeping, medication management, and suicide prevention training for staff (Dober, 2014). Corizon denied the report's findings and hired the National Commission on Correctional Health Care to conduct an "independent review," which found Corizon's practices to be adequate (Dober, 2014). However, the Commission had accredited the

company in the first place, and its Certified Correctional Health Professional program's board of trustees contains Corizon officials, contriving a potential conflict of interest (Dober, 2014).

Addressing the Gap in the Research

There is little existing contemporary literature about MHSs in public and private correctional facilities. The most relevant study is a 2012 comparison between public and private prisons using a dataset from the 2000 Census of Federal and State Correctional Facilities. Makarios and Maahs (2012) reviewed census data submitted by 1,129 facilities consisting of 105 private facilities, 80 federal facilities, and 955 state facilities. Three of their variables, *treatment*, *mental health*, and *suicide prevention*, indicated the presence of twenty different policies and programs. Treatment programs were educational and on the subjects of “drug dependency,” “alcohol dependency,” “psychological,” “HIV/AIDS,” “sex offender,” “employment,” “life skills,” and “parenting/child rearing” (p. 353). Mental health policies included “intake policy for mental disorder,” “psychiatric evaluations and assessments,” “24-hr mental health care,” “therapy/counseling,” “psychotropic medications,” and “assist-inmate to community health service” (p. 353). Suicide prevention policies included “assessment at intake,” “staff training,” “inmate counseling or psychiatric services,” “monitoring high risk,” “watch cell or special location,” and “prevention teams” (pp. 353-354). Federal prisons performed better on the *treatment* variable, on which private and state prisons performed similarly. Comparisons with federal prisons could not be made for the latter two variables, but there were no significant differences between private and state prisons with respect to them (Makarios & Maahs, 2012).

Bačák and Ridgeway (2018) examined the availability of health services in statistically comparable private and public prisons. They used the 2005 Census of State and Federal Adult Correctional Facilities, which surveyed 1,821 facilities, and applying their study's inclusion

criteria left them with 360 private facilities and 1,030 public state and federal facilities (Baćak & Ridgeway, 2018). Measures of overcrowding, conditions of confinement, educational programs, locality of management, and geographical region were included (Baćak & Ridgeway, 2018). They found that indeed, private facilities were more likely to be minimum-security, and less likely to have educational programs and reports of assault. They also found that private facilities hosted significantly fewer psychological/psychiatric services (Baćak & Ridgeway, 2018).

Other studies mentioned by Baćak and Ridgeway (2018) were all published 19+ years ago: Armstrong and MacKenzie (2003), Logan (1992), and Sellers (1989). They noted that many of these studies, plus the aforementioned 2012 study, contained methodological issues relating to reliability and validity. For example, studies focusing on one state cannot be generalized to greater geographical areas. Although Baćak and Ridgeway's (2018) study was much more methodologically sound, the data used in their study were collected in 2005 (Stephan, 2008). With so many amendments in federal and state statutes, and updates in research, it could be reasoned that the availability of MHSs has increased since then. It could also be reasoned that it has not, as the issues with the delivery of MHSs for both private and public prisons show a continued struggle to deliver sufficient services. Either way, it is important to continuously measure the prevalence of MHSs in correctional facilities to understand what they look like in the present day.

Another aspect of Baćak and Ridgeway's (2018) article that differs from the current study is the depth of its subject matter. The information their article provides is indicative of whether or not different kinds of health services, in addition to MHSs, are present in the facilities in the sample. It does not speak to the details of the MHSs. Makarios and Maahs's (2012) study expanded upon the details a bit, but did not provide much more information. The current study

aims to look at the policies and practices of select private and public facilities to gain an updated understanding of how their MHSs are organized, and what types of services are available. By default, it also builds on previous research by identifying whether MHSs are available in these facilities at all, in the present day.

The Present Study

To reiterate, this study reports on data collected regarding individual prisons to answer the following questions: what kinds of MHSs are available in prisons today, and how are they organized? Do MHSs differ among private and public prisons? What factors appear to be associated with their availability? Are certain types of prisons more transparent with their information than other types? The answers provide insight into the contemporary capacities and practices of the selected facilities. It was hypothesized that private prisons, prisons in less wealthy states, and prisons in rural communities will have fewer available services than public prisons, those in wealthier states, and those in urban communities. Public prisons may also be much more transparent with their information than private prisons. Lastly, it was the author's hope that all prison residents have access to MHSs either directly in the facility, or by traveling to a nearby facility.

Methods

Sample Selection and Demographics

This study includes at least one private prison and one public federal or state prison from every U.S. state that contained a private prison at the time of data collection, with federal-level prisons as the priority. Thus, the 23 states represented are Arizona, California, Colorado, Florida, Georgia, **Idaho**, Indiana, Kansas, Kentucky, Louisiana, Mississippi, **Montana**, **Nevada**, New

Jersey, **New Mexico**, Ohio, Oklahoma, Pennsylvania, **Rhode Island**,¹ Tennessee, Texas, Virginia, and Washington. Those indicated with bold text did not contain a federal prison, therefore one public state facility was selected from each. The 75th percentile of these states' incarceration rates, 859+ per 100,000 people,² was used to determine which states would contribute more than two prisons for increased representation among states with higher criminal justice involvement. States with an incarceration rate at or above 859 contributed an additional private and public prison to total four each when possible, as not all states had more than one private prison: Arizona, Georgia, Louisiana, Mississippi, and Oklahoma.³ This resulted in a sample size of 57 facilities: 28 private, and 29 public. Each state's facility or facilities were randomly selected from a list of eligible facilities created by the author for each state, with separate lists for private and public facilities. Facilities were deemed eligible if they were a prison, were not medical in nature, and contained adult populations.

It should be noted that although this method of prison facility selection was optimal for keeping the sample size manageable, it affected the degree to which each state's facilities were accurately represented. For example, one federal prison facility out of 13 eligible federal prison facilities was selected from Texas, but one federal prison facility selected out of only one from Washington implies that Washington's federal prison facilities were well represented in this sample, while Texas' were not. This was the case for both public and private facilities, as the number of eligible private facilities in a state ranged from one to 15.

¹ Rhode Island's facility of interest, Donald W. Wyatt Detention Facility in Central Falls, is publicly owned but privately operated, which warrants its inclusion in this study.

² Based on the most recent incarceration rates available as per Widra and Herring (2021) of the Prison Policy Initiative.

³ Throughout the course of data collection in 2022, the year after this figure was calculated, five states and Washington D.C. were removed from the sample due to the closure of private facilities, or new information that was gleaned. The 75th percentile of the finalized list of states' incarceration rates is 816.5, and two states with incarceration rates greater than that did not contribute four facilities: Texas and Tennessee. Therefore, the figure used represents those states which hosted a private prison up until very recently.

Over half of the facilities in the sample were medium-security or mixed-level-security. Most facilities were not a special type of facility, and the others were categorized as *administrative* facilities,⁴ U.S. Immigration and Customs Enforcement (ICE) facilities, *work camp* facilities,⁵ *substance abuse or other health need-focused* (but not strictly medical) facilities, or facilities with two or more of the previous specialties. In addition to those owned or contracted at the state or (public) federal level, some facilities were owned or contracted by ICE and/or the U.S. Marshals Service, and some were contracted by both state and federal agencies. The vast majority of facilities hosted male residents only. The facilities were most often in suburban communities, and the Western, South Central, and Southeast regions consisted of the highest numbers of facilities. Interestingly, the mean population/capacity of the facilities in the Southeast region ($M = 1735.60$, $SD = 748.20$, 95% confidence interval (CI) of the mean [1200.37, 236.60]) is the largest of all the regions but was only significantly larger than that of the Western region ($M = 945.00$, $SD = 532.71$, 95% CI of the mean [637.42, 1252.58]), as demonstrated by an analysis of variance on the region and population/capacity variables ($F(5, 51) = 2.739$, $p = .029$) and follow-up Bonferroni tests ($p = .020$, 95% CI [73.78, 1507.42]). Lastly, CoreCivic and The GEO Group, the two most prominent private prison corporations in the study, owned a combined 71.5% of the 28 private facilities in the sample. See Table 1 for more information.

⁴ “Administrative facilities are institutions with special missions, such as the detention of pretrial offenders, the treatment of inmates with serious or chronic medical problems, or the containment of extremely dangerous, violent, or escape-prone inmates” (BOP, n.d.).

⁵ Work camp facilities are those dedicated to running work crews staffed by facility residents who are typically those convicted of low-level, nonviolent crimes. See for example, Washington State Department of Natural Resources (2022).

Table 1*Key Facility Characteristics and Demographics: Public vs. Private Facilities*

Characteristic	Public Facilities	Private Facilities	Total
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Type			
Public			29 (50.9)
Private			28 (49.1)
Gender of Residents			
Male	24 (82.8)	16 (61.5)	40 (70.2)
Female	1 (3.4)	0 (0)	1 (1.8)
Both/Any	4 (13.8)	10 (38.5)	14 (24.6)
Unknown	-	-	2 (3.5)
Population/Capacity			
<i>(n = 57, Mean = 1300.9, Median = 1260.0, SD = 604.2)</i>			
100-499	2 (6.8)	2 (7.2)	4 (7.0)
500-899	7 (23.8)	5 (18.0)	11 (19.3)
900-1299	11 (37.4)	6 (21.6)	17 (29.8)
1300-1699	10 (34.0)	5 (18.0)	15 (26.3)
1700-2099	0 (0)	5 (18.0)	5 (8.8)
2100-2499	0 (0)	0 (0)	0 (0)
2500-2899	0 (0)	3 (10.8)	3 (5.3)
2900-3299	0 (0)	1 (3.6)	1 (1.8)
Security			
Minimum	1 (3.4)	6 (25.0)	7 (12.3)
Low	7 (24.1)	1 (4.2)	8 (14.0)
Medium	13 (44.8)	9 (37.5)	22 (38.6)
High	4 (13.8)	2 (8.3)	6 (10.5)
Mixed	4 (13.8)	6 (25.0)	10 (17.5)
Unknown	-	-	4 (7.0)
Special Type			
Administrative	4 (13.8)	0 (0)	4 (7.0)
ICE	0 (0)	9 (32.1)	9 (15.8)
Substance Abuse/Other Health Need	0 (0)	3 (10.7)	3 (5.3)
Work Camp	1 (1)	0 (0)	1 (1.8)
Mixed	0 (0)	2 (7.1)	2 (3.5)
Other	0 (0)	2 (7.1)	2 (3.5)
None	24 (82.8)	36 (42.9)	36 (63.2)
Government Level			
BOP	24 (82.8)	1 (3.6)	25 (43.9)
State	5 (17.2)	17 (60.7)	22 (38.6)
ICE and/or U.S. Marshals	0 (0)	8 (28.6)	8 (14.0)
Both state and federal agencies	0 (0)	2 (7.1)	2 (3.5)
Owner (private facilities only)			
CoreCivic	-	12 (42.9)	-
GEO Group	-	8 (28.6)	-
Management & Training Corporation (MTC)	-	5 (17.9)	-
LaSalle Corrections	-	2 (7.1)	-

Central Falls Detention Facility Corporation	-	1 (3.6)	-
Region			
Western	7 (24.1)	7 (25.0)	14 (24.6)
South Central	6 (20.7)	6 (21.4)	12 (21.1)
North Central	3 (10.3)	3 (10.7)	6 (10.5)
Southeast	5 (17.2)	5 (17.9)	10 (17.5)
Northeast	4 (13.8)	4 (14.3)	8 (14.0)
Mid-Atlantic	4 (13.8)	3 (10.7)	7 (12.3)
Community Type			
Rural	5 (17.2)	10 (35.7)	15 (26.3)
Suburban	24 (82.8)	15 (53.6)	39 (68.4)
Urban	0 (0)	3 (10.7)	3 (5.3)

Procedure

Data collection was intended to occur by two means: scouring the Internet for publicly available information, and gaining information directly from facility representatives in whatever means they felt most appropriate (answering questions during a meeting with the author, filling out a survey prepared by the author, or sending the author policy or procedure documents related to facility-specific MHSs). The facilities were invited to participate in the study via e-mails and letters (sent to facilities without an e-mail listed online). They were informed that the study was purely observational and did not involve human subjects, they could participate via meeting, email, or survey response, and their answers would be confidential should they choose to provide information. Only one facility responded and was willing to participate in the study, one that was public and state-level. Curiously, this was the only facility in the sample that did not have MHSs available on its campus because its residents' designated care level indicated that they do not require them. The 12 other facilities that responded either directed the author towards unanticipated, overly burdensome procedures necessary to obtain information for research purposes, non-facility-specific documents publicly available online, or they rejected the invitation to participate entirely. It became evident that even if other facilities were recruited for the study, it would not be fruitful for data collection. Consequently, the data collected for 56 out

of 57 facilities was sourced solely from publicly available information on the Internet; therefore, strict confidentiality is only maintained for the one facility that directly contributed to data collection.

Facility-specific information was sought by first using materials such as the most recent available prison resident intake and orientation handbooks, staff handbooks, facility websites, news articles, studies, Prison Rape Elimination Act (PREA) audit reports, and Office of Detention Oversight (ODO) compliance inspection reports. This left much data uncollected, so for the sake of a more complete analysis, more generalized materials were used to conservatively fill in the “blanks” under the assumption that there was policy compliance at each of the facilities’ respective government levels. This included, but was not limited to, state Department of Corrections (DOC)/BOP/contractor/governmental entity-level policies, procedures, infographics, annual reports, performance standards, and informational website pages. Certain kinds of information were not assumed, however. If a state DOC’s policy on sex offender treatment stated something like “For facilities in which a sex offender treatment program exists...” and it was unknown whether the selected facility hosted one or not based on additional searching, it was indicated in the dataset that the facility did *not* provide that kind of treatment. This approach was used for each piece of data that needed to be filled in using generalized materials.

Variables

There were 52 variables in the dataset. Seventeen of these addressed demographics and basic facility/geographic characteristics to illustrate the sample and view associations between characteristics and MHSs. For example:

- *State Wealth Rank*: The wealth rank assigned to the state in which a facility resides as per an analysis by the Chamber of Commerce (2022), in which the 50 states are listed in order of “most wealthy” to “least wealthy.”
- *Facility Type*: Identifies whether a facility is privately or publicly owned/operated.
- *Gender*: Identifies the gender of the residents in a facility (men, women, or both).
- *Owner*: Identifies the company that runs a private facility (e.g. CoreCivic, GEO Group)

Fourteen variables addressed MHS departmental roles (job titles) and procedures. This helped to create an idea of what types of positions are utilized for different roles within a facility’s MHSs, and how they designate treatment to residents. For example:

- *MHS Location*: Identifies whether MHSs in a facility took place within the facility, in another DOC facility, or in a non-DOC facility.
- *Management*: Identifies who oversees/manages the MHSs in a facility.
- *Facilitator*: Identifies who facilitates treatment (e.g. who conducts therapy sessions).
- *Initial Screening Procedures*: Identifies when a facility first screens residents for mental health issues once they arrive at the facility.

Fifteen variables addressed how many different kinds of MHSs were available and what they were. They represent the basic components of what comprehensive MHSs should look like in a prison facility. The BOP Program Statement (2014) was used to inform this in order to gain an understanding of what the facilities are and/or should be capable of providing. For example:

- *Treatment Programs*: The total number of distinct MHS types that a facility provides.

- *AA/NA*: Identifies whether Alcoholics Anonymous and/or Narcotics Anonymous is available to facility residents.
- *Group Therapy*: Identifies whether a facility's MHS department provides group therapy to facility residents.
- *Psychiatric Services*: Identifies whether a facility has made psychotropic medication and its management via medical provider (psychiatrist, advance practice nurse, etc.) available to its residents.
- *Residential Sex Offender Treatment*: Identifies whether a facility provides residential sex offender treatment for residents.

Two variables addressed facility transparency with their information and what kinds of information were provided. These were not often used, as so few facilities provided information.

They are:

- *Information Given*: Identifies what type of information (policy documents, survey response, email response, reference to online materials, other materials, or none) a facility/company representative provided.
- *Transparency*: A judgment by the author of a facility's transparency based on whether it was willing to provide information and which kind(s) (not transparent, somewhat transparent, extremely transparent).

Two exploratory variables were created to identify the facilities that have had significant issues associated with health services and/or MHSs since 2015. They are:

- *Questionable Media*: Identifies whether any media documenting relevant significant issues with mental health care and/or physical health care services came up while

researching a facility (nominal; 0 = No questionable media was discovered, 1 = Yes, questionable media was discovered).

- *Questionable Media Type(s)*: Identifies what kind(s) of media came up (nominal; 0 = lawsuits filed by facility residents, 1 = reports of inadequate care in news articles or studies, 2 = suicides related to healthcare issues, 3 = alleged corruption among health service providers or facility management, 4 = relevant policy deficiencies identified by media such as official governmental reports, 5 = more than one type of the medias listed).

The final variable kept a record of which facilities, or their geographical representatives, sent anything in response to the invitation to participate.

Analysis

Most of the quantitative analyses consisted of measures of frequency/cross tabulations, chi-square analyses, analyses of variance, and t-tests with characteristic variables such as *Facility Type*, *Government Level*, and *Community Type* as the independent variables and the others, when appropriate, as dependent variables. Frequency tables/cross tabulations were used to determine the demographic makeup of the sample and what kinds of MHSs were available in which kind(s) of facilities and where.

Results

All percentages presented in this section reflect the percent of all facilities in the sample, not the percent of the facilities that contributed data to each variable (e.g. 96.5% of all facilities in the sample had MHSs available to residents on the facility's campus) unless otherwise stated.

All Facilities in the Sample

Prevalence of Mental Health Services. Nearly all of the facilities in the sample had MHSs available to residents on the facility's campus ($n = 55, 96.5\%$). The location of one facility's MHSs could not be determined (1.8%). The most frequently available MHS offered was psychiatric services (medication prescription and management) ($n = 56, 98.2\%$). The other services from most frequently available to least frequently available were group therapy/counseling ($n = 54, 94.7\%$), other elective programs (such as anger management, stress management, Moral Reconciliation Therapy, etc.) ($n = 53, 93.0\%$), crisis intervention ($n = 52, 91.2\%$), diagnosis of a mental disorder ($n = 51, 89.5\%$), nonresidential drug treatment ($n = 49, 86.0\%$), individual therapy/counseling ($n = 47, 82.5\%$), Alcoholics Anonymous/Narcotics Anonymous (AA/NA) ($n = 42, 73.7\%$), drug abuse education ($n = 32, 56.1\%$), psychological testing/evaluation ($n = 29, 50.9\%$), special mental health housing units ($n = 26, 45.6\%$), residential drug treatment ($n = 23, 40.4\%$), nonresidential sex offender treatment ($n = 7, 12.3\%$), and residential sex offender treatment ($n = 2, 3.5\%$).

A one-way analysis of variance was used to evaluate whether the mean number of MHSs offered in each geographic region significantly differed from one another, and they did not ($F(5, 51) = .269, p = .928$), as the greatest mean difference was between the Mid-Atlantic ($M = 9.71, SD = 1.11, 95\% \text{ CI of the mean } [8.69, 10.74]$), and Western ($M = 8.71, SD = 2.76, 95\% \text{ CI of the mean } [7.12, 10.31]$) regions, which was only one. The same test for the means among community types showed that rural ($M = 8.60, SD = 2.87, 95\% \text{ CI of the mean } [7.01, 10.19]$), suburban ($M = 9.36, SD = 1.50, 95\% \text{ CI of the mean } [8.87, 9.84]$), and urban types ($M = 9.00, SD = .00, 95\% \text{ CI of the mean } [9.00, 9.00]$) also did not significantly differ ($F(2, 54) = .848, p = .434$). A Pearson r correlation coefficient test between the number of treatment programs and *state wealth rank* reported a very slightly negative non-significant correlation, $r(56) = -0.083, p =$

.537; a state's wealth has no association with the average number of services its prison facilities provide. A new variable, *wealth group*, was created to assign a value of 0 to facilities whose wealth rank fell from 0-9, a value of 1 to facilities whose wealth rank fell from 10-19, etc., for creating cross tabulations for each MHSs type and the wealth groups. The prevalence of each MHS type was indeed similar among each of the wealth groups, showing support for the idea that the types of services available are also not dependent on a state's wealth. Tables 2 and 3 provide a detailed description of which types of services were found in which types of communities and regions.

Table 2
Mental Health Service Prevalence within Community Types
(Percent within community type)

	Rural <i>n</i> (%)	Suburban <i>n</i> (%)	Urban ^a <i>n</i> (%)	Total <i>n</i> (% of all facilities in sample)
MHS				
AA/NA	10 (71.4)	32 (82.1)	0 (0.0)	42 (73.7)
Crisis Intervention	12 (85.7)	37 (94.9)	3 (100.0)	52 (91.2)
Diagnosis of Mental Disorder	12 (85.7)	36 (92.3)	3 (100.0)	51 (89.5)
Drug Abuse Education	5 (35.7)	27 (71.1)	0 (0.0)	32 (56.1)
Group Therapy/Counseling	13 (92.9)	38 (97.4)	3 (100.0)	54 (94.7)
Individual Therapy/Counseling	12 (80.0)	32 (82.1)	3 (100.0)	47 (82.5)
Nonresidential Drug Treatment	11 (78.6)	35 (89.7)	3 (100.0)	49 (86.0)
Nonresidential Sex Offender Treatment	3 (21.4)	4 (10.3)	0 (0.0)	7 (12.3)
Psychiatric Services	14 (93.3)	39 (100.0)	3 (100.0)	56 (98.2)
Psychological Testing/Evaluation	8 (57.1)	18 (47.4)	3 (100.0)	29 (50.9)
Residential Drug Treatment	6 (40.0)	17 (44.7)	0 (0.0)	23 (40.4)
Residential Sex Offender Treatment	2 (14.3)	0 (0.0)	0 (0.0)	2 (3.5)
Special MH Units	8 (57.1)	15 (38.5)	3 (100.0)	26 (45.6)
Other Elective Programs	13 (92.9)	37 (94.9)	3 (100.0)	53 (93.0)

Note. Follow-up chi-square tests were not conducted due to the small number of facilities in urban communities relative to those in suburban and urban communities.

^aThere are only three facilities in the sample that are in urban communities, so the information provided for them should not be generalized to those across the US, and discussions regarding community type will not involve them.

Table 3
Mental Health Service Prevalence within Regions
(Percent within region)

	Western	South Central	North Central	Southeast	Northeast	Mid- Atlantic
MHS	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
AA/NA	9 (64.3)	7 (58.3)	5 (83.3)	8 (88.9)	6 (75.0)	7 (100.0)
Crisis Intervention	11 (78.6)	12 (100.0)	6 (100.0)	9 (100.0)	7 (87.5)	7 (100.0)
Diagnosis of Disorder	11 (78.6)	12 (100.0)	6 (100.0)	9 (100.0)	6 (75.0)	7 (100.0)
Drug Abuse Education	7 (50.0)	7 (58.3)	3 (60.0)	7 (77.8)	4 (50.0)	4 (57.1)
Group Counseling	13 (92.9)	12 (100.0)	5 (83.3)	9 (100.0)	8 (100.0)	7 (100.0)
Individual Counseling	10 (71.4)	11 (91.7)	4 (66.7)	9 (90.0)	8 (100.0)	5 (71.4)
Nonres. Drug Treatment	12 (85.7)	9 (75.0)	5 (83.3)	8 (88.9)	8 (100.0)	7 (100.0)
Nonres. S.O. Treatment	0 (0.0)	0 (0.0)	2 (33.3)	1 (11.1)	2 (25.0)	2 (28.6)
Psychiatric Services	13 (92.9)	12 (100.0)	6 (100.0)	10 (100.0)	8 (100.0)	7 (100.0)
Psych. Testing/Eval.	9 (64.3)	7 (58.3)	2 (40.0)	4 (44.4)	4 (50.0)	3 (42.9)
Res. Drug Treatment	6 (42.9)	3 (25.0)	3 (60.0)	5 (50.0)	3 (37.5)	3 (42.9)
Res. S.O. Treatment	1 (7.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (14.3)
Special MH Units	8 (57.1)	6 (50.0)	3 (50.0)	4 (44.4)	3 (37.5)	2 (28.6)
Other Elective Programs	13 (92.9)	12 (100.0)	5 (83.3)	9 (100.0)	8 (100.0)	6 (85.7)

Note. Follow-up chi-square tests could not be conducted due to too many cell counts fewer than the expected count of five and Fisher's Exact Tests could not be conducted due to cross tabulation table dimensions greater than 2x2.

Mental Health Service/Psychology Department Roles and Procedures. The following describes some structural roles and procedures of MHSs:

MHS Provider (n = 11): In a few facilities, it was indicated which entities/companies provided mental health treatment. They were Centurion Correctional Healthcare of New Mexico ($n = 1$, 1.8%), ICE Health Service Corps ($n = 2$, 3.5%), MTC + University of Texas Medical Branch ($n = 1$, 1.8%), MTC Medical Services ($n = 2$, 3.5%), Wellpath ($n = 4$, 7.0%), and Wexford Health Services Incorporated ($n = 1$, 1.8%).

Employer (n = 15): In nine (15.8%) facilities, mental health staff were directly employed by the facility/owner company, while five (8.8%) were outsourced (i.e. contracted by another provider, such as Wellpath), and one (1.8%) used both facility and outsourced staff.

Management (n = 49): The individuals tasked with overseeing the implementation and functioning of MHSs in their facilities were most often defined as some type of doctorate-level degree holder, such as “Chief Psychologist,” “Doctor of Psychology,” or “Chief Psychiatrist” ($n = 28, 49.3\%$). Other individuals were defined clinically (e.g. “Clinical Services Manager”) ($n = 5, 9.0\%$), in terms related to mental health (e.g. “Mental Health Lead”) ($n = 7, 12.6\%$), or in terms related to the facility (e.g. “Facility Head”) ($n = 5, 9.0\%$). In two facilities (3.6%), it was indicated that management consisted of a team of individuals.⁶

Planner (n = 48): Those responsible for creating treatment plans. In general, they were “clinicians” ($n = 28, 50.4\%$), “mental health providers” ($n = 5, 9.0\%$), and/or psychologists ($n = 34, 61.2\%$). It should be noted that most facilities/governments used one blanket term to refer to those who are legally qualified to provide professional mental health services; for example, an “experienced corrections qualified mental health professional” is defined in Michigan as a person who “performs a full range of professional mental health assignments in a full-functioning capacity” (Michigan Civil Service Commission, 2021).

Facilitator (n = 49): Those who facilitate mental health treatment. Again, these roles typically indicated licensure appropriate to a jurisdiction’s qualifications requirement, such as “treatment specialists and psychologists” ($n = 20, 35.1\%$), “qualified mental health providers/professionals” ($n = 6, 10.6\%$), or individuals along the lines of “licensed mental health clinicians/social workers/psychologists/psychiatrists” ($n = 13, 22.9\%$).

Medication (n = 50): Those responsible for prescribing and managing mental health medications. The majority of the time, facilities utilized either a staff or contract/consulting

⁶ Some facilities were counted more than once in the summary of this variable, such as when a data piece referred to multiple categories (e.g. “Facility Mental Health Authorities”) or multiple job titles (e.g. “Senior Psychology Associate/Chief of Mental Health Services/Medical Director/Mental Health Clinical Supervisor”).

psychiatrist or psychiatric provider ($n = 35$, 67.3%). Otherwise, facilities referred to health or medical services ($n = 4$, 7.2%), and in nine facilities, a “duly licensed medical professional” (15.8%).

Education/Training ($n = 30$): Those responsible for the continuing education and training of MHS staff. Those within BOP facilities answered to the BOP’s Continuing Professional Education Program ($n = 25$, 43.9%), and in Georgia, the Georgia Professional Regulatory Boards ($n = 1$, 1.8%). Otherwise, it was dictated by a leading role within the department, such as “Chief Mental Health Officer” ($n = 2$, 3.5%) or “Facility Behavioral Health Manager” ($n = 2$, 3.5%).

Continuity ($n = 45$): Those responsible for ensuring the continuity of care for those either in the facility or being released to the community. In six cases (10.7%), there was a role specific to one’s continuity of care (e.g. “Mental Health Discharge Planner”). In 29 cases (51.0%), the role was deferred to existing psychology services/behavioral health staff. In nine facilities (15.8%), it was managed by a “Medical Case Management Unit,” and in one (1.8%), it was managed by a forensic social worker.

Initial screening ($n = 52$): The majority of facilities first screened incoming residents for mental health issues upon admission or within 24 hours ($n = 43$, 75.4%). Other facilities either screened within the first week ($n = 2$, 3.5%) or within 2-4 weeks, ($n = 6$, 10.5%).

Criteria ($n = 45$): Most facilities have established a standardized method of classifying residents to indicate their “care level,” which corresponds to the severity of their mental issues and what kinds of care they must receive ($n = 32$, 56.1%). For example, residents with the BOP were assigned a care level of CARE1-MH (“No significant mental health care,” “shows no significant level of functional impairment associated with a mental illness,” “has no history of serious functional impairment due to mental illness”) through CARE4-MH (“Inpatient

psychiatric care,” “may meet the criteria for CARE4-MH and require acute care in a psychiatric hospital if the inmate is gravely disabled and cannot function in general population in a CARE3-MH environment”) (BOP, 2014). Nine (15.8%) allocated care to residents depending on their respective medical documentation and/or the observation of facility staff. The remaining three facilities had either standardized steps for taking one through their MHSs ($n = 2$, 3.5%) or simply made the distinction between “seriously mentally ill” and “non-seriously mentally ill” ($n = 1$, 1.8%).

Questionable Media Prevalence. *Questionable media* was present for 27 (47.4%) out of all 57 facilities in the sample. There were three lawsuits (5.3%), five reports of inadequate care via media such as news articles and studies (8.8%), one alleged case of suicide(s) related to healthcare issues (1.8%), two cases of alleged corruption among the healthcare provider or the facility owner which impacts the functioning of the facility (3.5%), five cases of relevant policy deficiencies, such as those identified in ODO reports (8.8%), and the eleven remaining facilities had multiple types of the previous media categories (19.3%). This variable is explored further in the following section regarding public vs. private facilities.

Public vs. Private Facilities

Comparing the Prevalence of Mental Health Services. An independent samples t-test was used to compare the difference between the mean number of treatment programs for the group of public facilities ($M = 9.34$, $SD = 1.97$) and the group of private facilities ($M = 8.93$, $SD = 1.88$). It indicated that the difference was not statistically significant ($t(55) = .815$, $p = .949$, 95% CI of mean difference [-0.61, 1.44]); thus, the number of treatment programs offered by a facility is likely independent from its status of private or public. To expand upon any differences between these types of facilities, Table 4 (Appendix A) demonstrates the prevalence of specific

types of MHSs among them. Chi-square tests using Fisher's Exact Test for analyzing statistical significance identified it for the frequency differences in four MHS types between public and private facilities: AA/NA ($\chi^2(1) = 10.513, p = .002$), drug abuse education ($\chi^2(1) = 24.976, p < .001$), psychological testing/evaluation ($\chi^2(1) = 25.262, p < .001$), and special MH units ($\chi^2(1) = 12.016, p = .001$).

T-tests were then conducted to compare the mean numbers of MHSs available between state-level facilities ($n = 22, M = 9.27, SD = 2.37$) and those owned by the BOP ($n = 25, M = 9.56, SD = 1.04$). The mean difference between the groups was very small (-0.29) and not statistically significant ($t(45) = -0.548, p = .586$, 95% CI of mean difference $[-1.34, 0.77]$). This showed the possibility that most facilities in the country offer similar numbers of MHS types regardless of both government level and status as public or private.

One of the questions initially posed in this study was "what factors appear to be associated with their [MHS] availability?" Additional factors, or independent variables, to consider would be population/capacity, security level, gender of residents, and each of the government levels recorded. However, because there were no significant differences among these variables with respect to the number of MHSs, and sometimes not enough facilities in each of a variable's levels to produce good results, a separate analysis was not conducted to answer this question.

Facility Transparency. The difference in transparency between public and private facilities unfortunately could not be empirically evaluated, because only one facility was willing to submit information for the study. It was coded "extremely transparent" because it submitted a survey response after a brief phone conversation between the author and a staff member of its managing DOC. To reiterate, the only MHS-related services it supported were psychiatric

services, which are managed/provided by a separate DOC prison facility, and a few self-help group programs as per an activity budget published online in approximately 2021.⁷ However, notably, many of the owners of public facilities (e.g. state DOC, BOP) had policy and procedure documents directly related to MHSs available to the public on their websites (not facility-specific), such as the aforementioned 2014 BOP Program Statement, and facility handbooks for residents, which also provide some health/MH service information. None of the private facility owners had publicly published any of the same kinds of policy or procedure documents. Their chosen methods of providing MHS-related information typically consisted of infographics and annual reports, if they provided any at all, such as CoreCivic's aforementioned 2020 ESG report. Naturally, the policy and procedure documents reviewed for this study were usually much more informative than the other materials, as the other materials are meant to concisely convey lots of information on different topics. The only private facility owner to provide MHS-specific materials to the public was ICE via infographic (U.S. Department of Homeland Security & U.S. Immigration and Customs Enforcement, 2022), which addressed many of the MHS-related variables in the dataset, but not all of them. Based on this information, it appears that public facilities and the entities which own them had greater transparency when it comes to sharing their non-facility-specific policies and procedures publicly.

Comparing the Prevalence of Questionable Media. In terms of questionable media, Table 6 (below) and Table 5 (Appendix B) demonstrate the results of cross tabulations and a chi-square test to compare the frequencies between public and private facilities, and the frequency measures of some additional characteristics of interest. The result of the chi-square test indicated that the difference in questionable media prevalence between public ($n = 10$, 34.5% of public

⁷ Reference not provided in order to maintain confidentiality for the participating facility.

facilities) and private ($n = 17$, 60.7% of private facilities) facilities was significant ($\chi^2(1) = 3.932$, $p = .047$). Though there were not enough facilities for which the MHS provider was known to draw any meaningful conclusions, it may be worth acknowledging that four out of four facilities staffed by Wellpath (a for-profit medical and behavioral health care company providing services in the U.S. and Australia (Lyon, 2018)) were associated with questionable media: one lawsuit, one report of alleged corruption, and two facilities with multiple media types. The facilities were located in California, Kentucky, Oklahoma, and Florida; the former three were private, and the fourth was public.

Table 6

*Questionable Media Prevalence among Additional Facility Characteristics
(Percent within characteristic)*

Characteristic	Yes <i>n</i> (%)	No <i>n</i> (%)	Total <i>n</i> (%)
Region			
Western	4 (28.6)	10 (71.4)	14 (100.0)
South Central	4 (33.3)	8 (66.7)	12 (100.0)
North Central	4 (66.7)	2 (33.3)	6 (100.0)
Southeast	5 (50.0)	5 (50.0)	10 (100.0)
Northeast	5 (50.0)	3 (37.5)	8 (100.0)
Mid-Atlantic	5 (62.5)	2 (28.6)	7 (100.0)
Community Type			
Rural	9 (60.0)	6 (40.0)	15 (100.0)
Suburban	16 (41.0)	23 (59.0)	39 (100.0)
Urban	2 (66.7)	1 (33.3)	3 (100.0)
Government Level			
State	11 (50.0)	11 (50.0)	22 (100.0)
BOP	8 (32.0)	17 (68.0)	25 (100.0)
US ICE and/or US Marshals	6 (75.0)	2 (25.0)	8 (100.0)
Both state and federal agencies	2 (100.0)	0 (0.0)	2 (100.0)
Owner			
CoreCivic	8 (66.7)	4 (33.3)	12 (100.0)
LaSalle	2 (100.0)	0 (0.0)	2 (100.0)
MTC	2 (40.0)	3 (60.0)	5 (100.0)
GEO Group	4 (50.0)	4 (50.0)	8 (100.0)
Central Falls Detention Facility Corp.	1 (100.0)	0 (0.0)	1 (100.0)
Security Level			
Minimum	2 (28.6)	5 (71.4)	7 (100.0)
Low	2 (25.0)	6 (75.0)	8 (100.0)
Medium	10 (45.5)	12 (54.5)	22 (100.0)

High	5 (83.3)	1 (16.7)	6 (100.0)
Mixed	6 (60.0)	4 (40.0)	10 (100.0)

Note. Note. Follow-up chi-square tests could not be conducted for any characteristic variables due to too many cell counts fewer than the expected count of five and Fisher's Exact Tests could not be conducted due to cross tabulation table dimensions greater than 2x2.

Discussion

This study provides us with a general idea of the state of MHSs in American prison facilities today and whether they differ based on basic facility characteristics. It contributes to the mixed nature of research findings on this topic in terms of private versus public facilities; here, the hypothesis that private facilities would have fewer MHSs was unsupported. It also demonstrates that the state, federal, and other governmental entities seem to be on the same page in terms of best practices for prison facility MHSs on a surface level. The prevalence of certain MHS types did vary based on characteristics such as facility type, region, and community type, but it cannot be safely concluded that this is accurate to what is genuinely available. If any facility characteristics truly contribute to the extent of MHS availability, they are likely not any of the characteristics that were observed in this study. Questionable media associated with both private and public prisons reminds us that despite the presence of policies and procedures, there may be flaws with MHS quality, delivery, and/or accessibility that is reminiscent of research findings based on data from over a decade ago (Baćak & Ridgeway, 2018; Terry et al., 2018).

MHSs that are applicable to more individuals, such as psychiatric services and group therapy, appeared to be more frequently available than those required for fewer individuals, and in particular, treatment for those convicted of sexual crimes. This makes sense, as different facilities are often dedicated to serving specific demographics of individuals. For example, certain BOP facilities offer Sex Offender Management Programs, which are meant to take those

individuals and house them together for the purpose of “population management” (BOP, 2013, p. 4).

Individual therapy/counseling was widely available (in at least 82.5% of the facilities in the sample), which is contrary to what was expected considering that there was often what seemed like few psychology services staff at a given facility compared to the size of a facility’s population. For example, in one public BOP facility with a population of 1,015, facility documents noted that the psychology services department consists of 8 psychologists and 5 treatment specialists. However, no data on MHS usage or demand for the facility were available, so it is possible that 13 staff are adequate to address the mental health needs of the facility’s population. Lastly, it would be ideal to see AA/NA available in greater than 73.7% of facilities, considering the large proportion of individuals with substance abuse issues in prisons across the country.

Since much of the data for the sample were pulled from broad, non-facility-specific documents/policies, it also makes sense that there were no significant differences in the average number of MHSs available between geographic regions and community types. There were some notable differences in the cross tabulation results; the prevalence of drug abuse education in rural communities ($n = 5$, 35.7%) differed greatly from that in suburban communities ($n = 27$, 71.1%), and the prevalence of special MH units was different between rural communities ($n = 5$, 57.1%) and suburban communities ($n = 15$, 38.5%). The difference in prevalence between regions for AA/NA and residential drug treatment is interesting as well; the former prevalence ranged from 58.3% (South Central)-100.0% (Mid-Atlantic), and the latter from 25.0% (South Central)-60.0% (north Central). It could not be determined whether any of these differences were statistically significant, so the following discussion is merely speculation.

The most obvious explanation for these differences is simply chance; maybe the facilities selected within these regions and communities just happened to be those that did or did not provide certain services. It could also be that the facilities behind the lower prevalence percentages did have the services they appear to lack, but did not report it in their public documents. Otherwise, it is possible that the difference in drug abuse education between rural and suburban communities was because public facilities ($n = 26, 89.7\%$) were much more likely to offer it than private facilities ($n = 6, 23.1\%$), and there were more public facilities in suburban communities ($n = 24, 82.8\%$) than private facilities ($n = 15, 53.6\%$). However, only 15 facilities were in rural communities versus 39 in suburban communities, so comparisons between community types may not be accurate. Heat maps created by the Substance Abuse Mental Health Services Administration (SAMHSA) (2021) based on the 2019-2020 National Survey on Drug Use and Health show that the rate of substance use disorder was higher in people age 12 and up in the North Central region than in the South Central region. This could explain the lower prevalence of residential drug treatment in the South Central region. The lower prevalence of AA/NA is not entirely explained by this theory, though, because the rate of alcohol use disorder was slightly higher in the South Central region than in the Mid-Atlantic region (SAMHSA, 2021).

Another unsupported hypothesis is that the states' wealth would have some effect on their number of treatment programs. This is a very good thing, as MHS accessibility may not be hindered by a state having less money to spend on supporting these services. This observation is highly surface-level, though, and is missing important context, such as the quality of the services available in states of higher or lower wealth, and their psychology departments' capacities. All

that can be observed from this finding is that regardless of wealth, American prisons should be offering approximately the same amount and types of different MHSs.

It was hypothesized that private facilities would offer fewer MHSs to their residents on average. This is mainly because the author did not previously consider that many private facilities are held to the standards set by state- or federal-level policies and procedures. Therefore, there *should not* have been a significant difference between public and private facilities, especially since it is likely that there was a consensus among their respective government levels' policies regarding best MHS practices. This contrasts with Baćak and Ridgeway's (2018) finding based on data from 2005 that private prisons offer fewer MHSs, but aligns with Makarios and Maahs's (2012) finding based on data from 2000. The difference could be methodological; Makarios and Maahs's (2012) study design was more similar to this one, while the other was less clear regarding the computation of the variable *psychological/psychiatric programs*. Sample selection, group comparisons, and statistical analyses were also different among the three studies, which could have contributed to the variance in results.

The analyses revealed statistically fewer available AA/NA and drug abuse education programming in private facilities than public, and fewer available psychological testing/evaluation services and special MH units in public facilities than private. This is interesting considering that private facilities have historically hosted large populations of individuals convicted of drug-related crimes. The latter two differences make more sense; there are likely fewer prison facilities within a state than there are federal facilities across the country, therefore it is more likely that the private facilities selected for the sample are facilities with designated population types. The presence of psychological testing/evaluation and special MH

units point towards populations with greater psychological health needs, however, which also does not align with the assumption that private facilities host populations with fewer health needs. It is possible that the lower count for special MH units in public facilities occurred because approximately 111 BOP facilities have one of three types of restrictive housing units, *special housing units*, and they can be used to house residents with mental illness, but there are no absolute policies or guidelines for managing this (Office of the Inspector General, 2017). Facilities were not coded as having a special MH unit unless it was explicitly stated that it was used for accommodating those with mental illness. Therefore, public federal facilities in the sample that used restrictive housing units for this purpose but did not say so in facility-specific documents were likely not included in the special MH unit count.⁸ Future research on this topic should seek clarity on the prevalence of these types of services to gain a more accurate understanding of any differences between public and private facilities.

Although this study was unable to judge the “true” transparency levels of the different types of prison facilities, there was some evidence supporting the evolution of transparency among correctional facilities when it comes to health/mental health care. Makarios & Maahs (2012) made an interesting and surprising observation, “preliminary analysis of the data revealed federal prison administrators systematically failed to answer questions regarding particular sets of questions” (p. 343), which included their measures of health and mental health care. It seems that federal facilities were reluctant to be transparent about this in the year 2000, but since then, the BOP has made public *Inmate Admission & Orientation Handbooks* for most of its facilities online as well as its program statements regarding health care. It is possible that a similar

⁸ There is evidence that using restrictive housing for those with mental illness in BOP facilities is not beneficial to them, and possibly even harmful, so it is questionable in terms of whether it positively contributes to their MHSs; see Office of the Inspector General (2017).

phenomenon could have occurred among the private facilities in this study (perhaps in the form of refusing to participate) since they have not published any policies, but this hypothesis would have to be tested in a future study.

What *has* occurred is that the majority of the facilities in the sample did not acknowledge the invitation to participate in the study. Eleven out of the 12 that did respond either pointed the author towards burdensome and time-consuming procedures necessary to gain information for research purposes or towards generalized online resources. One facility operated by the GEO Group rejected the invitation without providing any additional resources or information, and this facility was the only one to respond out of the 13 private facilities who were invited to participate via mail. It makes sense that the facilities whose owners/operators require researchers to undergo said procedures to collect data would not be able to participate in a study without prior approval. What is interesting is the complete lack of engagement by so many facilities, especially by those that may not be held to such procedural standards, such as the public state-level facilities and private facilities owned by smaller correctional corporations. Why did so many facilities ignore it rather than provide some kind of helpful direction, at the least? Additionally, the only facility that participated was the only one that does not offer any MHSs. We could speculate that the prison facilities did not want researchers to investigate their MHSs because their findings would not be in the facilities' favor. Maybe they did not want to contribute their time to research studies without being compensated for it. On the other hand, maybe they were simply too busy to address every email or letter they receive due to the extensive demands placed upon the American carceral system. Either way, we do not know all of the reasons for such lack of engagement, and we now know that data collection for research purposes within the

carceral system requires lots of time and planning, even if a study does not involve human subjects.

Nearly half of all facilities in the sample were accompanied by a form of questionable media, and the private facilities had slightly significantly greater counts of it than did the public facilities. Over half of the 17 private facilities ($n = 9$, 52.9% of private facilities, 15.8% of all facilities) were associated with multiple types of this media. For example, researching the MHSs at Richwood Correctional Center (Louisiana) brought a few significant issues to light. In 2020, the U.S. Department of Homeland Security's Office for Civil Rights and Civil Liberties published a memo regarding "concerns at Richwood including medical and mental health treatment, suicide prevention, PREA, use of force, food storage and laundry service" following an onsite investigation (Mina & Salvano-Dunn, 2020, p. 1). The investigation was likely instigated by the case of Roylan Hernandez Diaz, a resident who died by suicide in October 2019 after taking part in a hunger strike and subsequently being placed in administrative segregation. Much of the memo's text was redacted, but it contained policy recommendations for improving suicide prevention, staff training, telepsychiatry, mental health documentation, medical records, professional conduct, and confidentiality (Mina & Salvano-Dunn, 2020). The other media, an ODO compliance inspection report from 2021, flagged four relevant policy/procedure deficiencies. Richwood "did not verify that health care staff are licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements, "does not maintain copies of all health care licenses or credentials onsite and readily available for review," did not inquire about several mandatory health topics on the women's initial health assessment form, and "did not document monitoring every 15 minutes" for one out of 11 suicide watch logs (ODO, 2021, pp. 8-9). The research completed for this study indicated that usually the agencies

providing health care at a facility also provide its mental health care services, so these documents illustrate the ways in which correctional health and mental health care can fall short.

In addition, this study merely observed the issues that were brought to light while researching the facilities' MHSs; locating all existing questionable media for each facility was not part of the study methodology. If it was, perhaps there would be a more even spread of questionable media among public and private facilities. It could also be that privately run prisons are under greater scrutiny due to the increase in anti-private-prison rhetoric among the public in recent years,⁹ so media outlets and studies are more likely to report on the issues among them than on their public counterparts. Alternatively, there could be more issues worth documenting via questionable media among the public facilities, but government entities have a greater ability to suppress it. If it is true that private prisons' MHS conduct creates more significant issues than those in public prisons, perhaps the difference lies in the delivery and quality of the services themselves. It was beyond the scope of this study to investigate the specific program models used in each facility; it could be that one provider's approach to group therapy/counseling is not evidence-based and/or is less effective than is another's. Plus, not enough data could be collected to discern whether the variables MHS Provider and Employer were associated with questionable media or facility type. A more thorough study on this topic would be useful for addressing these concerns and understanding any patterns or trends in the issues plaguing U.S. prisons, and possibly, for identifying why those patterns or trends may be occurring.

Previous studies have shown that in the past, private and public, and even state and federal prisons may have varied significantly in the availability and scope of their MHSs. This study is likely the first to collect up-to-date data on MHSs in prison facilities across the country,

⁹ See for example, Private Prison News (n.d.).

and at the least, its findings demonstrate that prison facilities of all types are allocating time and energy to providing comprehensive MHSs to their populations. While the findings provide some evidence for promising similarities between public and private prisons, it is accompanied by questions, observations, and limitations that should be addressed in future research. It also shows that it is still relatively common for significant adverse events related to health and mental health services to take place. This should serve as a call to action to prisons to consistently, and not reactively, evaluate their health providers for quality and efficacy, as putting policies in place may not be enough to prevent further harm.

Limitations

It was the author's intent to collect data directly from prison facilities across the U.S. so that an updated and accurate understanding of their MHSs is available. Though some facility-specific documents were available, the most important limitation in the study methodology is that not all data was facility-specific due to the lack of engagement by facilities; thus, the accuracy of the data that was collected could not be validated by facility representatives/staff. Therefore, *the results only pertain to the information that the facilities and their governing entities had chosen to share with the public*, and it is not guaranteed that the generalized policies/practices set by those entities were applicable to the facilities in the sample or up-to-date.

Relatedly, approximately 10 private facilities and 25 public facilities contained data related to MHS roles and procedures that were collected from generalized documents, and most likely all of the facilities in the sample contained data on the types of MHSs provided based on generalized documents as well. It was assumed that there was policy compliance among the facilities in the sample, but was not always clear whether certain policies applied to certain kinds

of facilities. For example, policy documents from state DOCs did not always indicate whether the policies applied to both their public and private prison facilities. It was assumed that a given private facility's MHSs would be informed by the policies set by their governing jurisdictions if it was not explicitly stated. If that is true, then it is not so much a matter of "what do private versus public facilities do" that this study observed than it is "what do different government entities do versus what the BOP does." Because of this, while this study expands upon previous research on MHSs in public and private prisons, it lacks the context that is crucial for truly understanding them and any differences. Again, there was a lack of data on the Employer and MHS Provider variables and the quality of services being provided in each facility. The number of different types of services provided is not necessarily meant to operationalize the adequacy of a facility's MHSs, and there was no way to assess this. These details could have explained why private prisons were associated with greater questionable media or whether there are any true differences between the MHSs in public and private prisons.

Naturally, due to the method of data collection, the amount of resources that were used to collect data varied from facility to facility. For some, there may have only been one Web page and a single government report that mentioned MHSs, but for others, there may have been multiple news articles, one or two handbooks, and multiple different types of government reports. This impacted the amount of data that was collected for each of the variables, and further complicates the matter of whether all of the data was up-to-date and accurate. Missing data could have skewed the outcomes of certain analyses in favor of the facilities for which there was more information available. Certain types of sources might have been more accurate or specific with their reporting than other types (e.g. ODO reports versus news articles). Different sources might have offered conflicting information, in which case the author investigated further and judged

which was most likely to be correct. This is especially applicable for comparisons between public and private prisons, as most of the public facilities were consistent with the information available and their ownership, while private facilities had fewer resources available overall and more variability among owners and government levels.

Another methodological limitation is that the language used to describe MHS-related constructs (roles, procedures, and types of services) from facility to facility was not universal and not always specific, which led to certain assumptions. This occurred the most often with substance abuse treatment services because it was frequently not indicated whether said services were residential or nonresidential. If a facility did not explicitly say which kind it offered, it was assumed that the service was nonresidential because that kind is more common (e.g. nonresidential substance abuse treatment is available in all BOP facilities, but residential substance abuse treatment is not). The data might not be completely accurate because of this issue as well, and having had the input of the facilities themselves might have ameliorated this.

Similarly, the operationalization of *community type* and the utilization of *state wealth ranking* were not precise. *Community type* was coded based on a subjective judgment by the author, which depended on a facility's proximity to an established community and the density of said community. The variable could have been better standardized if the author had relied on a resource such as the website Niche to provide a calculated determination (i.e. "area feel") (Niche, 2021), which possibly could have created more evenly-sized and thus comparable *community type* groups, although it would have added six more levels to the variable. *State wealth ranking* was used under the assumption that it could represent how many resources a given facility could allocate towards supporting its MHSs. However, this assumption does not necessarily reflect the degree to which MHSs were supported by its funding agencies. A

different, possibly more direct way to look at this could be to identify budget reports by the facilities' operating agencies and the amounts allocated to their correctional facilities' health/mental health programming, and standardize those amounts to reflect approximately how much support the MHSs are receiving with respect to how costly they are in the state. We must consider the possibility that this operationalization could have resulted in a significant association with MHS availability, while the operationalization used did not.

This study used a form of random sampling to create a sample of prisons that is close to representative of those in America. This works well when observing the 57 facilities as a whole, but it could pose issues in terms of the public vs. private comparisons. Baćak and Ridgeway (2018) made the point that “adequately matching private with public prisons has been identified as a critical but rarely used strategy in research on prison privatization” (p. 7), so their methodology consisted of matching them based on facility characteristics. Indeed, this study did not seek to match the two types of facilities on any characteristics. The sample of private facilities is especially of concern in this regard because it contained greater variability in terms of variables such as government levels and gender of residents. There was not enough data to demonstrate whether other types of facilities differed from one another in terms of MHS availability, such as ICE facilities vs. state-level facilities, so if there were any true differences, they might have also affected comparisons between public and private facilities. Despite this, the current study sought to demonstrate differences between samples of public and private facilities as a whole, which justifies the discussions on alternative explanations for any differences between them.

Finally, this study only sampled prisons from states that had a private prison at the time of data collection for the sake of comparable group sizes. This resulted in a study that represents

fewer than half of the states in the U.S., which may in turn have produced inaccurate results in terms of the group of public facilities. The sample size was also somewhat small considering there are over 100 BOP facilities in the country alone (Office of the Inspector General, 2017), and at least 80 private facilities were considered for selection. Future studies observing MHSs in American prisons in general should consider selecting more than two or four prison(s) from all 50 states for more representative results.

Conclusion

There is little existing research on what MHSs look like in American prisons, let alone research using data from the past decade and research that compares public and private prisons with respect to MHSs. This study analyzed MHSs in these types of facilities using the most contemporary, publicly available online materials that could be found. It appears that in states with a private prison, the MHSs in private and public facilities are comparable in type and prevalence, both of which are unrelated to basic demographic and facility characteristics. However, considering that nearly half of this study's sample was associated with some form of relevant questionable media, it seems that there may still be ongoing issues with MHSs in correctional facilities despite the amount of services that are in place. It is also possible that private prisons' MHSs are not quite as adequate or are associated with greater adverse events than those in public facilities, as demonstrated by their respective prevalence of questionable media. Future studies should seek to clarify this study's findings by improving facility engagement/collecting data directly from the facilities themselves and observing the quality and capacity of the services offered within them. Being incarcerated is a psychologically damaging experience at the least, and those residing in prisons both deserve and have the right to adequate mental health treatment.

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Appendix A

Table 4

*Mental Health Service Prevalence within the Public and Private Prison Facilities
(Percent within facility type)^a*

MHS	Public <i>n</i> (%)	Private <i>n</i> (%)	Total <i>n</i> (%)	Chi-Square	<i>p</i> -value
AA/NA	27 (93.1)	15 (55.6)	42 (75.0)	10.513	.002
Crisis Intervention	27 (93.1)	25 (92.6)	52 (92.9)	.006	1.000
Diagnosis of Mental Disorder	26 (89.7)	25 (92.6)	51 (91.1)	.148	1.000
Drug Abuse Education	26 (89.7)	6 (23.1)	32 (58.2)	24.976	.000
Group Therapy/Counseling	28 (96.6)	36 (96.3)	54 (96.4)	.003	1.000
Individual Therapy/Counseling	22 (75.9)	25 (89.3)	47 (82.5)	1.774	.297
Nonresidential Drug Treatment	27 (93.1)	22 (81.5)	49 (87.5)	1.727	.244
Nonresidential Sex Offender Treatment	3 (10.3)	4 (14.8)	7 (12.5)	.255	.700
Psychiatric Services	29 (100.0)	27 (96.4)	56 (98.2)	1.054	.491
Psychological Testing/Evaluation	6 (20.7)	23 (88.5)	29 (52.7)	25.262	.000
Residential Drug Treatment	15 (51.7)	8 (29.6)	23 (41.1)	2.820	.111
Residential Sex Offender Treatment	1 (3.4)	1 (3.8)	2 (3.6)	.006	1.000
Special MH Units	7 (24.1)	19 (70.4)	26 (46.4)	12.016	.001
Other Elective Programs	28 (96.6)	25 (92.6)	53 (94.6)	.432	.605

^aPercent values reflect the prevalence among facilities for which information on an MHS could be obtained. Sample sizes for each MHS are as follows: AA/NA ($n = 56$), crisis intervention ($n = 56$), diagnosis of mental disorder ($n = 56$), drug abuse education ($n = 55$), group therapy/counseling ($n = 56$), individual therapy/counseling ($n = 57$), nonres. drug treatment ($n = 56$), nonres. sex offender treatment ($n = 56$), psychiatric services ($n = 57$), psychological testing/evaluation ($n = 55$), res. drug treatment ($n = 56$), res. sex offender treatment ($n = 55$), special MH units ($n = 56$), and other elective programs ($n = 56$).

Appendix B

Table 5

*Questionable Media Prevalence among the Public and Private Prison Facilities
(Percent within facility type)*

Media Type	Public <i>n</i> (%)	Private <i>n</i> (%)	Total <i>n</i> (%)	Chi-Square	<i>p</i> -value
Lawsuit	2 (20.0)	1 (5.9)	3 (11.1)	-	-
Reports of inadequate care	3 (30.0)	2 (11.8)	5 (18.5)	-	-
Suicides related to healthcare issues	1 (10.0)	0 (0.0)	1 (3.7)	-	-
Alleged corruption	1 (10.0)	1 (5.9)	2 (7.4)	-	-
Relevant policy deficiencies	1 (10.0)	4 (23.5)	5 (18.5)	-	-
Multiple types	2 (20.0)	9 (52.9)	11 (40.7)	-	-
Total	10 (100.0)	17 (100.0)	27 (100.0)	3.932	.047

Note. Follow-up chi-square tests for Questionable Media Type and Facility Type could not be conducted due to too many cell counts fewer than the expected count of five and Fisher's Exact Tests could not be conducted due to cross tabulation table dimensions greater than 2x2.