Characteristics of the Behavioral Health Workforce in Correctional Facilities

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Table of Contents

Key Findings 1
Background 2
Methods 3
Findings 3
Conclusions 10
References 11

KEY FINDINGS

The majority of incarcerated individuals who have mental health conditions and/or substance use disorders do not receive adequate treatment. Behavioral health interventions during incarceration yield positive health outcomes for those in the correctional system. This study seeks to better characterize the workforce capacity in correctional settings.

Surveys were conducted with twenty corrections representatives from six states. The survey instrument included six main themes: facility setting; behavioral health workforce characteristics; behavioral health workforce development initiatives; recruitment and retention efforts; scopes of practice for the behavioral health workforce providing services in correctional settings; and workforce efforts in transitioning out of incarceration.

Survey results show that 70% of respondents agree that their facility has difficulty retaining competent behavioral health staff; 85% agree that their facility has difficulty filling open behavioral health positions and has high turnover of behavioral health staff. Nearly all (95%) respondents offer behavioral health services to individuals who will soon be released from the facility, and about 70% of facilities indicated that their behavioral health staff perform duties that match state-established scope of practice guidelines.

BACKGROUND

More than half of all individuals in correctional facilities experience a mental health issue, with 70% also experiencing a co-occurring substance use disorder (SUD).[1] Although the majority of prisons and jails screen for, assess, and provide treatment for mental health conditions, few inmates receive adequate mental health treatment.[2] In a study authored by James and Glaze,[3] only 34% of inmates in state prisons, 24% in federal prisons, and 17% in local jails receive mental health treatment after admission to a correctional facility. Further, many are not treated for SUD.[2] Access to behavioral health care in correctional facilities is critical, as inmates with mental health conditions and SUDs are more likely to recidivate than inmates without.[4] Additionally, access to services at the start of the transition back into the community is vital for determining reentry success and minimizing the likelihood of recidivism.[5]

The behavioral health workforce shortage within the correctional system, combined with the behavioral health provider shortage in the U.S., limit the workforce available for the incarcerated population.[6] The Health Resources and Services Administration projects that by 2025, there will be shortages in five major behavioral health worker disciplines.[7] To supplement these shortages, some institutions have begun to use service extenders to increase access to care. Correctional officers play a central role in caring for inmates who have behavioral health disorders, including assisting with interventions.[8] Further, a study on Texas Correctional Facilities showed that peer recovery specialists can improve health outcomes and reduce recidivism among incarcerated populations.[4]

The high demand for mental health services along with strained behavioral health workforce capacity affects the availability of in-facility transition/re-entry planning services.[9] Six of the 10 states in the U.S. with the lowest access to mental health care also have the highest incarceration rates (Alabama, Arkansas, Mississippi, Texas, Georgia, and Florida),[10] and wait times for mental healthcare services in correctional facilities can be up to 12 months.[11] A 2011 study by Fuehrlein et al.[11] found that 72% of suicides in correctional facilities were deemed foreseeable and preventable, and involved some measure of inadequate assessment, treatment, or intervention.

This study, conducted by the Behavioral Health Workforce Research Center at the University of Michigan, aimed to better characterize the behavioral health workforce in correctional facilities. Study

findings summarize barriers and best practices to improving employee retention and increasing behavioral health workforce capacity in correctional facilities.

METHODS

This study consisted of an organizational survey of correctional facilities. The survey instrument was developed from literature review findings and existing questionnaires conducted in correctional facilities. Researchers used Qualtrics survey software to develop the online questionnaire. The University of Michigan Institutional Review Board deemed the organizational-level survey exempt from ongoing review. The survey included 25 questions organized into the following themes:

- facility setting;
- behavioral health workforce characteristics;
- behavioral health workforce development;
- recruitment and retention of the behavioral health workforce;
- scopes of practice of the behavioral health workforce practicing in correctional facilities; and
- workforce involved in transitioning the incarcerated population to decarceration.

The survey was disseminated in February–March 2018 by MHM Services, Inc. (MHM) on behalf of the Behavioral Health Workforce Research Center. MHM provides medical, behavioral, and dental health services to governmental agencies, including state hospitals, courts, juvenile facilities, community clinics and correctional facilities. MHM specifically provides correctional facility behavioral health services in 16 U.S. states, six of which agreed to participate in the study. A total of 20 organizational representatives participated in the survey. Representatives at MHM were sent a recruitment e-mail with an overview of the Behavioral Health Workforce Research Center's research activities, a summary of the importance of the study, and an invitation to participate in the survey.

FINDINGS

Facility Setting

All participating correctional facilities reported provision of behavioral health services for incarcerated individuals. Responding facilities are located in Georgia, Massachusetts, New Mexico, Pennsylvania, Mississippi, and Vermont. The number of individuals currently incarcerated in 18 (90%) of the reporting correctional facilities ranged from 240 to 19,000, with a mean of 2,239 individuals.

Seventeen (85%) of the responding facilities described their correctional facility as state funded, whereas two (10%, 2/20) described their facility as private/for-profit and one (5%, 1/20) described their facility as county-funded. Eighteen (90%) responding facilities described their correctional facility as State Adult Correctional Facility, whereas two (10%) respondents described their correctional facility as County or City Adult Correctional Facility.

Workforce Characteristics

All responding facilities reported that behavioral health workers practice in an integrated care team to provide health services. The three types of primary health care professionals with whom facilities reported their behavioral health providers work include Correctional Nurses (present in 21.5% responding facilities), Primary Care Providers in Facility (20.3%), and Case Managers (15.2%). The number of regularly employed full-time behavioral health staff members in the responding correctional facilities averaged to 19 with a range of 2.5 to 36.8 staff. Table 1 summarizes the distribution of worker FTEs across behavioral health occupations. The behavioral health occupations with the greatest maximum FTEs were Mental Health Counselors, Clinical Social Workers (Master's Level), and Psychologists.

Table 1. Distribution of Full-Time Equivalents Across Behavioral Health Occupations Within Correctional Facilities

Occupation	n	Mean Number of Workers per Facility	Maximum Number of Workers per Facility
Mental Health Counselor	19	4.7	23
Clinical Social Worker (Master's Level)	20	3.1	16
Psychologist	20	1.0	10
Licensed Practical/Vocational Nurse	20	0.6	7.2
Psychiatrist	19	1.4	6.8
Advanced Practice Registered Nurse	20	0.4	5
Registered Nurse	20	0.8	4.2
Marriage and Family Therapist	20	0.3	4
Case Manager	20	0.2	4
Primary Care Physician	20	0.2	3

Addiction Counselor	20	0.2	3
Psychiatric Aide/Technician	20	0.1	2
Physician Assistant	20	0.1	2
Behavioral Health Specialist	20	0.2	2
Pharmacist	20	0.1	1
Other	19	0.9	5

Note: no responding correctional facilities employed Peer Support Specialists. The range minimum was 0 for all occupations except Clinical Social Worker, which was 1. Responding facility totals presented correspond to the number of facilities that provided data for each occupation, out of twenty total facilities present in the study.

Workforce Development Initiatives

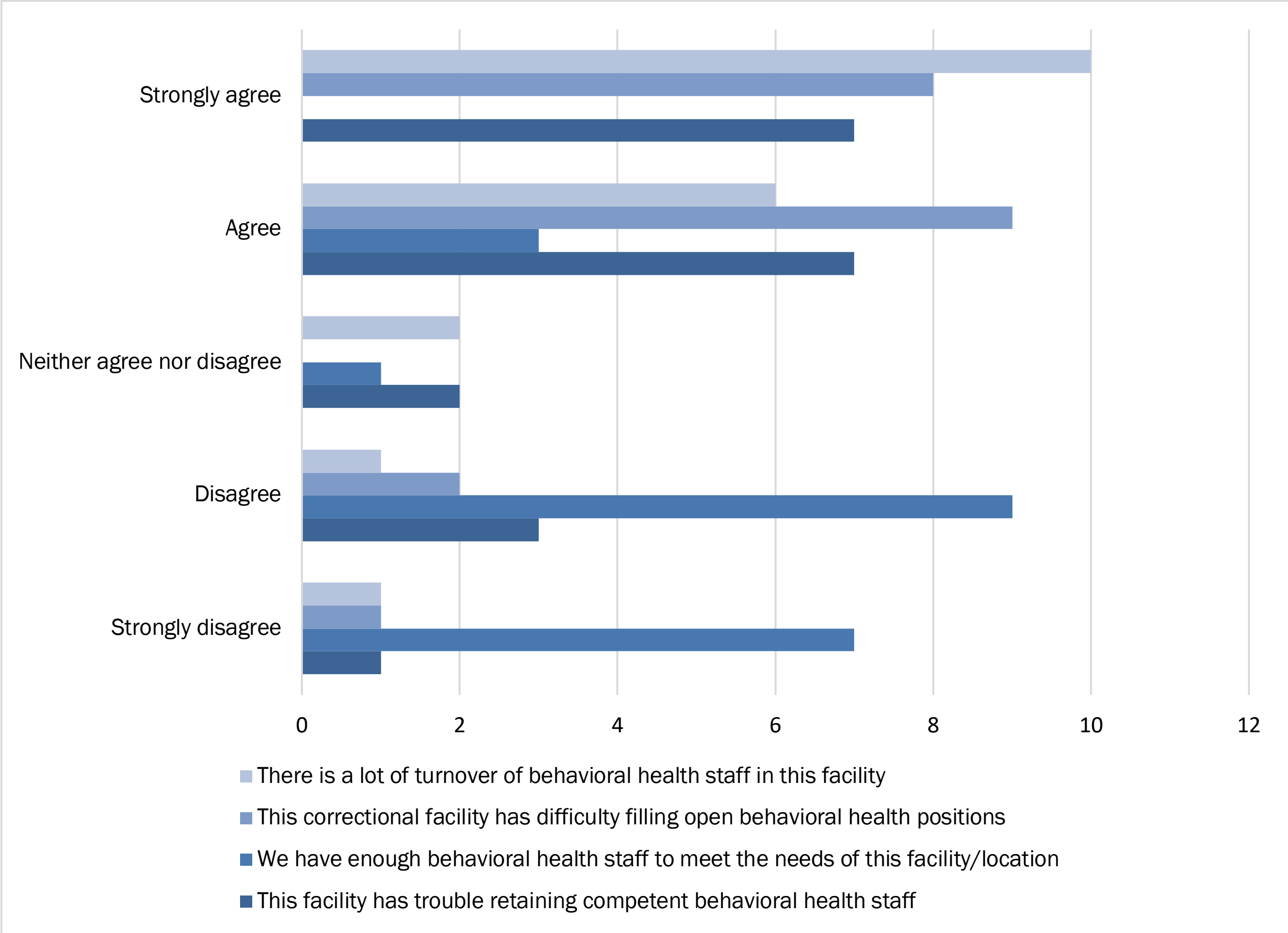
All 20 responding facilities reported their organization provides on-site training for behavioral health providers. Nineteen (95%) pay for fees associated with trainings, 18 (90%) allow use of working hours to participate in training, and 16 (80%) facilities assess behavioral health training needs on an annual basis, and/or provide employees recognition of training completion. Additionally, 15 (75%) include competence in job descriptions, and/or include education and training objectives in performance reviews and 13 (65%) facilities have a designated staff member responsible for development and implementation of training activities and/or track behavioral health provider participation in training activities. Responding facilities also identified three main knowledge/skill areas in which their correctional staff requires additional behavioral health service training: 1) understanding and dealing with security issues (11.9%, 14/118); 2) treatment models, methods, and planning (11%, 13/118); and 3) professional and ethical responsibilities (9/118, 7.6%).

Recruitment and Retention

From a list of 11 response choices, facility representatives were asked to identify all strategies they use to recruit and retain behavioral health staff. Twelve (19.7%, 12/61) facilities reported offering competitive health coverage of other benefits, 11 (18%, 11/61) provide competitive salary offerings, ten (16.4%, 10/61) reported offering ongoing training opportunities, and nine (14.8%, 9/61) identified employee recognition/appreciation opportunities as a strategy.

Most correctional facilities in this study disagreed or strongly disagreed that they have enough behavioral health staff to meet the facility's needs (85%, 16/20). Further, the majority of respondents "agreed" or "strongly agreed" that: their correctional facility has difficulty filling open behavioral health positions (85%, 17/20); there is a lot of turnover of behavioral health staff in their facility (80%, 16/20); and their facility has trouble retaining competent behavioral health staff and that (70%, 14/20) (Figure 1), with 93 unfilled positions open at the time of survey administration.

Figure 1. Correctional Facility has Difficulty Retaining Competent Staff (n=20)



Responding facilities also identified issues that are barriers "to a great extent" for people entering the behavioral health workforce in a correctional setting. Table 2 depicts the barriers for those entering the behavioral health workforce in correctional settings.

Table 2. Barriers for people entering the behavioral health workforce in a correctional setting

Barrier	n	Not at all	Very Little	Somewhat	To a Great Extent
Difficulties providing care in correctional setting	16	0 (0%)	2 (13%)	5 (31%)	9 (56%)
Administrative work/Required effort	18	0 (0%)	2 (11%)	6 (33%)	10 (56%)
Inadequate compensation	18	2 (11%)	1 (5%)	5 (28%)	10 (56%)
Competition from other fields	17	2 (12%)	3 (18%)	4 (23%)	8 (47%)
Stigma	16	0 (0%)	7 (44%)	4 (25%)	5 (31%)
Concerns about working with correctional population	17	0 (0%)	3 (18%)	9 (53%)	5 (29%)
Little opportunity for career advancement	18	1 (5%)	5 (28%)	7 (39%)	5 (28%)
Cost or amount of education/Training needed to work in corrections	15	3 (20%)	7 (47%)	3 (20%)	2 (13%)
Lack of encouragement	17	1 (6%)	10 (59%)	5 (29%)	1 (6%)
Discrimination/Demographic preferences	16	6 (37%)	7 (44%)	2 (13%)	1 (6%)
No barriers to entering the field	12	7 (58%)	2 (17%)	2 (17%)	1 (8%)

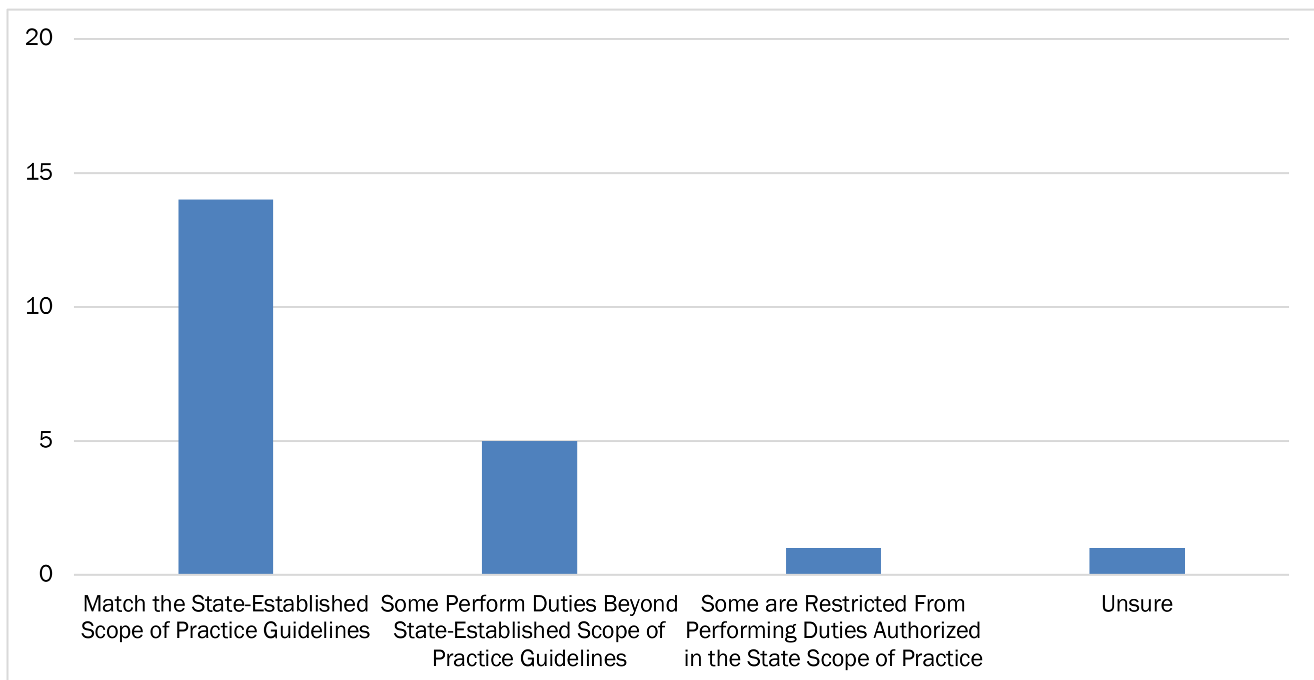
Note: Responding facility totals presented correspond to the number of facilities that provided data for each barrier specified, out of twenty total facilities present in the study.

Correctional institution representatives identified the following open behavioral health staff vacancies their facilities are currently seeking to fill: mental health counselors (33 available positions across all 20 facilities), psychiatrists (11), master's-level clinical social workers (10), psychologists (7), behavioral health specialists (2), addiction counselors (1), advanced practice registered nurses (1), peer support specialists (1), and primary care physicians (1), among others. Facilities also identified the following behavioral health staff vacancies their facilities have filled in the past year: mental health counselors (15 newly filled positions across all 20 facilities), master's level clinical social workers (12), psychologists (2), psychiatrists (2), registered nurses (2), advanced practice registered nurses (1), and licensed practical/vocational nurses (1), among others.

Scopes of Practice

Fourteen (66.7%) of the twenty responding facilities reported they would best describe the scope of duties performed by behavioral health staff in their facility as “all behavioral health staff perform duties that match the state-established scope of practice guidelines.” Five (25%) reported “some behavioral health staff regularly perform duties beyond state-established scope of practice guidelines,” while one (5%) reported “some behavioral health staff are restricted from performing duties authorized in the state scope of practice” due to behavioral health staff only being allowed to perform those duties that are within their state-authorized scope of practice. One (5%) facility reported being “unsure” about the scope of duties (Figure 2).

Figure 2. Scopes of Practice of the Behavioral Health Workforce in Correctional Facilities (n=20)



Eleven of the twenty (55%) responding facilities reported that new behavioral health providers typically require additional training upon employment, which is provided in-facility, while four (20%) responding facilities reported that new behavioral health providers typically require additional training provided outside of the facility. Three (15%) responding facilities indicated that behavioral health providers generally have all the training required to work in a correctional facility prior to their employment. Two (10%) of the twenty responding facilities provided additional information about new

employee training: one responding facility specified that “training is provided both in and out of the facility,” and another indicated that behavioral health providers are “not trained enough” and are “placed too soon on shift without a proper orientation.”

Transitioning to Decarceration

Facilities were asked about re-entry services provided for incarcerated individuals. Of the nineteen facilities that responded, eighteen (94.7%, 18/19) responding facilities provide services that address transition of behavioral health care for incarcerated individuals who will soon be released from custody; one (5.3%, 1/19) facility does not. Respondents were asked to select all types of services available for individuals re-entering the community. Sixteen (43.2%, 16/37) responding facilities provide Mental Health Services, ten (27%, 10/37) provide Primary Care Services, nine (24.3%, 9/37) provide SUD Services, one (2.7%, 1/37) provides none of these services, and one (2.7%, 1/37) reported being “unsure” about provided services.

Responding facilities were asked to report the services or resources they connect individuals re-entering the community to as a part of coordinated transition of care. Five main themes were reported: outpatient services (24%; 14/59), pharmacologic intervention or medication management (19%; 11/59), step-down programs (10%; 6/59), primary care providers (10%; 6/59), and self-help programs (10%; 6/59). Facilities also reported providing aid with the following social services post-release: public assistance (25%; 12/49), housing placement services (22%; 11/49), halfway house (14%; 7/49), health insurance (12%; 6/49), employment training (10%; 5/49), self-care or psychoeducation (6%; 3/49), education services (4%; 2/49), job placement services or job-seeking training (4%; 2/49), and other—specified as “not sure” (2%; 1/49).

CONCLUSIONS

There are severe shortages of behavioral health professionals in correctional facilities. Eighty percent of the 20 responding facilities do not have enough behavioral health staff to meet the needs of their inmates. As noted in the findings section, there are 93 unfilled positions in the group we surveyed with 17 of 20 facilities saying they have difficulty filling open positions. Barriers to recruitment include: difficulty providing care in correctional facilities, administrative work and required effort, and inadequate compensation. Even when those positions are filled, retention rates are low, with 14 of 20 facilities reporting they have trouble retaining competent staff. It is imperative that correctional

facilities have adequate behavioral health resources in order to reduce recidivism in the incarcerated population.

One potential way to improve workforce retention is to encourage staff development, education, and professional networking opportunities with other behavioral health providers as a way to combat high turnover rates.[12] Further, introducing behavioral health workers, such as psychiatry residents, to correctional facilities during their clinical training may help generate practitioner interest in providing behavioral health services to incarcerated populations.[11] Increasing worker retention and minimizing turnover in rural areas could be achieved through adequate rewards and compensation, including recognition of professional accomplishments and promotion as careers progress.[12]

Behavioral health staff in correctional facilities often face challenges beyond their scope of practice. Behaviors by inmates with unrecognized and untreated mental disorders disrupt the operation of the prison and divert staff resources and time, impacting staff ability to operate in a safe and orderly manner.[8,13] Training for correctional staff must raise awareness of human rights; broaden understanding, identification, and management of mental disorders; encourage mental health promotion; and challenge stigmatizing attitudes regarding both mental health work and incarcerated populations in order to properly prepare behavioral health providers for working in prison facilities.[13]

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