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Educating Counselors about Offenders with Mental Illness: An Exploratory Study

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Abstract

Racially and economically disenfranchised offenders with mental illness (OMI) are incarcerated at disproportionately high rates but experience less access to and utilization of mental healthcare. There is a need for trained counselors to work in forensic environments who are competent to provide multiculturally sensitive social justice-oriented interventions. However, there is little research exploring the extent counseling students are offered didactic or experiential training for working with OMI. Utilizing concurrent embedded mixed methods to explore relationships between opportunities and obstacles to counseling programs offering this training, this study finds interest in training exists but potential concerns about bias, safety, and other barriers need to be considered. Analysis of these findings and implications for further study, advocacy and continuing education are discussed.

Keywords

offenders with mental illness, forensic mental health counseling, counselor education, social justice

Rates of mental illness in correctional settings are significantly higher than the general population (Gonzalez & Connell, 2014). Further, most people with mental illness in these settings do not receive treatment, and when they do, it is often pharmaceutical rather than therapeutic counseling (Gonzalez & Connell, 2014). Due to the growing incidence of incarceration of individuals with serious mental illness (SMI), substance use disorders (SUDs) and trauma histories (Kaeble et al., 2015; Peterson et al., 2014; Steadman et al., 2009), correctional settings need well-trained correctional counselors, which is reflected by the more than ten thousand open jobs for correctional counselors (Zip Recruiter, 2021).

OMI as a Social Justice Advocacy Issue

The rate of incarceration in the United States has grown tremendously over the last 35 years due to the combined effects of increased mandatory sentencing for drug offenses, deinstitutionalization of the mentally ill, decreases in available community mental health resources, and the rise of privatized prisons, each contributing to high rates of offenders with mental illness (OMI) in correctional settings (Osher et al., 2012; Torrey et al., 2010; Torrey et al., 2014). Despite accounting for only 4.4% of the world's population, the United States (U.S.) has 22% of the world's prisoners (Walmsley, 2013). Further, a recent meta-analytic study indicates that people suffering with SMI are over-represented in jails, prisons, probation, and parole settings (Prins, 2015).

SMI Treated in Correctional Settings

Research indicates among the 2.2 million incarcerated people in the country, almost half (1 million) suffer with SMI, a number that is three to six times that of the general population (Kaeble et al., 2015; Peterson et al., 2014; Steadman et al., 2009). OMI suffer from higher rates of bipolar disorder, schizophrenia, and major depression (Lamb & Weinberger, 2014; Lovell et al.,

2002; Torrey et al., 2010); substance use disorders (Najavits, 2002; Osher et al., 2012), and trauma-related disorders like post-traumatic stress disorder (PTSD; Federal Interagency Reentry Council, 2016). As such, more OMI live in jails and prisons than in 44 states' psychiatric facilities, making the justice system one of the largest providers of mental health services in the country (Torrey et al., 2014).

Further, although 95% of OMI are released back into the community, they recidivate at twice the rate of offenders without mental illness (Carson & Golinelli, 2013; Cloyes et al., 2010). Those with trauma-related disorders, SUDs, and other mental illness have higher rates of re-arrest, parole violations, and eventual return to custody (FIRC, 2016). Further, this group of clients frequently belong to marginalized groups such as racial and ethnic minorities and people who are economically disenfranchised (National Alliance on Mental Illness, 2017; Nellis, 2016; Torrey et al., 2014; Western & Pettit, 2010). As such, they are less likely to have access to community mental health care, less likely to take advantage of care when available, and more likely to be arrested and spend more time in jail than non-marginalized populations (Holzer, 2009; Nellis, 2016; Torrey et al., 2014; Western & Pettit, 2010).

Race and Ethnicity

The highest rates of incarceration are among men of color between the ages of 20 and 39 (Western & Pettit, 2010). According to the Sentencing Project's 2016 report entitled The Color of Justice: Racial and Ethnic Disparity in State Prisons, African American individuals are over five times more likely to be incarcerated than White individuals, and in at least five states, (Iowa, Minnesota, Vermont, Wisconsin, and New Jersey) the ratio is 10:1 (Nellis, 2016). Additionally, ethnic minorities who are mentally ill experience less access to mental health treatment and lower quality of care, often due to lower rates of health insurance coverage and barriers created by

culturally insensitive health care providers and implicit biases these clients experience in treatment settings (National Alliance on Mental Illness, 2015; Nellis, 2016). Therefore, SMI and SUDs are more often untreated in this population and subsequently contribute to increased risk of arrest.

Economic Disenfranchisement

Limitations in access to and utilization of mental healthcare are also illustrative of individuals who live in lower socio-economic status (SES) environments (Nellis, 2016; Torrey et al., 2014). Simultaneously, incarceration is disproportionately higher for this population (Holzer, 2009). These concerns are compounded by incarceration, which further diminishes economic opportunities for these already disenfranchised individuals, due to stigma and challenges which former prisoners face gaining employment upon release to the community (Holzer, 2009; Holman, 2020; Western & Pettit, 2010).

OMI and Counselors' Social Justice Responsibility

Clearly, there is a cycle of poverty and racial bias undergirding access and utilization of mental health care for OMI who have intersecting marginalized identities (Holman, 2020; Nellis, 2016). These circumstances ultimately increase the likelihood of incarceration feeding an ongoing cycle of structural systemic inequities (Nellis, 2016; Tyler & Brockmann, 2017). Professional counselors are bound by the American Counseling Association (ACA, 2014) Code of Ethics to "promot[e] social justice" as a core professional value (p. 3), and under the ACA Multicultural and Social Justice Counseling Competencies are expected to "employ social advocacy to remove systemic barriers … experienced by marginalized clients within social institutions" (Ratts et al., 2015, p. 12). Therefore, it is incumbent upon professional counselors to understand potential gaps in mental health services available to OMI and to advocate for competent care that addresses these identified mental health service inequities. For decades, the psychology profession has recognized

the need for specialized clinical training for psychologists working in forensic settings, resulting from the work of researchers in such settings, such as John Bowlby (1952, 1973, 1980, 1983) and Robert Hare (1993). However, the counseling profession has not offered the same type of training to counseling students, despite the significant and growing need for trained counselors in forensic settings.

Mental Health Treatment for OMI

Although under the Eighth Amendment (Klein, 1979; Osher et al., 2012), OMI are entitled to competent mental health care while in custody, most do not receive mental health counseling (Bronson & Berzofsky, 2017). The quality and competency of care offered to OMI in forensic settings is often questionable (Osher et al., 2012). Some facilities offer mental health treatment provided by trained mental health professionals, some only offer medication management, and others a combination of the two (Lovell et al., 2002; Osher et al., 2012; Torrey et al., 2014). Therefore, it is important for counselor education programs to train counselors to work in these settings and expose them to OMI as a special population.

A major reason that competent mental healthcare may not be readily available is that correctional settings were not designed to support the mental health needs of OMI (Torrey, et al., 2014). As such, a significant portion of prisons only offer mental health case management by correctional officers (COs) with little or no training in the complex mental health issues OMI experience, much less the ability to providing trauma-informed care (Cloyes et al., 2010; Osher et al., 2012; Torrey et al., 2014). Although there are attempts to standardize assessment of needs and risks of OMI beyond criminogenic risks, these assessments are frequently completed by criminal justice-trained staff, rather than mental health counselors (James, 2015; Newsom & Cullen, 2017; Osher et al., 2012; Vaske, 2017).

In both the general population of prisoners and on prison mental health units, correctional officers are charged with monitoring individuals with SMI to "ensure psychiatric stability. . . [and] to ensure staff and inmate safety" (Galanek, 2015, p. 116). Evidence suggests that CO's training deficits and their focus on safety, which is only one component of treatment, may unintentionally contribute to further unfair treatment of OMI. For instance, OMI are placed in disciplinary segregation (e.g., solitary confinement) at disproportionately high rates, in an attempt to control, rather than treat, behaviors related to mental illness (Galanek, 2015). Therefore, increasing the availability of competent Forensic Mental Health Counselors (FMHCs) is a human rights and social justice issue worthy of attention by professional counselors.

Forensic Mental Health Counselors' Roles

People often think of forensic mental health evaluators or forensic psychologists when they think about OMI. Forensic evaluators are impartial professionals trained in psychology or counseling who do not have a therapeutic relationship with the subject of their services (Holman, 2020). They conduct psychological assessments of competence to stand trial, risk assessments of dangerousness, custody evaluations, and they provide court testimony about their findings (Chadda, 2013). Although these are all important tasks in which counselors in forensic settings may be involved, the role is much larger.

Social workers, chemical dependency counselors, or criminal justice professionals are also sometimes charged with providing mental health intervention; however, they do not generally have the extensive supervised clinical training that counselors have in assessment, diagnosis, or treatment of the full array of mental health challenges OMI face (Holman, 2020). Therefore, they tend to focus on helping offenders with casework tasks like working through administrative requirements related to their sentencing, linking offenders with resources (e.g., housing, job

placement, and mental health treatment), holding offenders accountable to court orders, and enforcing retribution-oriented sentences handed down by the courts or prison administrators. So, these professionals are focused on the legal management or case management tasks more than rehabilitation and treatment (Galenek, 2015; Gonzalez & Connell, 2014; Holman, 2020).

Alternatively, FMHCs focus on rehabilitation, rather than retribution and treatment of mental health challenges rather than case management. They are clinically trained professional counselors who engage in, "[t]asks . . . include[ing] assessments, treatment, providing expert witness testimony or sentencing recommendations to the court, [and] client advocacy" (Holman, 2020, p. 3). In *The British Journal of Psychiatry*, Mullen (2000) further defines forensic mental health counseling as "an area of specialization that, in the criminal sphere, involves the assessment and *treatment* of those who are both mentally disordered and whose behavior has led, or could lead, to offending" (p. 307). He admonishes definitions limiting forensic psychological intervention to assessments as insufficient because they fail to include mental health counseling needs that forensic mental health counselors can provide, if trained to do so.

Special Counselor Training Issues for Forensic Settings

Although we were unable to find any literature advocating for culturally competent specialized treatment for OMI, there is clear advocacy in the *Journal of Addictions and Offender Counseling* for "counselor education programs [to] prepare future counselors to understand the depth and impact of addictive disorders, implement culturally relevant interventions, and recognize and treat multifaceted dully diagnosed clients" (Golubovic et al., 2021). We would argue the evidence here supports a similar need to train counselors to provide culturally competent care to OMI in correctional settings. Due to the legally situated environment of this type of counseling, professional counselors need exposure to didactic coursework and supervised experience that

addresses the unique ethical, legal, and practice intervention issues commonly encountered in forensic contexts (Holman, 2020; Magaletta et al., 2011). For instance, working in forensic settings results in unique ethical and clinical challenges related to informed consent with mandated clients and different types of confidentiality limits than non-forensic settings. Working on interdisciplinary treatment teams in specialized 'problem-solving courts' like Drug, Veteran's, Domestic Violence, and Mental Illness treatment courts may include law enforcement, lawyers, and other individuals who counselors are unlikely to gain training to work with in traditional program offerings (Haskins, 2019).

Additionally, there are unique legal concerns when working with OMI that counselors need to be aware of including offense-specific laws like competency laws, domestic violence laws, and sex offender laws, among others. For instance, when treating sex offenders, counselors need to understand legal requirements for advanced training, certification or licensure required by many states to work with sex offenders, as well as understanding sex offender commitment laws, sex offender registry laws, and interstate compact agreements related to offenders moving from state to state while on probation (Association for Treatment of Sexual Abusers, n.d.). When working in correctional settings, counselors need to understand the differences in working with a client pre-trial or post-conviction, the differences in resources available in jails as opposed to prisons, differences in levels of security and how that affects what counselors can do as part of treatment, issues related to solitary confinement decisions and the impact on clients when in segregation, the differences between specialized treatment units and those mental health units not considered specialized treatment units (Holman, 2020) and laws relevant to work in prisons like the Prison Rape Elimination Act of 2003 (United States, 2003). Further, there are advocacy and clinical concerns that forensic mental health counselors need to learn how to maneuver in systems intended

to punish, rather than rehabilitate. This includes learning how to work with individuals who often have complex cases with over-lapping personality disorders with SUDs and SMI or who have significant trauma often triggered in correctional environments (Holman, 2020; Najavits, 2002).

Additionally, counselor wellness is unique in these settings and self-care and burnout need to be addressed so that counselors learn how to manage their own stress levels, specifically in environments where they do not feel safe or when they work with clients who engender strong countertransference reactions (Holman, 2020). Providing such training is consistent with the ACA Code of Ethics (2014) provisions on counselor competence.

Training Counseling Students to Work with OMI

We believe that targeted counselor preparation addressing these unique legal, ethical, and clinical issues and exposure to this marginalized population during graduate school would likely increase the probability that counselors are prepared to meet the high need for counselors in correctional settings. However, little is known about the opportunities or barriers to didactic coursework or field training in forensic counseling settings, nor the potential to integrate OMI into counselor education programs' social justice or multicultural curricula.

As such, we explored whether there are established professional training standards for counselors specific to work with OMI. We found no 'best practices' for training counselors offered by the International Association of Addiction and Offender Counselors (IAAOC), which is the ACA division for counselors working with OMI (IAAOC, n.d.). We also conducted a search of current peer-reviewed counseling literature and a review of ACA and ACES conference proposal offerings over multiple years to try to identify any existing discussion of the topic and found little on working with OMI and even less on training counselors to do this work.

We also sought direction from the Council on Accreditation of Counseling and Related Educational Programs (CACREP, 2015), which requires counselor training programs to meet certain specific minimum standards in order achieve accreditation. Our review of the CACREP 2016 standards indicates they establish minimum training standards for several counseling specialties, such as addictions and clinical mental health counseling, each of which are tangentially related to working with OMI. We found only one standard which requires CACREP accredited programs to integrate information about counselor's interacting with the legal system but found no current CACREP training standards for counselors working in forensic settings, either embedded within the general standards or within counseling specialty standards (CACREP, 2015). To determine if the lack of explicit standards may affect the inclusion of preparation to work with OMI in coursework or fieldwork, we thought it important to understand whether there were any relationships between CACREP status and available coursework and fieldwork opportunities, and to explore whether there were differences in perceived barriers to offering such opportunities. This approach is consistent with previous literature comparing CACREP and non-CACREP programs finding that CACREP students demonstrated significantly higher levels of counselor professional identity development (Person et al., 2020), significantly higher scores on the National Counselor Exam (Adams, 2018), and significantly less sanctions for ethical violations (Even & Robinson, 2012; Neukrug et al., 2001), although self-perception of multicultural competence was not found to be significant between CACREP and non-CACREP programs (Hill et al., 2013).

Therefore, this study sought to improve our understanding of CACREP and non-CACREP counseling programs' coursework and fieldwork opportunities with OMI in correctional settings and program directors' perceived barriers to offering these opportunities. To gather this information, we interviewed current counseling program leaders using a semi-structured interview

protocol exploring the current state of FMHC training for graduate level counseling students in the U.S., with the hope of informing our practice as counselor educators.

Method

In examining the literature, only one previous study is available that touches on the topic of graduate level training on forensic mental health counseling among helping professions, focusing solely on clinical psychology programs, which we used as a model for this research (Magaletta et al., 2013). After submitting our research protocol to the IRB, we obtained a determination that the study was exempt from further review due to the collection of non-identifying program data.

Participants

To gain a representative sample of all counseling programs, we decided to include both non-CACREP and CACREP-accredited programs. We found contact information for 278 CACREP programs listed on the CACREP website. Since there is no central listing of non-CACREP counseling sites, we conducted an internet search for counseling programs and cross-referenced the results with the list of CACREP sites, to determine which sites were not CACREP accredited. Search terms included ‘counseling programs,’ ‘master’s in counseling,’ ‘non-CACREP counseling programs,’ non-accredited counseling programs,’ among others. We went through every program listing for an average of 15 pages, until we reached saturation, using each search term. The search yielded an additional 50 non-CACREP sites whose accreditation status we verified during interviews. Although we included on-ground and online programs in the potential participants we contacted, we only gained participation from on-ground programs. Therefore, the generalizability of our findings is limited to on-ground programs.

Participants were the chairs or directors of graduate level counseling programs in the United States. Since the focus of the study is on the programs and their training offerings, we delimited the study to focus on the program demographics including whether the institution is private or public and the geographic region where the program is located. The current study represents interviews with graduate level counseling program directors at 35 public and 33 private institutions. Eight programs are in the west, six in the southwest, 12 in the Midwest, 25 in the southeast, and 17 in the northeast. We did not request information specific to specialty areas offered, for the purposes of this study; however, if a forensic track was available, the participant had the opportunity to describe the specialty track, during the interview.

Interview Protocol

With permission from Magaletta et al. (2013), we modified their semi-structured interview protocol that explored the availability of OMI-related didactic and experiential training for students in counselor education programs, changing the word 'psychology' to 'counseling.' Many of the questions are forced choice or closed questions gathering categorical data, analyzed with quantitative methods. These were identical to the clinical psychology study by Magaletta et al. (2013). However, given that we were unable to find research on this topic in the counseling literature, we wanted to gain a deeper understanding of each program's reasoning for including or excluding instruction or fieldwork with OMI. Therefore, we chose to add embedded open-ended questions, consistent with literature on mixed-methods research (Creswell, 2014; Johnson & Onwuegbusie, 2004; Johnson et al., 2007; Morgan, 2007; Venkatesh et al., 2016), which were reviewed by experts in counselor education (Jacob, 2012). We added the following embedded questions 'Are there any factors you'd like to expand on or additional factors you can think of that might limit your ability to implement training experiences in corrections?' and 'Which of the

aforementioned limiting factors would you say has the most impact?' Consistent with Young et al. (2018), the questions allowed participants to expand on their thoughts, beliefs, and attitudes about graduate clinical training related to OMI populations. Additionally, we read this definition of social justice,

> Social justice involves promoting access and equity to ensure full participation in the life of a society, particularly for those who have been systematically excluded on the basis of race/ethnicity, gender, age, physical or mental disability, education, sexual orientation, socioeconomic status, or other characteristics of background or group membership. Social justice is based on a belief that all people have a right to equitable treatment, support for their human rights and a fair allocation of societal resources." (Lee, 2007, p. 2)

Then, we asked a series of questions about whether the program offered didactic and experiential opportunities for students to gain training with a diversity of populations and whether they believed that OMI are a population under this social justice definition.

The final semi-structured interview protocol was 36 questions (Appendix A). We used a concurrent embedded mixed method design (Creswell, 2014) because it allows researchers to explore both quantitative (e.g., frequencies of responses on closed-ended questions) and qualitative (e.g., descriptive) data for maximum exploration of variable relationships (Creswell, 2014). Multiple research methodology experts agree that this design offers a broad range of data allowing researchers to leverage the strengths and minimize weaknesses of using only one of these methods in isolation (Johnson & Onwuegbusie, 2004; Johnson et al., 2007; Morgan, 2007; Venkatesh et al., 2016).

Data Gathering Procedures

We utilized phone interviews to gather data using the semi-structured interview protocol. Phone interviews are more efficient, allow for a broader geographic region to be surveyed, and generally provide quality data on par with in-person interviews (Knox & Burkard, 2009). Three researchers evenly divided the programs identified, alternating days they called program directors on a secure university phone. When a program director was not available, the researcher left a message, and a follow-up call was initiated on a different day and time to maximize the likelihood of gaining participation. All 337 programs were contacted; however, only 68 responded and agreed to participate (53 CACREP and 16 non-CACREP; 20% response rate). The researcher gained verbal consent from the participant, consistent with the research protocol submitted to IRB, then followed the semi-structured interview protocol. As data was gathered, the researcher entered the data into a secure computer for analysis.

Consistent with the data analytic procedures for concurrent mixed methods research described by Creswell (2014), both quantitative and qualitative data was collected simultaneously. We utilized a concurrent embedded strategy, nesting into the interview protocol secondary but related issues regarding inclusion of correctional counseling training as part of the social justice curricula and the exploration of barriers to providing training opportunities (Creswell, 2014).

Data Analysis

Quantitative Data

We first analyzed the categorical data gathered from closed-ended questions to ensure that it met two assumptions necessary to calculate a chi-square. The data met the assumptions of independence and that the data had “no more than 20% of the expected counts less than five and all individual counts one or greater” (Yates et al., 1999, p. 734). Next, we calculated frequencies

for each response. Then we conducted a chi square to explore relationships between CACREP and non-CACREP programs with a correctional course, those with one or more faculty interested in corrections, programs with one or more training opportunities, and those that cover OMI in non-specific multicultural or social justice coursework. Finally, we conducted a chi square to explore relationships between CACREP status and limiting factors that program directors perceived as barriers to offering didactic or clinical training opportunities for working with OMI. Finally, we conducted a chi square to explore relationships between CACREP status and limiting factors that program directors perceived as barriers to offering didactic or clinical training opportunities for working with OMI.

Qualitative Data

The qualitative analysis initially focused on the open-ended responses asking program directors to discuss the most significant barriers to offering coursework or fieldwork opportunities with OMI in correctional counseling settings. Each researcher reviewed the open-ended responses using emergent data analysis techniques commonly used in mixed methods research to identify patterns across responses (Drozdova & Gaubatz, 2016; Onwegbuzie & Combs, 2010, 2015). Utilizing thematic analysis (Fereday & Muir-Cochrane, 2006; Nowell et al., 2017) and researcher triangulation, peer debriefing, and team consensus on themes to strengthen credibility (Creswell, 2014; Nowell et al., 2017), two researchers independently familiarized themselves with the data by reading and reflecting upon it. The researchers generated initial codes reflective of the barriers identified by Magaletta et al. (2013).

However, since the open-ended questions asked the participants to expand on the limiting factors used in the Magaletta et al. (2013) study, we reached consensus through discussion that we would use the Magaletta et al. (2013) categories as the coding framework. These included the

following limiting factors ‘limited faculty interest in the area,’ ‘no correctional setting nearby to conduct practicum,’ ‘faculty busy meeting other specialty or program requirements,’ ‘students are not interested in this area,’ ‘students have concerns about safety,’ ‘students are unaware that this is a practice environment for counselors,’ ‘students lack empathy toward offenders,’ and ‘students prefer to work with clients who are more similar to them and have similar values.’

Each researcher then re-read the data, coding the participant comments within this framework, keeping detailed notes about connections between the comments and the larger issues being investigated regarding the students’ opportunities to learn about and work with OMI in correctional settings. The remaining researchers on the project who were not coding the comments then reviewed the coding and made additional notations about connections between these patterns and potential meanings or additional questions, as some comments referred to overlapping limitations.

Results

Quantitative Analysis

As illustrated in Table 1, this study found that 97.1% of respondents indicated their programs did not offer any courses directly related to correctional counseling, however over half (60.3%) indicated having at least one faculty member interested in correctional counseling. Additionally, although most program directors reported no specific didactic training opportunities on forensic mental health counseling, two thirds reported (67.3%) offering at least one fieldwork opportunity in a correctional setting.

Table 1

Forensic Training Opportunities in Counseling Programs

	Programs with correctional course ***	Programs with one or more faculty interested in corrections	Programs with one or more training opportunities	Programs that cover OMI in other courses **
CACREP Accredited Program	0% (0)	59.6% (31)	71.2% (37)	44.2% (23)
Non-CACREP Accredited	12.5% (2)	62.5% (10)	56.3% (9)	75% (12)
Total Programs	2.9% (2)	60.3% (41)	67.6% (46)	51.5% (35)

Note. CACREP n = 52. Non-CACREP n = 16. Total N = 68. Marked column frequencies significantly differ between CACREP and Non-CACREP programs, * = x^2, $p < .10$, ** = x^2, $p < .05$, *** = x^2, $p < .01$.

Table 2 illustrates the frequency of responses to various limiting factors the participants identified as barriers to including OMI training in didactic or fieldwork opportunities. Participants could endorse multiple barriers. The most common barrier endorsed was that faculty were busy meeting other program requirements (61.8%). This was followed by several evenly distributed answers including fear or concerns for student safety at field placements (47.1%), limited faculty interest (44.1%), the program director's perception of limited student interest (44.1%) and their belief that students wanted to work with clients who are more similar to themselves (42.6%). Finally, they reported that their students were unaware of corrections as a practice environment (41.2%). When asked which barrier most impacted OMI training options, 23.4% identified the primary barrier as faculty being busy meeting other program requirements, followed by 21.9% who selected their belief that students lacked interest.

Table 2

Barriers to Implementing Forensic Training in CACREP and Non-CACREP Counseling Programs

	CACREP Programs	Non-CACREP Programs	All Programs	Ranked limitations with most impact
Limited Faculty Interest	40.4% (21)	56.3 (9)	44.1% (30)	6.3%
No Correctional Setting Nearby	15.4% (8)	25.0% (4)	17.6% (12)	7.8%
Faculty Busy Meeting Other Requirements	63.5% (33)	56.3% (9)	61.8% (42)	23.4%
Limited Student Interest	40.4% (21)	56.3% (9)	44.1% (30)	21.9%
Student Safety Concerns **	50.0% (26)	25.0% (4)	44.1% (30)	10.9%
Students Unaware of Practice Environment*	48.1% (25)	18.8% (3)	41.2% (28)	6.3%
Students May Lack Empathy for Offenders	32.7% (17)	18.8% (3)	29.4% (20)	1.6%
Students' Desire to Work with Similar Clients	48.1% (25)	25.0% (4)	42.6% (29)	3.1%

Note. CACREP n = 52. Non-CACREP n = 16. Total N = 68. Marked row frequencies significantly differ between CACREP and Non-CACREP programs, * = x^2, $p < .10$, ** = x^2, $p < .05$, *** = x^2, $p < .01$.

This study also examined whether programs offered a course devoted to social justice and whether programs cover OMI as part of their larger social justice or multicultural training. Of the programs surveyed, 22.1% report offering a specific social justice course and 86.8% responded that they infuse social justice into one or more courses; some programs did both, so the total percentage is over 100%. However, although all the programs indicated teaching social justice issues in some part of their program, only half (50.8%) reported providing instruction

pertaining to OMI as a specific topic within their greater social justice or multicultural curriculum. This was interesting in that 98.5% of those surveyed endorsed a belief that OMI should be included in the social justice movement within the counseling profession. Additionally, 86.8% of participants indicated that they would be willing to consider more training opportunities (e.g., fieldwork, courses, research) in OMI settings.

To determine if there were differences in program delivery for OMI between CACREP and non-CACREP programs, a series of chi-square tests of independence were conducted. The first chi-square examined the relationship between CACREP accreditation and correctional counseling coursework in masters' level counseling programs. A significant relationship was found, x^2 (1, N = 68) = 6.697, p = .01, demonstrating that non-CACREP programs were more likely to offer correctional counseling coursework than CACREP programs. Next, the relationship between CACREP accreditation and the inclusion of OMI in the social justice curriculum was examined. The relationship between these variables was also significant, x^2 (1, N = 68) = 4.637, $p < .05$, indicating that non-CACREP programs were more likely to include offenders with mental illness as a part of their social justice curriculum. Alternatively, when the relationship between CACREP accreditation and OMI fieldwork experiences was examined, there was no relationship, x^2 (1, N = 68) = 1.242, p = .265.

Finally, a chi-square test was conducted to examine the relationship between CACREP accreditation and the perceived barriers to including OMI coursework or fieldwork in counseling programs. There was a significant relationship between CACREP accreditation and faculty perceptions that student's had safety concerns, x^2 (2, N = 68) = 6.218, $p < .05$; as was the relationship between CACREP accreditation and their report that students were unaware of OMI settings, x^2 (2, N = 68) = 5.580, $p < .10$. These results indicate that faculty in CACREP programs

perceive their students as more concerned about safety and as less aware of opportunities for post-graduate practice in correctional settings than non-CACREP programs.

Qualitative Analysis

We used the Mageletta et al. (2013) framework of barriers to code program chair responses to open-ended questions regarding their perceptions of the most salient barriers for excluding coursework or fieldwork opportunities specific to OMI in correctional settings. The first was *limited faculty interest*. Several program chairs focused on their beliefs that social justice issues are already thoroughly covered in their curricula without needing specific instruction on working with OMI in forensic settings. Some of the chairs made comments like, "I think our program already incorporates social justice initiatives in our existing field placements" and "Social justice is embedded in the majority of our classes."

The second was *no correctional opportunities*. We included statements about barriers to developing field placement sites in correctional settings. We included participant comments indicating that a self-imposed barrier "I don't know if students are specifically prepared to work in that area because we don't focus on it when training students" [in reference to FMHC], and barriers that were external to the program's control, "We have to be invited by the sheriff to go there and we haven't been invited yet." Several program chairs expressed challenges related to supervisory requirements, which can be difficult in an unestablished practice site like corrections. Some of these comments were "We've had difficulty with student taping and observation when students go there" [about a correctional facility]; "It's difficult to get students into prisons for practicum because there are no counselors with credentials to act as supervisors in the local jail;" and "We require video-taping for practicum students and the prison does not allow that."

The third code included comments labeled *faculty busy meeting other requirements*. Some statements falling under this theme are "There isn't enough room for correctional counseling courses with CACREP" and "CACREP already requires so much. There just isn't any extra space to expand our curriculum for coverage of offenders right now."

The fourth code in the framework focused on the chair's belief that students were not interested in learning about counseling offenders with mental illness, which we call *limited student interest*. Some of the comments under this theme are "I think I've only got one student interested in working in prisons, so I would say low student interest;" "Rarely have students chosen that setting" [referencing a correctional facility].

The fifth was *student safety concerns* with participants noting their perceptions that working in correctional settings "could make students nervous." Although the chair's perception of students' thoughts/feelings may not provide actual student reactions to working with the population, the chair's perception is highly likely to influence curricula decisions made regarding what didactic and field training opportunities are provided students. Therefore, it is important to note additional comments like "It's [working with OMI in corrections] intimidating" and "many of them have misconceptions from what they've seen in other places like movies or music."

The sixth code in the framework was labeled *students unaware of practice environment*. An example of this theme was, "Because we don't have coursework about this, I don't know if students are exposed to learning about the population or not." The seventh was labeled *students may lack empathy for offenders*. Some of the comments program chairs made that we included under this label were 'it's harder to build rapport in a scary situation," which we agreed demonstrates an underlying implicit bias that working with offenders would be 'scary' for the students. Another revealing comment in this category was "they might just see them more as

criminals than clients," indicating a lack of empathy for them as human beings and focusing on their criminal behaviors as defining them.

The final code in the framework was *students' desire to work with clients similar to themselves*. One participant's comments were illustrative of this code stating, "Students can make a personal choice about what site they go to, so they get the experience with the clients they want" and "It's not a familiar place."

Discussion

Below we will discuss the results, considering the literature that training counselors to work with OMI is a social justice issue. We will further elaborate on the surprising finding that participants from CACREP accredited programs cited accreditation demands as a barrier to offering OMI-specific coursework, even though they overwhelmingly acknowledged the social justice curriculum need to do so. We will also discuss other barriers participants identified to offering coursework and how these may be related to a lack of knowledge about OMI, from a multicultural perspective. Finally, we will discuss the interesting finding that despite not offering OMI-specific coursework, many programs are placing interns in correctional settings, which further supports the lack of understanding of the unique ethical and legal issues students will face in these settings, leading to potential client welfare concerns.

OMI in Social Justice Coursework

As reported in the results section, 98.5% of the counselor educator participants endorsed a belief that the mental health needs of individuals involved in legal/forensic settings is a social justice issue needing attention from the counseling profession. This is consistent with literature asserting that CACREP-accredited programs need to "prepare future counselors to understand the depth and impact of addictive disorders, implement culturally relevant interventions, and recognize

and treat multifaceted dully diagnosed clients" (Golubovic et al., 2021). As we know significant portion of OMI have dual diagnoses of addictive disorders and other serious mental illness, but these disorders go untreated due to lack of access and utilization of care in the community, which is higher for OMI who frequently have multiple marginalized identities (Kaeble et al., 2015; Peterson et al., 2014; Steadman et al., 2009). We find it hopeful that counselor educators appear to be aware that treatment of OMI is a social justice issue.

However, despite a high percentage of participants recognizing this need and a similar percentage of participants reporting that they teach social justice topics in counseling coursework offered in their programs, only half the participants reported that they include OMI specifically, as part of the social justice coursework they offer. Therefore, we recommend further study regarding the reasons for this apparent disconnect between the belief that it is an important social justice advocacy issue and the lack of instruction specifically addressing this population as a unique social justice concern.

It is possible that when counselor educators are asked specifically about mentally ill individuals in correctional and forensic settings, they feel an obligation to answer in a socially acceptable manner, acknowledging the need for addressing the disparities in mental health treatment for this marginalized population. However, when prioritizing the time spent on social justice issues within their limited time with students, treatment for OMI is not rated as important as other special populations that garner more attention. This may further indicate a need for research examining the relative value counselor educators place on different social justice issues. As part of this research, it may also be important to examine how personal or professional experiences with OMI might impact the counselor educator's or counselor's attitudes towards OMI

and their values related to the access and utilization of competent mental healthcare for people involved with the legal system.

Barrier to OMI Coursework: CACREP Demands

Among the minority of participants who report offering coursework about counseling OMI, these were more-often non-CACREP accredited programs. However, our finding that more non-CACREP programs reported offering coursework or training with OMI than CACREP programs should be evaluated considering the most cited barrier to offering such coursework. Most of the participants stated that they were most inhibited by needing to meet other program requirements.

The pressure to achieve CACREP-accreditation for Clinical Mental Health Counseling programs has increased over the past decade, due to decisions by the National Board of Certified Counselors (2014) to only certify counselors who graduate from CACREP programs, the endorsement of the American Counseling Association (2015; 2016) implying CACREP programs as superior to non-CACREP program, and the requirement for CACREP-accredited degrees for any counselor hired by Veteran's Affairs or to be eligible for TRICARE reimbursement (Urofsky et al., 2013). Despite this pressure, one qualitative study examining the perceptions of faculty in non-CACREP accredited programs, indicated faculty "feared that obtaining CACREP accreditation could limit their creativity and ability to focus on niche areas [like OMI] that faculty had worked hard to create" (Wilson et al., 2018, p. 9). This viewpoint likens CACREP accreditation to a loss of academic freedom. Our findings may support these fears, given that participants from CACREP-accredited programs specifically discussed limitations to offering any instruction outside of the significant mandates that come with achieving accreditation.

The 2016 CACREP standards do not specifically include nor exclude individual groups of people that programs must discuss. Instead, the CACREP Social and Cultural Diversity standards

state that programs should generally cover the following topics, which are relevant when working with OMI: diverse groups, social justice and advocacy, effects of power and privilege for counselors and clients, help seeking behavior of diverse clients, and strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination (CACREP, 2015). When considering these CACREP standards, one can conceptualize counselor educators' addressing the incidence and prevalence of minorities, socio-economically disadvantaged, and mentally ill individuals among those involved with the U.S. legal system, as well as, how counselors can meet the needs for OMI, and advocate for competent mental health interventions for those in correctional and forensic settings (Holman, 2020; Magaletta et al., 2011). Given that this was an unexpected result, it invites further inquiry regarding potential implicit bias among counselors and counselor educators regarding the mental health needs of offender populations. Therefore, it may be helpful to further explore the reasons counselor educators fail to address this population within their existing programmatic social justice framework.

Barrier to OMI Coursework: Lack of Knowledge about OMI

Although most participants indicated they were open to considering more OMI coursework and training opportunities in correctional and forensic settings, they identified several additional perceived barriers to doing so. For instance, participants endorsed beliefs that students did not know there were employment opportunities with OMI, although there are hundreds of correctional counseling jobs listed on ZipRecruiter and similar sites. They also report beliefs that students were fearful of working with OMI, particularly in correctional settings.

It is important to recognize that a lack of knowledge about a marginalized population or fearful attitudes toward that population are core concerns addressed in The Multicultural and

Social Justice Counseling Competencies (Ratts et al., 2015). Therefore, we perceive this, perhaps unconscious, rationale suggesting that counselor educators experience barriers to offering training opportunities with a socially marginalized population (OMI) as legitimate *because* the population is feared and not much is known about them, directly contradicts the values articulated in the competencies. This highlights a practice implication indicating a need for values clarification and diversity training for counselor educators and counselors related to OMI.

These findings are reminiscent of the struggle addictions advocates experienced working toward inclusion of addictions in the standard counseling curriculum (Golubovic et al., 2021; Gonzalez & Connell, 2014; Osher et al., 2012; Prins, 2015; Torrey et al., 2014). Counselors once lacked awareness of the prevalence of addictions in the population, much like they appear to lack awareness of the large numbers of OMI who cannot access needed treatment because of the lack of culturally competent counselors trained to do this work (Golubovic et al., 2021; Gonzalez & Connell, 2014). Further, addictions were once perceived through a morality lens. Given that OMI have broken laws, it is reasonable to consider that counselors may similarly lack empathy for OMI based on morality grounds. Subsequently, they may not attend to OMI's mental health needs on equal footing with other, less marginalized populations. This reality compounds the fact that OMI more often have multiple marginalized identities, resulting in their lack of access to and utilization of care in the community (Osher et al., 2012; Prins, 2015; Torrey et al., 2014). Our findings offer support to existing literature, indicating a need for counselors to receive more training to provide culturally competent care to large numbers of untreated OMI.

However, potential biased beliefs among counselor educators also need to be addressed for instruction to be valuable. As evidenced by the variability across addictions instruction in CACREP programs, simply including OMI training is insufficient to ensure quality instruction

(Chasek et al., 2012; Golubovic et al., 2021; Iarussi et al., 2013; Lee, 2014). When exploring this variability among courses, researchers identified that instructors with positive attitudes and experience working with specific populations provided a different quality of instruction than those who had little experience working with the population or those with negative perceptions of these populations (Golubovic et al., 2021). Therefore, further professional development for counselor educators is also warranted.

Fieldwork Opportunities with OMI

Interestingly, although CACREP status seemed to negatively impact didactic coursework in forensic mental health counseling, we found that CACREP accreditation did not affect whether programs offer fieldwork in a correctional setting. In fact, two-thirds of the programs surveyed currently offer fieldwork in a correctional setting. This leads us to wonder if programs are offering fieldwork without specialized didactic training because the counselor educators or training directors, who develop training opportunities, lack knowledge about special issues in forensic mental health counseling settings.

Some special concerns a counselor educator should address with emerging counselors placed in forensic settings include unique issues related to confidentiality, challenges to informed consent with mandated clients, respecting client autonomy when client behavior is potentially destructive to themselves or society, the counselor's role in ensuring the Prison Rape Elimination Act (United States, 2003) requirements are met, counseling theories and skills most adaptable to engaging and working with forensic clients, and socio-cultural and historical trends in correctional mental health that affect OMI, among other topics (Holman, 2020). As such, future research should further examine the level of awareness or knowledge of specialized forensic mental health counseling issues among counselor educators and counselors. This is true particularly considering

ACA (2014) ethical guidelines that emphasize that counselors need training to work with specialized populations to ensure competent quality mental health counseling and improved client welfare.

Limitations

Although not unusual for this type of research, one limitation of this research is the 20% response rate; therefore, the reader should consider this when evaluating the results. However, despite this limitation these results offer preliminary data consistent with an exploratory study. This study was also delimited by the researchers' choice not to request personal demographic information from participants. By not providing individual demographics the researchers were able to better guard participants' identities and hopefully encourage more open, honest responses. However, given the results, as they related to potential implicit biases regarding attitudes and beliefs about OMI, it would be helpful to have this information to analyze differences in responses based on ethnicity, gender, or other demographic factors. As such, we are unable to draw conclusions on whether there were correlations between participant ethnicity and perceptions that OMI are 'scary' or 'not like' the participants' students. The choice to survey program directors about their perceptions of student's reasons for not participating in opportunities to work with OMI also limits the conclusions we can draw. It would be helpful to survey students directly to understand their thoughts and feelings about working with OMI.

Also, literature discusses several limitations in concurrent embedded mixed methods design, which need to be considered. For instance, this design requires leadership in directing the research team so that continual dialogue about the project's vision and strategy are maintained (Creswell et al., n.d.). Otherwise, the result could be a confusing mix. For instance, having different research team members calling participants at different times could be problematic if team

members do not have a shared vision of the project aims and strategy, as well as an established infrastructure for collecting and recording the data gathered (Creswell et al., n.d.). Another potential limitation to our study is that we chose to record participant responses by typing them out while interviewing the participant, which could limit the accuracy of intended meaning, rather than recording and transcribing the interviews. Mixed methods data can also be difficult to analyze and represent in written findings because of the use of both quantitative and qualitative data (Creswell et al., n.d.). This was a struggle when placing our results in article format to communicate to a larger audience, extending the writing process. Also, when quantitative and qualitative results conflict in mixed methods designs, it can lead to difficulties in reconciling these differences (Creswell et al., n.d.), although not an issue in the current study.

Implications

A major implication of this study is that faculty from CACREP accredited programs report the perception that the requirements for accreditation create perceived barriers to offering coursework in working with special populations, like OMI, even when faculty overwhelmingly report such training as important and deserving of attention. This hypothesis should be further examined by future research. Additionally, these findings may be helpful to consider as CACREP re-evaluates standards moving forward. If counselor educators consider integrating training to work with OMI within their current curriculum, they may benefit from instructional consultation regarding creative ways to integrate important topics related to OMI, within the current CACREP framework, in consultation with practitioners and educators experienced with OMI.

It appears that counselor educators may need professional development to expand their awareness of OMI treatment needs, the social justice issues related to this population, and the unique systemic, ethical, and legal issues regarding working with OMI that require specific

training. One recommendation is that IAAOC, the ACA division that represents offender counselors, expend more resources about counseling in forensic and correctional settings. For instance, several divisions of ACA have developed specific competencies that provide guidance on the attitudes, knowledge, and skills necessary to work with special populations. IAAOC may be able to provide guidance and leadership through their expert members by developing competencies for this population. Additionally, the IAAOC process addictions committee provides a model for professional development activities and raising awareness with counselors and counselor educators about people with behavioral and process addictions, which may be informative in developing research, training, and advocacy for OMI (Cartwright et al., 2019; Crozier & Agius, 2012; Wilson & Johnson, 2013).

Further, we recommend counseling organizations focus more resources on webinars, conference presentations, and publishing research on OMI populations and settings. Potential ideas for how these organizations can increase awareness of OMI populations include sponsoring a conference track on the topic, publishing a special topic journal issue with an OMI theme, and developing webinars and advocacy projects focused on OMI counseling issues. Given the growing impact of racial justice initiatives, like the Black Lives Matter movement, we believe this topic would be of particular interest to a growing number of counselors who have become more aware of potential bias within the legal system. Further, these recommendations would result in professional development resources for counselor educators and counselors interested in working with this marginalized population.

Potential implicit bias towards marginalized populations is a particularly salient issue needing purposeful attention. Although increasingly diverse over the past five decades, the counselor education field is not representative of the population's diversity (Baggerly et al., 2017;

Turner et al., 2008). This, despite the recognition that faculty diversity is important to modeling multicultural competency and social justice advocacy (Smith et al, 2008; Worthington et al., 2010) so students are better prepared to serve diverse clients (Lee, 2013) and because they may attract more diversity among student counselors who are more likely to work with marginalized populations (Braley & Holcomb-McCoy, 2004). Further, racial diversity among faculty in CACREP programs lags behind APA programs (Baggerly et al., 2017). As such, research should explore whether there is any relationship between knowledge and attitudes towards OMI among faculty from marginalized backgrounds with their willingness to include training to work with OMI within current instructional offerings.

Although the current research primarily focused on counseling programs, the perspectives informing this study were only those of counselor educators. In this study, we asked program directors their views on whether their students had an awareness of forensic practice environments, whether students lacked empathy or desire to work with this population, and whether students had safety concerns, but these questions are likely to better answered by students themselves. Counselor educators would be expected to have some insight into the needs and goals of their students, but it is possible future research could discover a discrepancy between counselor educator and student perspectives on these topics. The student viewpoint was outside the scope of this exploratory study but should be considered before drawing concrete conclusions about the limiting factors endorsed by the counselor educators in this study.

The student or emerging counselor perspective is particularly important when considering the high rates of incarcerated OMI and the likelihood of OMI continuing to need mental health counseling in the future (Torrey et al., 2010; Torrey et al., 2014). To develop a competent professional FMHC workforce, it should be a priority for counselor educators to develop didactic

coursework and practical training opportunities for emerging counselors to learn more about working with OMI. Additionally, with increased funding through re-entry grants and the Second Chance Act (2008), counselor educators may have an opportunity to pursue external support to develop mental health programming that targets recidivism reduction and improved counseling outcomes for OMI.

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Appendix A

Hello, Dr. _____, my name is _____.

My team and I are conducting an outreach survey to help us understand how graduate students within counseling programs are exposed to correctional counseling or counseling practice with offenders. This survey should take no longer than ten minutes. This study has been submitted for IRB approval and it has been deemed exempt, because we are collecting aggregate data regarding counseling programs and professional training within those institutions. No names of institutions or any identifiable information will be included in the publications or presentations produced from this study. Do you consent to participate in this short survey?

I would like to begin by providing you with a definition of correctional counseling.

For the purpose of this study, correctional counseling refers to treatment and management work with offenders who are currently in the custody of a jail, detention center, prison or correctional system or facility.

Using this definition, does your program currently have any of the following:

1. Correctional counseling courses. (No skip to 2)

    If yes: Is it within your department or in another department, such as criminology?

2. Do you have a field experience, practicum, or internship in a correctional setting such as a prison or jail? (No skip to 2b)

    If yes: Do these experiences include contact with prisoners identified with mental illness?

2b. Do you have a field experience, practicum, or internship in a correctional setting such as a half –way house, adjudicated diversion program, or treatment facility for adjudicated offenders with mental illness or co-occurring drug/alcohol issues? (No skip to 3)

If yes: Do these experiences include contact with prisoners identified with mental illness?

If yes: Is this field experience: Required? Optional? Assigned by Faculty? Selected by the Student? Selected by the Site? Combination?

3. Now I am going to ask you some general questions about practicum within your department.

3a. Does your program have a training clinic within the department ("in-house")?

Yes/No

3b. Does your program have a training clinic affiliated with another department?

Yes/No

3c. Are your off-site practicums: Required? Optional? Both? Not Offered?

3d. In what semester do students begin taking practicum? _____

3e. Do you have faculty members interested in corrections? (No go to 5)

Yes: How many of your faculty have interests in corrections? ___

Yes: Is their interest oriented toward: Research? Practice? Both?

4. Ok, next I have a list of limiting factors that graduate programs may encounter when trying to implement training experiences in corrections. Please endorse any from this list that you believe to be accurate for your program.

a. Limited faculty interest in this area

Yes/No

b. No correctional setting nearby to conduct practicum

Yes/No

c. Faculty busy meeting other specialty or program requirements

Yes/No

d. Students are not interested in this area

Yes/No

e. Students have concerns about safety

Yes/No

f. Students are unaware that this is a practice environment for counselors

Yes/No

g. Students lack empathy toward offenders

Yes/No

h. Students prefer to work with clients who are more similar to them and have similar values.

Yes/No

4a. Are there any factors you'd like to expand on or additional factors you can think of that might limit your ability to implement training experiences in corrections?

4b. Which one of the aforementioned limiting factors would you say has the most impact?

5. Now I am going to ask you some questions related to social justice starting with a definition of social justice "Social justice involves promoting access and equity to ensure full participation in the life of a society, particularly for those who have been systematically excluded on the basis of race/ethnicity, gender, age, physical or mental disability, education, sexual orientation, socioeconomic status, or other characteristics of background or group membership. Social justice is based on a belief that all people have a right to equitable treatment, support for their human rights and a fair allocation of societal resources" (Lee, 2007, p. 2)

5a. Given this definition does your program currently have any of the following:

a. Social justice courses. No (skip to b)

Yes: Is it in the department? What does it cover?

Yes: Do these courses provide instruction pertaining to offenders with mental illness?

b. Do you have a field experience, practicum, or internship in a social justice setting such as a LGBT community center or a homeless shelter?

5b. Do you believe that offenders with mental illness deserve attention as a social justice cause?

5c. Would you consider including coursework, practicum training or research devoted to corrections and offenders with mental illness into your program?

Yes: Coursework, practicum opportunities, or research?

Thank you for your participation.