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Addressing Shortages of Mental Health Professionals in U.S. Jails and Prisons

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Abstract

Many jails and prisons in the United States do not have enough mental health professionals (MHPs) to meet the mental health needs of the people incarcerated in these facilities. This article examines strategies used to address MHP shortages in U.S. jails and prisons, including compensation incentives, telemental health services, interdisciplinary health care, flexible work schedules, and training rotations in correctional settings. These measures may help alleviate some of the shortages of MHPs in correctional facilities; however, these shortages will likely persist without broader policy reforms that decrease the size of U.S. correctional populations or increase the number of MHPs across the country.

Keywords: correctional facilities, mental health care, shortages, recruitment, incarceration

Mental disorders and substance use disorders are prevalent among incarcerated populations, typically at higher rates than in the general population (Gottfried & Christopher, 2017; Prins, 2014; Steadman *et al.*, 2009). In addition, suicide and self-harm are leading causes of morbidity and mortality among incarcerated people (Favril *et al.*, 2020; Fazel *et al.*, 2017). However, many U.S. jails and prisons do not have enough mental health professionals (MHPs) to address these mental health needs (Buche *et al.*, 2018; Kolodziejczak & Sinclair, 2018; Morris & West, 2020).

Writing in a 2010 book chapter on correctional mental health administration, Carlson noted that ''one of the greatest challenges in ensuring access to care is that it is extremely hard to find qualified and motivated clinicians who are willing to work inside a correctional facility'' (Carlson, 2011, p. 65). In a survey of corrections representatives from six states, 17 of 20 (85%) respondents agreed that their facility had difficulty filling open behavioral health positions and 16 of 20 (80%) respondents disagreed that they had enough behavioral health staff to match the facility's treatment needs (Buche *et al.*, 2018).

A 2018 position statement by the American Psychiatric Association (APA) noted that ''the fundamental goal of mental health services in a correctional setting is to provide the same level of care to patients in the criminal justice process that should be available in the community'' (Trestman *et al.*, 2018, p. 1). Incarcerated people require access to a variety of mental health services, which may include initial screening evaluations, ongoing follow-up care, medication prescribing, psychotherapy, and emergency or inpatient psychiatric care (American Psychiatric Association, 2016).

In 2016, the APA stated that every correctional facility should have ''adequate numbers of appropriately trained [MHPs], performing duties for which they are trained and authorized,'' with MHP staffing requirements depending

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on the specific needs of individual facilities (APA, 2016, p. 7). Still, employing MHPs can require considerable financial and logistical resources, so correctional systems with limited resources may not be able to adequately support these positions or offer specific mental health services inside their facilities (Carlson, 2011).

When correctional facilities lack adequate mental health staff, the responsibilities of managing incarcerated individuals with mental health needs may fall on general medical or custody staff with less or no mental health training (Kolodziejczak & Sinclair, 2018), increasing risks of undue suffering, morbidity, and mortality among incarcerated people. In some situations, particularly when MHPs are unavailable, custody staff may resort to use-of-force measures, such as electroshock weapons, chemical sprays, or cell extraction teams, to manage people in psychiatric distress, which has led to litigation and media coverage over in-custody deaths associated with these practices (Barua & Worley, 2009; Galanek, 2015; Martin, 2006).

Despite the need for MHPs in correctional settings, MHPs often do not wish to work in these environments for various reasons, such as safety concerns, lack of prior exposure to correctional work, remote locations of correctional facilities, and stigma against incarcerated people (Morris & West, 2020). This article examines several strategies used to address MHP shortages in U.S. correctional facilities and considers the limited degree to which these strategies may be able to overcome the broader context of mass incarceration and nationwide MHP shortages.

Compensation

Correctional facilities often turn to compensation incentives to recruit and retain MHPs (Roth, 2018; Tamburello *et al.*, 2017). As noted in a 2017 article on correctional mental health administration, ''offering salaries modestly higher than those available in the community for comparable work is required to effectively attract qualified candidates'' (Tamburello *et al.*, 2017, p. 5).

Pointing to recent efforts in California and Illinois to increase correctional psychiatrist salaries by more than 20% to fill open positions, Roth highlighted that ''some states and counties have become so desperate they have started to offer bigger salaries to lure psychiatric staff, despite facing limited budgets'' (Roth, 2018, p. 123). Correctional systems may also use compensation incentives beyond salaries, such as loan forgiveness or pension benefits, to attract MHPs to work in their facilities (Roth, 2018).

Nevertheless, compensation incentives can require considerable funding and may be insufficient alone to resolve correctional MHP shortages. A 2016 report on staffing challenges at the Federal Bureau of Prisons (BOP) indicated that compensation adjustments up to $30,000 for difficult-to-fill positions were not always sufficient to recruit psychiatrists; the BOP even received approval to use an alternative compensation system with additional salary potential specifically for recruiting psychiatrists (Office of the Inspector General U.S. Department of Justice, 2016). In the California prison system, despite court orders to maintain specific MHP staffing levels and repeated salary increases to recruit MHPs, one in three psychiatrist positions were vacant as of 2020 (*Coleman v. Newsom,* 2020; Roth, 2018).

Telemental Health Services

Although some evidence suggests that correctional settings are not necessarily more dangerous than other mental health settings (e.g., inpatient psychiatric units, emergency departments), MHPs frequently cite safety concerns when asked about correctional work (Morris & West, 2020). Remote provision of mental health care has emerged as another strategy to address correctional MHP shortages, with correctional facilities attempting ''to make the job more appealing [by enabling MHPs] to work at a comfortable distance from the institutions themselves'' (Roth, 2018, p. 122). In 2015, Chan *et al.* noted that ''within the correctional setting, more than 10,000 psychiatric consultations have taken place annually in Texas since 2006, while at least eight other states have implemented telepsychiatry programs within correctional facilities'' (p. 89).

A 2013 literature review indicated that telemental health services may expand access to mental health care and reduce financial costs in correctional systems (Deslich *et al.*, 2013); nonetheless, research comparing outpatient and inpatient correctional telemental health care with traditional in-person care remains ongoing. Remote provision of correctional mental health care may not be appropriate for all clinical scenarios, including situations wherein patients require physical examinations or pose an imminent danger to themselves or others. Considerable resource investments may be necessary to establish telemental health services in aging or rural correctional facilities, such as establishing reliable internet service throughout these facilities, setting up audiovisual equipment, and training on-site staff to help coordinate mental health care from afar.

In addition, telemental health services may help fill some, but not necessarily all, of the mental health needs in correctional contexts. For example, California established a statewide prison telepsychiatry program to recruit psychiatrists and expand access to care; yet, in 2020, a judge overseeing litigation against the prison system noted that ''even if the COVID-19 pandemic presented some opportunity for exploration of the efficacy of expanded use of telepsychiatry in the prison context…defendants' ongoing substantial psychiatrist vacancy

rates suggest telepsychiatry is not the panacea for which defendants had hoped'' (*Coleman v. Newsom,* 2020, pp. 11–12).

Interdisciplinary Health Care

When addressing correctional MHP shortages, media outlets and scholarly articles often focus on MHPs with doctoral-level degrees (e.g., MD, PhD, PsyD), such as psychiatrists and psychologists. However, correctional facilities may rely on a wide range of health staff to provide mental health services. For instance, general medical staff, such as registered nurses, physician assistants, nurse practitioners, and physicians, can often assist with screening intakes, triage, initial treatment, and referrals for people with mental disorders and substance use disorders. In some cases, general medical clinicians may be responsible for providing the bulk of care for these patients, such as managing medications and other treatments for opioid use disorder (Kanan, 2018).

Beyond general medical staff, many correctional systems employ social workers, master's-level therapists or counselors, and other MHPs who are not psychiatrists or psychologists to provide mental health care. In a 2011 study of MHPs working at 165 state correctional facilities from 47 U.S. states, approximately 80 (35%) of 230 respondents had doctoral-level degrees, whereas the majority of respondents had a master's degree, bachelor's degree, or other qualification (Bewley & Morgan, 2011).

By partnering with a wide range of health staff to provide correctional mental health services, correctional systems can expand the pool of available clinicians to care for patients with mental disorders and substance use disorders, as well as utilize the unique skills of these different types of providers. As examples, general medical staff may be well equipped to integrate mental health care into a patient's broader medical treatment, and master's-level therapists or counselors may be well positioned to complete mental health screening, provide supportive visits, coordinate group therapy, and fulfill other clinical duties for patients.

At the same time, correctional systems should not rely on or pressure health staff to provide care outside the scope of their training, experience, and licensure (APA, 2016). Depending on their clinical background, some health staff may not be equipped to provide certain aspects of mental health care, such as prescribing medications, interpreting the results of diagnostic studies, or admitting patients to inpatient care settings.

Flexible Schedules

U.S. correctional facilities frequently promote flexible work schedules to recruit MHPs. Allowing full-time employees to work flexible schedules, such as the choice of working five 8-hour days or four 10-hour days (''4/10s'') each week, is one approach (Office of the Inspector General State of California, 2011). Many correctional facilities also rely on part-time (e.g., less-than-full work week) or temporary (e.g., locum tenens) contractors to fulfill mental health services as needed (Carlson, 2011). Correctional facilities may use additional schedule-related incentives, such as requiring minimal-to-no call shifts or paying extra for voluntary call duties, to appeal to MHPs.

These work–life balance incentives may also entail drawbacks. Even if correctional facilities offer limited-to-no call requirements to attract MHPs, someone must be available outside of business hours to address acute mental health emergencies and other patient needs—additional pay incentives may not be enough to find MHPs willing to work overnight or on weekends. With 4/10 schedules, individual MHPs are not present for at least one workday per week, which can complicate scheduling of clinical appointments, require additional handoffs between mental health staff for consistent coverage of patients' needs, and limit communication between treatment team members (Office of the Inspector General State of California, 2011).

In 2011, the California Office of the Inspector General raised concern about 4/10 schedules in Mule Creek Prison, determining that MHPs often did not see patients for large parts of the day or even left work early (Office of the Inspector General State of California, 2011). By comparison, turning to part-time or temporary contractors for correctional mental health services can bring additional challenges, such as less familiarity between contractors and full-time correctional staff, higher rates of clinician turnover for patients, and difficulty keeping contractors updated regarding facility protocols.

Training Experiences

Some MHPs receive little-to-no training in correctional mental health care, which may keep MHPs in training at a distance from these environments, perpetuate stigmatizing attitudes toward incarcerated people, and decrease the willingness of MHPs in training to later work in these settings (Ford, 2021; Morris & West, 2020). A 2013 survey indicated that 59 (35%) of 170 doctoral psychology programs offered no correctional training opportunities, such as corrections coursework, faculty interest, or practicums (Magaletta *et al.*, 2013). In a 2014 study of 95 representatives from psychiatry residency programs, 45% of respondents reported having no correctional rotations available for trainees (Fuehrlein *et al.*, 2014).

Professional training organizations have typically not required that MHPs in training rotate in correctional settings (Magaletta *et al.*, 2013; Morris & West, 2020). For example, although the Accreditation Council for Graduate Medical Education (2021, pp. 29–31) requires that psychiatry residents participate in a ''forensic psychiatry experience,'' which can include a range of experiences at the interface of psychiatry and the law, these requirements do not specify rotations or training in correctional settings.

Training more MHPs in correctional contexts represents another strategy for addressing correctional MHP shortages (Fuehrlein *et al.*, 2012; Magaletta *et al.*, 2012; Morris & West, 2020). In describing an affiliation between the University of Massachusetts Medical School, a private correctional health vendor, and the Massachusetts Department of Correction, Appelbaum *et al.* highlighted how ''training programs provide a feeder system for recruiting high-quality young professionals into a correctional system'' (Appelbaum *et al.*, 2002, p. 186).

The authors added that university partnerships can also bring academic opportunities or perceptions of prestige to correctional facilities, with the Massachusetts correctional system experiencing ''an influx of highly qualified staff [and] the number of licensed mental health staff increas[ing] by about 40 percent'' (Appelbaum *et al.*, 2002, p. 187). After the Texas prison system developed correctional health care partnerships with academic medical centers in the state, vacancy rates for medical personnel roles fell from approximately 30% to 40% down to 8% to 12% (Raimer & Stobo, 2004).

More recent articles have offered mixed findings regarding the influence of correctional training rotations on the career paths of MHPs in training. A 2012 study of psychology interns who completed federal corrections internships during a 25-year period indicated that 394 (57%) of 695 were then hired into correctional positions (Magaletta *et al.*, 2012). Although trainees matching into corrections internships may have had pre-existing interests in correctional work, potentially influencing their later career decisions, the authors felt that these training opportunities independently contributed to the high rates of participating trainees pursuing correctional careers and concluded that correctional training rotations represented ''a robust and capable workforce recruitment strategy'' (Magaletta *et al.*, 2012; p. 1413).

In contrast, Fuehrlein *et al.* surveyed 44 Texas psychiatry residents and found that ''regardless of whether or not they had rotated [at a local jail] they were not very interested in working in a correctional facility upon completion of residency'' (Fuehrlein *et al.*, 2012, p. 759). Although the authors noted that their results did ''not support the hypothesis that increased exposure during [training] will by itself reduce this shortage,'' they nonetheless found that U.S. psychiatry residency programs were located a median of just 3 miles (4.8 kilometers) from any correctional facility and that continued efforts should explore how training rotations might shape correctional mental health workforces (Fuehrlein *et al.*, 2012, p. 759).

The Need for Broader Reforms

This article examines several strategies used to address shortages of MHPs in correctional settings, and correctional systems may use additional strategies, such as contracts with private correctional mental health companies, measures to combat staff burnout, or collaboration with state mental health departments, to maintain adequate mental health staff levels (Appelbaum *et al.*, 2002; Buche *et al.*, 2018; Olfson, 2016). Still, even when used together, these types of strategies may be unable to overcome the scale of mass incarceration in the United States and general MHP shortages across the country.

For instance, between 1970 and 2018, the number of people imprisoned under U.S. federal or state jurisdiction grew from approximately 196,441 to 1,465,158 (factor of 7.5), whereas the number of U.S. psychiatrists grew from approximately 23,236 to just 41,133 (factor of 1.8; Beck *et al.*, 2018; Carson, 2020; Langan *et al.*, 1988; Taube & Barrett, 1983). These statistics provide an incomplete picture, as they do not consider additional correctional populations (e.g., millions of annual jail bookings) or the number of nonpsychiatrist MHPs; still, these broader trends provide a backdrop for considering the challenges faced by correctional facilities in recruiting and retaining adequate mental health staff. These disparities are further exacerbated by general shortages of MHPs across the country; as an example, most U.S. counties had no psychiatrists as of 2018 (Beck *et al.*, 2018).

Correctional facilities are legally required to provide incarcerated people with access to mental health services (APA, 2016; Metzner, 2002; Morris & West, 2020). To meet these treatment needs, correctional systems will continue to compete over a sparse numbers of available MHPs and to use various strategies to attract MHPs to work in correctional contexts. Nonetheless, unless broader policy reforms increase the number of U.S. MHPs or decrease the size of U.S. correctional populations, these supply-and-demand imbalances will likely persist in correctional settings for the foreseeable future.

Expanding the national MHP workforce is a longstanding challenge that requires a number of policy reforms, including funding additional MHP training slots, incentivizing clinician recruitment into mental health specialties, and supporting ongoing MHP well-being and clinical practice (Olfson, 2016). MHP workforce projections from 2017 to 2030 indicate that the number of U.S. adult psychiatrists may decline from 33,650 to 27,020 (20%), largely as a result of psychiatrist workforce aging and retirement rates; however, these estimates also suggest that the number of other MHPs will increase considerably during this same period, with psychologists increasing from 91,440 to 103,440 (13%) and social workers increasing from 239,410 to 513,370 (114%; National Center for Health Workforce Analysis, 2020).

Policymakers must also consider issues of justice, equity, diversity, and inclusion, especially given the overrepresentation of Black and Latinx people in the carceral system and the persistent challenges of building a diverse

MHP workforce. Physicians from racial and ethnic minority backgrounds may be more likely to work with diverse and marginalized populations (Walker *et al.*, 2012). In addition, research suggests that training among more diverse medical school cohorts may shape physician attitudes regarding the care of diverse populations and equitable access to health care (Saha *et al.*, 2008).

Despite the potential benefits of diversity and inclusion in MHP workforce development, Black and Hispanic psychiatrists accounted for just 4% and 6% of practicing psychiatrists, compared with approximately 13% and 18% of the U.S. population in 2016, respectively (Wyse *et al.*, 2020). In a 2015 survey of more than 5,000 licensed psychologists, just 3% and 4% of respondents, respectively, identified as Black and Hispanic (Hamp *et al.*, 2016). Recruitment methods (e.g., compensation bonuses or workweek flexibility) may provide some short-term solutions for bolstering the correctional MHP workforce at local levels, but policymakers must strengthen the national MHP pipeline to cultivate a diverse workforce capable of caring for marginalized populations in correctional settings.

Reducing the scale of incarceration in the United States also requires multifaceted efforts, such as decreased criminalization of substance use, bail and sentencing reforms, and expansion of alternative programs to incarceration (e.g., mental health diversion; Kleinman & Morris, 2021; Morris, 2021; Travis *et al.*, 2014).

Despite the dramatic growth of U.S. correctional populations in recent decades, the total number of people incarcerated in U.S. jails and prisons has fallen in recent years, declining from 2.3 million in 2008 to 2.1 million in 2018 (8%; Maruschak & Minton, 2020). Owing to efforts to combat overcrowding and the spread of COVID-19, recent data suggest U.S. jail and prison populations decreased further during the COVID-19 pandemic, although some correctional populations appear to have rebounded in size since then (Kang-Brown *et al.*, 2021).

Whether these reductions in U.S. correctional populations will continue remains to be seen. Although individual recruitment incentives and other strategies explored in this article may alleviate some of the near-term shortages of MHPs in correctional facilities, these broader types of population-level shifts are poised to shape the future of correctional MHP shortages across the United States.

Authors' Contributions

Dr. Morris and Dr. Edwards participated in the creation, drafting, and editing of this article.

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