

STAFFING ANALYSIS FOR WOMEN'S PRISONS AND SPECIAL PRISON POPULATIONS

Special Issues in Corrections

December 2002

LIS, Inc.

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Project Method

The National Institute of Corrections (NIC) undertook this study in 2002 to explore staffing analysis processes and staffing outcomes in prisons or units housing three inmate populations: mentally ill inmates, medical needs inmates, and women offenders. A formal process of staffing analysis involves the use of formulas to calculate the number of positions needed to adequately manage correctional facilities or units. Of particular concern in this study were: 1) whether state departments of correction (DOCs) use the same formal process for these smaller populations as they do for the male general population; and 2) whether most states consider their current staffing to be adequate for optimal management of these facilities or units.

To conduct the research, the NIC Prisons Division and Information Center distributed a written survey instrument in March 2002 to DOC central offices. The survey covered several aspects of facility staffing:

- The types of housing DOCs operate for women and special populations;
- The use of formal or informal processes of staffing analysis for these facilities or units;
- Differences in their staffing patterns relative to staffing for the male general population; and
- Staffing needs in four position categories: mental health, medical, security, and program posts. Agency respondents were also invited to discuss

staffing challenges they experience with the target populations.

The survey did not examine the specific elements of the staffing analysis processes used by DOCs.

Responses were received from 50 DOCs, representing 46 state correctional systems as well as New York City, Guam, the Virgin Islands, and the Federal Bureau of Prisons (BOP).

Percentage figures presented in this report are based on the number of DOCs answering each particular question, and they cannot always be directly compared. Though the survey did not specify that questions about mentally ill and medical needs populations referred to male populations, it is assumed that DOC responses are for male populations rather than for both men's and women's housing.

Key Findings

Several main ideas emerged from the research:

- In women's housing, more than 90% of the responding DOCs that follow a formal staffing analysis process use the same process as they use for the male general population. In two-thirds of these DOCs, the same staffing pattern results in women's housing as in the male general population. The greatest staffing need in women's housing, reported by two-thirds of the responding DOCs, was found to be more medical positions.

- For mentally ill populations, 58% of responding DOCs follow the same formal staffing analysis process as is used for the male general population. In two-thirds of these agencies, a different staffing pattern from male general population is the result. More than 60% of responding agencies indicated a need for more program and security staff in their housing for mentally ill inmates.
- For medical housing, 69% of responding DOCs follow the same formal staffing analysis process as is used for male general population. The resulting staffing patterns are different in more than half (61%) of these DOCs. Though agencies already tend to have more medical staff in these units than in male general population housing, 72% of responding DOCs indicated a need for still more medical staff positions.
- Where DOCs follow different formal staffing analysis processes for these populations than for the male general population, a different staffing pattern is usually the result.
- For DOCs that use informal processes of staffing analysis, a different staffing pattern from the male general population results: for mentally ill housing in 62% of DOCs, for medical housing in 60%, and for women's housing in 50%.
- Asked to indicate which survey population poses the greatest staffing challenge, respondents chose the mentally ill population (26 DOCs), citing the staff-intensive nature of the work. The medical needs population followed (12 DOCs), with the main pressure point being the difficulty of recruiting credentialed medical care staff. The women offender population was selected by respondents in 5 DOCs, who cited women inmates' greater demand for both medical and mental health care services. (Some respondents did not select an answer, and some others chose more than one population.)

Themes in Staffing and Staffing Analysis

DOCs' approaches to housing and staffing analysis differ for each of the surveyed populations. The survey found differences in staffing patterns compared with staffing in male general population housing and varying needs for specialty staff positions.

Separate housing. DOCs were asked whether they operate separate facilities or units for mentally ill inmates, medical needs inmates, or women offenders.

- Separate housing for mentally ill inmates is available in all but two (2) DOCs. This population is housed in separate facilities in 15 DOCs, or 31% of the responding agencies, and in separate units in 40 DOCs, or 81%. Several DOCs operate both specialized facilities and units for mentally ill inmates.
- Separate facilities for inmates requiring specialized medical care are available in 15 DOCs, or 31% of responding agencies. Forty (40) DOCs, or 81%, operate separate units for medical needs populations. Several DOCs operate both facilities and units for medical needs populations. In two (2) DOCs, no separate facilities or units are provided for this population.
- Women inmates are housed in separate facilities in 42 responding DOCs, or 86%, and in separate units in 13 DOCs, or 26%. Several DOCs operate both separate facilities and units for women.

Staffing analysis techniques. The survey asked whether agencies use a formal process of staffing analysis for their facilities or units housing mentally ill inmates, medical needs inmates, or women. More than 60% of responding DOCs use a formal process of staffing analysis for at least one of the surveyed populations. (See Table 1, page 3.)

Where a formal process of staffing analysis is used for the surveyed population(s), DOCs were asked whether this process is the same as or different from the process used to staff male general population housing. For each surveyed population, more than

Table 1. Staffing Analysis Methods and Outcomes

	Agency Uses a Formal Process of Staffing Analysis	Process, If Formal, Is Same Used in Male General Population	Staffing Pattern Differs From Male General Population (formal or informal process)
Mental health populations	26 DOCs (60%)	15 DOCs (58%)	28 DOCs (64%)
Medical care populations	26 DOCs (60%)	18 DOCs (69%)	26 DOCs (56%)
Women offenders	31 DOCs (67%)	28 DOCs (90%)	16 DOCs (32%)

half of the DOCs using a formal process use the same process that they use for the male general population. The proportion is highest for women’s housing, for which 90% of DOCs use the same staffing analysis process as they use for the male general population. (See Table 1.)

Several respondents provided comments on the processes their agencies use to determine staffing for the surveyed populations.

- Among the DOCs following the same formal process for both a surveyed population and the male general population, comments most often focused on population-based models and staffing formulas. Other procedures range from following established guidelines and meeting national standards to considering a multiplicity of factors. For example, one agency’s formal process takes into account “the mission of the facility, offender custody level, capacity and design of the physical plant, program needs, health care needs, work programs, and special needs of the offender.”
- Where formal staffing processes differ from the process for staffing male general population facilities, a major factor is statutes or court orders establishing staffing ratios for mentally ill populations. Many DOCs use non-correctional staffing ratios or models as benchmarks. These included basing therapist-to-inmate ratios on community clinician standards and looking to infirmaries and HIV nursing homes as a guideline for staffing medical needs populations. One DOC cited using

a mental health services need classification system to determine professional staffing levels.

- Where medical and/or mental health care is staffed through contract positions, DOCs use a variety of benchmarks to determine appropriate staffing levels:
 - Based on levels of service/performance rather than number of positions, with staffing at contractor discretion (5 DOCs);
 - Established standards (4);
 - Prior experience and workload (3);
 - Need-based (3);
 - Community standards or models including accepted practice guidelines, infirmary level care, and HIV nursing home staffing levels (3);
 - Court order or statute (2);
 - Security level and inmate needs (2);
 - A matrix tied to scope of service (1); and
 - Hours of health care per inmate together with a system to monitor outcomes and make adjustments (1).

Staffing patterns for surveyed populations. The survey asked whether DOCs’ current staffing patterns for special populations are the same as or different from the staffing in the male general population. (See Table 1.)

- For mentally ill populations, the staffing pattern is different from the pattern in male general population facilities in 64% of responding DOCs.

- For medical needs inmates, the staffing pattern is different in 56% of responding DOCs.
- In women's housing, the staffing pattern is different in 32% of responding DOCs.

A review of processes and outcomes for each population compared to male general population housing is provided later in this report.

Also compared were staffing levels for specific position categories. DOCs were asked whether they have more, less, or the same numbers of medical, mental health, security, and program posts for each surveyed population as compared with the male general population. Few agencies were found to have fewer positions in any position category. The greatest difference is in mental health housing, where higher staffing levels exist in all four position categories. (See Tables 2, 3, and 4 for details for each population.)

Staffing needs. The survey explored staffing needs in specific position categories for each of the surveyed populations. Overall, mental health housing was found to have the greatest need for additional positions. (This information is presented for each special population in Tables 2, 3, and 4.)

Survey data show the following priority areas for staffing needs:

- The greatest need for additional *medical staff positions* was found in specialized medical care housing (72% of responding DOCs). A need for additional medical posts in women's housing was also expressed by a majority of respondents (66%).
- The greatest need for additional *mental health positions* was reported for women's housing (56% of responding DOCs) and mentally ill housing (55%).
- Additional *security positions* are most needed in mentally ill housing (62% of responding DOCs).
- Additional *program positions* are most needed in housing for mentally ill populations (65% of

responding DOCs), followed by women's housing (60%).

Staffing challenges. When asked which population poses the greatest staffing challenge, one-third of the DOC respondents could not choose only one answer. The mentally ill population was selected by 26 DOCs, or 63% of those responding. Medical needs populations were selected by 12 DOCs, or 29%. Five (5) DOC respondents, or 12%, selected women offenders. Long-term protective custody inmates and sex offenders were identified by one DOC respondent each as creating the greatest staffing challenge.

In many cases, an attendant issue rather than the population itself was cited as the reason for the difficulty.

- One respondent noted, "No one group of special needs population presents a greater staffing challenge over the others. Staffing in excess of any standard is the greatest challenge."
- Other DOCs cite budgetary constraints as the main reason for understaffing.
- Growing offender populations are another main concern. One respondent noted that the agency's facility for women is more than doubling in size; another noted a new facility opening July 2002. One agency's medical staffing has remained the same despite faster population growth.

Additional comments about staffing challenges are included in later segments of this report.

Staffing for Mentally Ill Populations

Survey data indicate that DOCs with separate housing for inmates receiving mental health care staff these units more richly than the male general population. Still, more than half of these agencies report that more positions are needed. Table 2, page 5, summarizes information provided about this population.

Table 2. Staffing in Housing for Mentally Ill Populations

a) Is a formal process used for staffing mentally ill housing? Yes: 26 DOCs (60%, N = 43 DOCs answering)

b) Is the formal process specialized for staffing mentally ill housing?

No, formal process is same as in men's general population: 15 DOCs

Yes, formal process is different than in men's general population: 11 DOCs

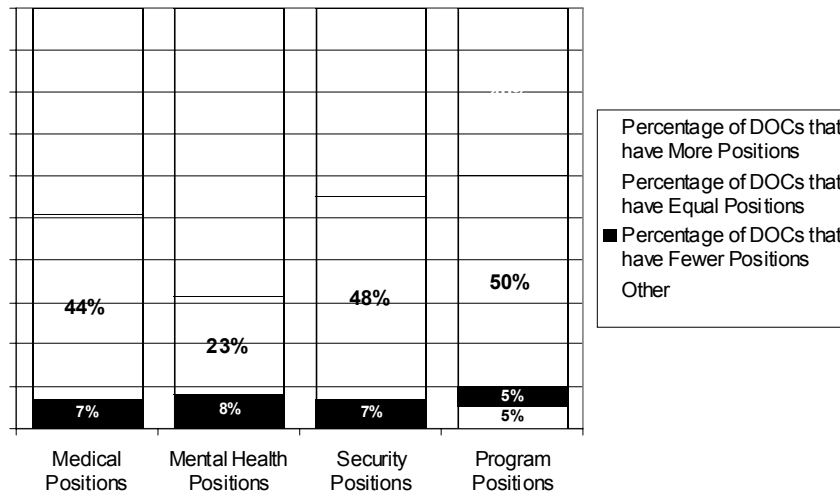
Same process yields same staffing pattern: 8 DOCs

Same process yields different staffing pattern: 7 DOCs

Different process yields same staffing pattern: 1 DOC

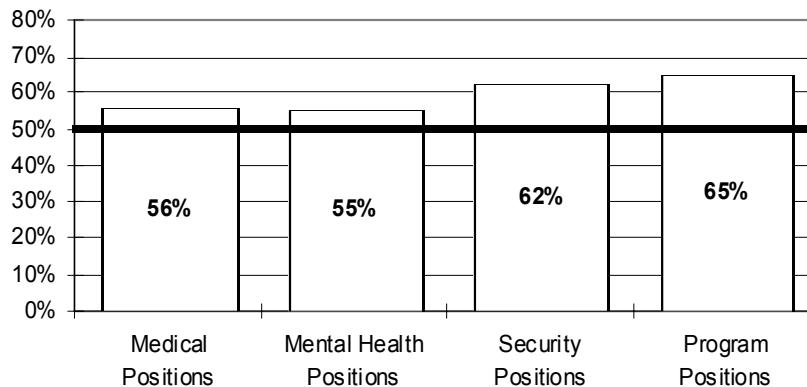
Different process yields different staffing pattern: 10 DOCs

c) How does staffing for mentally ill housing compare with staffing in men's general population?



d) What types of positions need to be added in mentally ill housing?

Percent of DOCs indicating more positions are needed



Staffing analysis process and outcomes. Staffing analysis findings for mentally ill housing include:

- Twenty-six (26) DOCs, or 60%, utilize a formal process of staffing analysis for their mentally ill populations.
- More than half of the DOCs with a formal process for staffing mentally ill units (15 DOCs, or 58%) use the same process for this population as they do for the male general population. In half, or seven (7) DOCs, a different staffing pattern is the result.
- Of the 11 DOCs using a different formal process of staffing analysis, all but one has a different staffing pattern for this population as compared with the male general population.

Current staffing levels. The majority of DOCs have more mental health posts for their mentally ill populations than are provided for the male general population. Numbers of medical, security, and program posts are in most agencies comparable to those in the male general population.

More than half of the DOCs reported that, for optimal management, their housing for mentally ill inmates needs additional posts in each of the survey's four categories:

- **Medical care posts.** Twenty-two (22) DOCs, or 49% of responding agencies, staff their housing for mentally ill inmates with more medical posts than are used in the male general population. Only three (3) DOCs, or 7%, have fewer medical posts than for the male general population. More than half the responding DOCs (55%) reported that they need more medical care posts in units for mentally ill inmates.
- **Mental health posts.** In 68% of responding DOCs, agencies have more mental health posts in their units for mentally ill inmates than in the male general population. One-half of these agencies (16 DOCs) report that they still need more mental health posts in these units. Overall, 25 DOCs (54%) report needing more mental health

posts than they now have in their units for mentally ill inmates.

- **Security posts.** DOCs are almost evenly split on whether they have an equal number of security posts (48% of DOCs) or more security posts (45% of DOCs) in their mental health units as compared with the male general population. A majority of responding agencies (26 DOCs, or 62%) reports needing more security posts in their housing for mentally ill populations.
- **Program posts.** In 55% of DOCs, program staffing for mentally ill units is equal to that in the male general population. Twice as many DOCs (63%) report needing more program posts as report being satisfied with the current number of posts (37%).

Factors behind current staffing challenges. The staff-intensive nature of the mentally ill population was cited as the main reason for the difficulty agencies experience in establishing and filling posts in dedicated facilities and units.

- Dually diagnosed inmates (for example, those with mental retardation or substance abuse in addition to mental illness), inmates with borderline personality disorder, and inmates with severe character disorders (Axis II diagnoses) pose particular challenges and require more staffing.
- One respondent noted the need for "specially-trained correction officers and mental health professionals who can implement and enforce strict behavioral modification programs." Another commented that this population requires "higher staff to inmate ratios and careful selection of staff to work effectively with special needs of mentally ill inmates without compromising security." One comment that echoed several others was, "Inmates do not respond to 'normal' interventions. The staff is frustrated and 'burned-out'."
- Another key reason cited by agencies is the constant shortage of qualified professionals. This not only has an impact on practical day-to-day aspects such as the dispensing and monitoring of

medications, the need for round-the-clock supervision, and the additional staffing needed for escort requirements and programs, but also on matters such as continuity of care. One DOC states that “due to the limited availability of qualified psychiatrists, use of locum tenens [temporary physician positions] has been required to fill vacancies, raising issues on continuity of care as providers change and costs rise.”

Observations on the optimal management of mentally ill populations. Again, the staff-intensive nature of the mentally ill was noted in many agency comments: “A greater allotment of counselor, social work, and nursing time is needed to provide and coordinate services for the mentally disordered offender.” Another states, “mentally ill inmates are very needy, somewhat dependent, need a lot of contact, have more problems, and all combined can therefore be very time consuming for the staff. Extra staff is needed, especially if we want to make a change in their behavior for their return to the communities, and for the safety of these communities.”

DOCs state that if they had more mental health posts, they could offer more treatment programs to inmates. One DOC states that “currently systems are not set up or adequately staffed to provide necessary services.” One agency “recently added staff to address the needs of the dually diagnosed (mental illness and substance abuse) housed in residential treatment units.” Several DOCs reported that the lack of designated housing units or facilities not only makes it difficult to protect mentally ill inmates from themselves and others, but is also disruptive to the institutional environment as a whole. One DOC states that it has only enough staff to provide acute and subacute care; it does not have the staffing resources to address the rehabilitation needs of the chronically mentally ill.

Even when posts are established, they are often difficult to fill due to a shortage of mental health professionals, particularly nurses and physicians. The rural location of some facilities poses a “significant hiring challenge for psychiatrists, psychologists, and nurses.” Many DOCs reported difficulty in recruiting

and retaining mental health staff, citing lower wages compared with the private sector.

The shortage of mental health workers is not the only problem, however. As several DOCs noted, security shortages can constrain programming and treatment options. One DOC states that “assessment services are inadequate” and that the agency is experiencing a “severe need regarding programming for personality disordered, behavior management, and potentially violent offenders.” Other adjunct services desired by agencies include art, work, music, horticultural, and recreational programming. Another cites a goal to increase staff positions for aftercare planning.

Several DOCs offered creative solutions. One DOC stated that “mental health units are in proximity with medical units and staff are expected to help one another depending on need.” Another suggests utilizing Nurse Practitioners (NP) who have psychiatric training. The respondent notes that this would involve a reclassification of the NP position, which would make the grade more equitable with the community market rate. Another DOC notes that “resident psychiatrists from the University School of Medicine provide contract psychiatric services.” The security staff at one agency is “provided additional training including communication and documentation skills, and basic information about mental illness and interactions with the mentally ill.” At another, the “correctional staff receive 40 hours additional training by mental health professionals. Staff volunteer for this assignment and rotate infrequently.”

Two final comments by agencies:

- “California recently has been dialoguing that in the acute setting for mentally ill individuals one nurse to five patients is necessary. This may soon be California State law. Corrections may need to look at that model. [The Health Care Financing Administration (now the Centers for Medicare & Medicaid Services)] has also designated types of professionals and criteria required for caring for seriously mentally ill. Staffing numbers are dependent on the acuity (severity of illness) of the offender.”

- “It is of the utmost importance to have an interdisciplinary team which includes psychology, nursing, psychiatry, recreational and art therapy, AND security. Facility standards should adequately compete with local community standards of care. All too often in criminal justice, the staffing ratios of security staff to inmates is the bench mark and always underestimates the actual need of clinical staff AND security staff with this special population.”

Staffing for Medical Needs Populations

DOCs that operate specialized housing for medical care populations indicate a need for additional medical staff posts. Table 3, page 9, summarizes information provided about this population.

Staffing analysis process and outcomes. Staffing analysis findings for medical care housing include:

- Twenty-six (26) DOCs, or 60% of agencies responding to this survey question, utilize a formal process of staffing analysis for their medical needs population.
- Eighteen (18) DOCs, or 69% of those using a formal process for staffing medical care units, use the same formal process for this population as they do for the male general population. The resulting staffing pattern is different from that in the male general population in fewer than half of these DOCs (seven [7] DOCs, or 39%).
- Of the eight (8) DOCs using a different formal process of staffing analysis for medical care housing, all but one have different staffing patterns than are seen in the male general population.

Current staffing levels. Survey data show that within specialized medical care facilities, the numbers of medical posts are higher than in facilities housing the male general population. Numbers of mental health,

security, and program posts are generally equal to those in male general population housing.

- Twenty-nine (29) DOCs, or 62% of agencies responding to this question, have more medical posts in their housing for medical needs populations than in male general population housing. Strongly, however, respondents indicate a need for still more additional posts: 34 DOCs, or 72% of respondents to a separate question, state that they need more posts to manage their medical needs populations optimally.
- Most often, the numbers of mental health, security, and program posts for medical care populations are equivalent to posts for the male general population. For these categories, fewer than half of the responding DOCs indicated a need for more posts.

Factors behind current staffing challenges.

Respondents were asked to identify what makes staffing medical care positions challenging. The difficulty of recruiting credentialed staff was cited as the main reason. Not only are wages often not comparable to the private sector, but facility locale often proves to be a determining factor. One facility blames its shortage of applicants on its location in a metropolitan center with its “wide variety of employment choices for nurses and medical professionals,” while another points to its rural setting as its main drawback.

Housing issues are another major concern. Several DOC systems are too small for a correctional hospital or a dedicated medical facility in which to house their geriatric, HIV, and chronically ill inmates. Another DOC is currently clustering unstable chronic disease cases in six to nine facilities. Respondents also noted the staff-intensive nature of this group, the shortage of qualified professionals, rising health care costs, and budgetary constraints. One cited the fact that these posts must be held by professionals who meet state standards and therefore require more training.

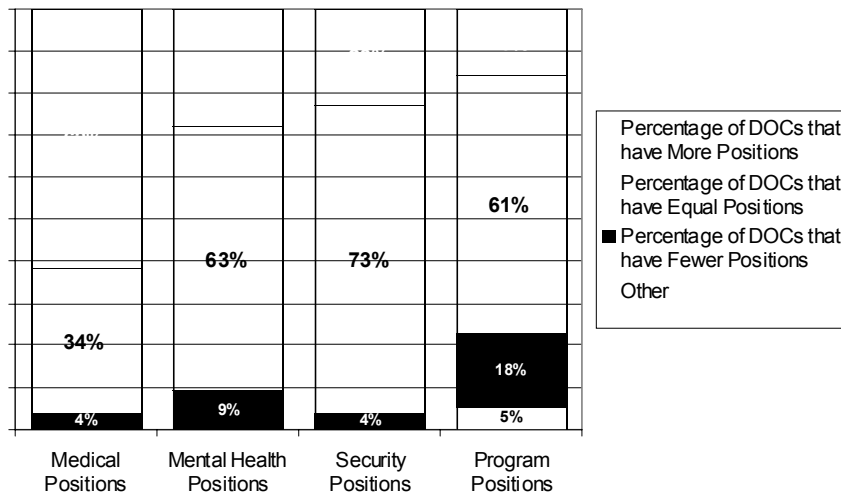
Table 3. Staffing in Housing for Medical Care Populations

a) Is a formal process used for staffing medical care housing? Yes: 26 DOCs (60%, N = 43 DOCs answering)

b) Is the formal process specialized for staffing medical care housing?

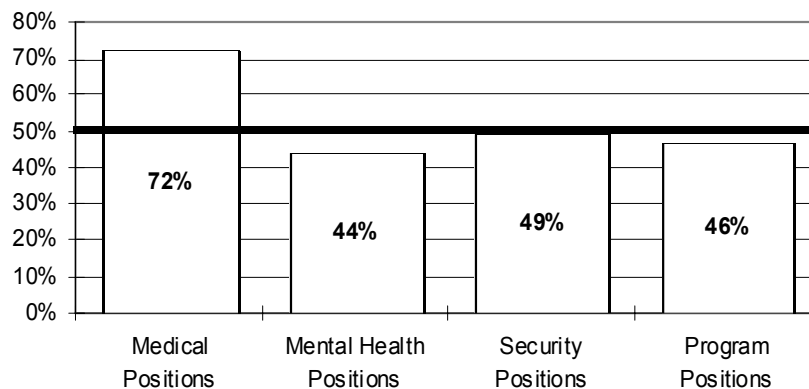
No, formal process is same as in men's general population: 18 DOCs		Yes, formal process is different than in men's general population: 8 DOCs	
Same process yields same staffing pattern: 11 DOCs	Same process yields different staffing pattern: 7 DOCs	Different process yields same staffing pattern: 1 DOC	Different process yields different staffing pattern: 7 DOCs

c) How does staffing for medical care housing compare with staffing in men's general population?



d) What types of positions need to be added in medical care housing?

Percent of DOCs indicating more positions are needed



Observations concerning the optimal management of medical needs inmates. The greatest concern expressed by DOCs for managing their medical needs populations is critically short staffing in medical positions. Many DOCs report experiencing a severe shortage of nurses and other medical professionals. Infirmaries and medical units are understaffed, particularly for inmates with chronic needs.

Several DOCs identified their geriatric populations as a special subcategory with its own set of issues. Geriatric populations require more medical staff and specialized housing, have similarly rising health care costs, and also present costs related to long-term care. Agencies must deal again with difficulty in recruiting qualified professionals and budgetary constraints.

One DOC's comment reflects the need to reassess based on changing populations: "Older facilities have staffing patterns that were developed based on a significantly lower and younger inmate population. We now have an aging population with higher acuity levels, which includes the complications of end-stage diseases. This requires greater expertise, skills, and experience on the part of our medical staff. Our staffing levels remain the same as years ago, which means we are doing more with less staff."

The lack of designated medical facilities also creates staffing challenges. One DOC notes that "much of the acute care treatment of inmates in medical referral centers is provided in a community hospital requiring several escorted trips and around the clock correctional posts at the hospital."

Several DOCs echoed one agency's comment that "services for frail, elderly, and chronic care patients are very limited; recreational, educational, and other activities for infirmary and chronic care inmates are not available." Program needs cited by DOCs include hospice, discharge planning, transitional care, health education, dietician services, and rehabilitation services including physical, occupational, and speech therapy. Another DOC cited a need for mentorship programs for medical care populations as well as adjunct services including art, work, music, horticulture, and recreation.

Staffing for Women's Facilities

Medical and program posts are most strongly needed in women's housing. Table 4, page 11, summarizes information provided about this population.

Staffing analysis process and outcomes. Staffing analysis findings for women's housing include:

- Thirty-one (31) DOCs, or 67%, utilize a formal process to determine staffing needs for facilities or units housing women offenders.
- Twenty-eight (28) DOCs, or 90% of those using a formal process for staffing women's housing, use the same process for women as for men. The resulting staffing pattern is different from that in the male general population in fewer than one-quarter of these DOCs (six [6] DOCs, or 21%).
- In two of the three DOCs that use a different formal process of staffing analysis in women's facilities than is used for men's facilities, a different staffing pattern is the result.

Current staffing levels. Among the responding DOCs, about half have comparable numbers of medical, mental health, security, and program posts in women's facilities as compared with the male general population.

- Forty-nine percent (49%) of DOCs have equal numbers of medical care posts in women's and men's facilities. Just under 40% of DOCs have more medical care posts for women than for men; five (5) DOCs, or 11%, have fewer medical posts in women's housing. The greatest reported need for additional staff in women's housing is in medical staff, with 31 agencies (66% of those responding) stating they need more positions than they currently have. Half of the DOCs stating a need for more medical posts for women inmates already have more medical positions relative to the male general population.
- Roughly 47% of DOCs have equal numbers of mental health care posts in women's and men's

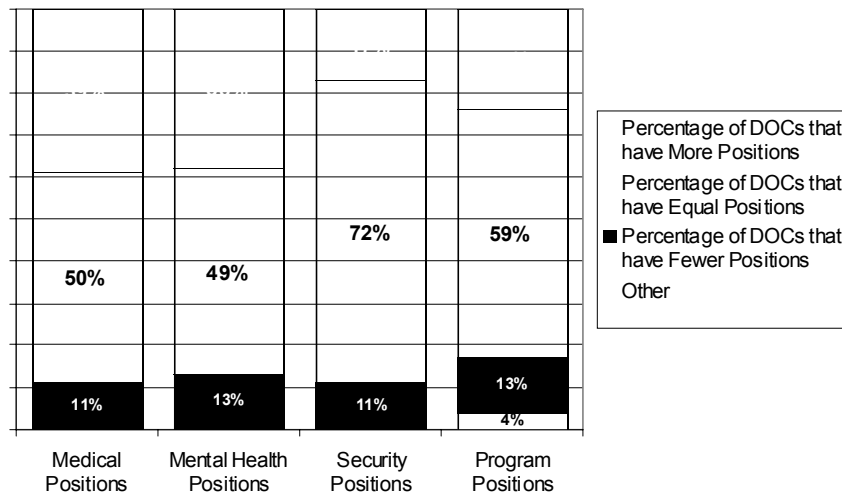
Table 4. Staffing in Housing for Women Offender Populations

a) Is a formal process used for staffing women’s housing? Yes: 31 DOCs (67%, N = 46 DOCs answering)

b) Is the formal process specialized for staffing women’s housing?

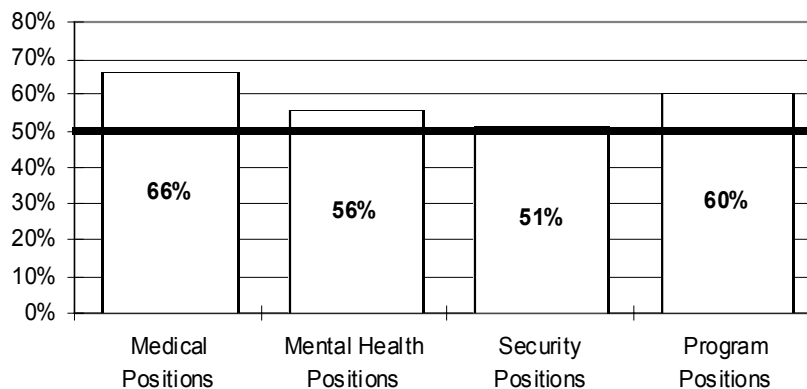
No, formal process is same as in men’s general population: 28 DOCs		Yes, formal process is different than in men’s general population: 3 DOCs	
Same process yields same staffing pattern: 22 DOCs	Same process yields different staffing pattern: 6 DOCs	Different process yields same staffing pattern: 1 DOC	Different process yields different staffing pattern: 2 DOCs

c) How does staffing for women’s housing compare with staffing in men’s general population?



d) What types of positions need to be added in women’s housing?

Percent of DOCs indicating more positions are needed



facilities. Just under 40% of DOCs have more mental health posts for women, while 13% have fewer mental health posts for women than for men. More than half the responding DOCs (26, or 56%) indicated they need more mental health posts in women's facilities.

- The number of security posts for women's housing is equivalent to that in the male general population in 34 DOCs, or 72%. About 18% of DOCs have more security posts in women's housing, and 10% of DOCs have fewer security posts. Just over half of the DOCs (51%) say they need more security posts in women's housing.
- The number of program posts for women is comparable to the number for men in 27 DOCs, or 59%. In 11 DOCs, or one-quarter of responding agencies, women's units have more program posts. In six (6) DOCs, or 13%, there are fewer program posts in women's housing. More than 60% of agencies indicated a need for more program posts in women's housing, compared with 19 agencies, or 40%, that indicated that the positions they have are adequate.

Factors behind current staffing challenges. The main challenge voiced by respondents is the greater demand for medical and mental health care services in women's facilities. One concern that surfaced repeatedly was the conviction that women on average utilize medical and mental health services from 25% to 100% more often than their male counterparts. Other observations were that a higher percentage of women initiate medical contacts, that intake physicals take longer for women than men, that a greater percentage of women are prescribed medications, and that transportation and supervision related to pregnancies require additional security staff.

More medical posts are required for practical day-to-day aspects: to supervise medications, ensure keep-on-person compliance monitoring, and to facilitate reviews of sick notes for a population whose medical needs are varied and numerous. Other concerns include a current shortage of both women correctional officers and qualified medical and mental health staff, combined with an increasing women

offender population. One DOC noted the considerable challenges presented by the initial staffing of a new women's facility.

Women offenders also have additional mental health and programming needs for issues including physical and sexual abuse, domestic violence, parenting, and child care. Waiting lists for treatment or other programs are common. Respondents also commented that women have an increased need for social services due to child custody, adoption, child placement, child support issues, and family unification planning. Women also show a greater lack of education and job skills upon incarceration, and meaningful vocational programs may be lacking. Additional security staff may be needed for women's populations to support more visitation, travel orders for medical services in the community, and hospital coverage.

Conclusion

Staffing analysis is only a part of the picture in the management of correctional facilities. Once staff positions have been approved and budgeted, DOCs may find it difficult to fill them, particularly where specialized skills and training are required. Nevertheless, this study suggests a clear need among U.S. correctional agencies for change in their staffing for the prison populations addressed in the survey. Greater use of specialized approaches to staffing analysis could help justify additional positions and aid in reaching decisions about adding staff.

Additional study is needed to explore staffing analysis methods specifically for facilities housing women and special populations. Staffing decisions will continue to reflect a balance between addressing inmate needs, ensuring staff and public safety, and working within available resources. ■