

Criminal justice and public health trends have converged bringing about an increased demand for mental health services for individuals ensnared in the criminal justice system. The expansion of sex offender commitment legislation, the surge in the rates of individuals with mental illness within jails and prisons (Lamb & Weinberger, 2005; Prins, 2014), the advent of specialty courts for drug offenders and military veterans (Mitchell, 2011), and the proliferation of diversion and community-based programs for adolescents within the juvenile justice system (Annie E. Casey Foundation, 2013; Howell et al., 2017) are just some of the major trends requiring mental health professionals trained to provide specialized assessment and treatment services within court and correctional settings.

The reach of the return of the “rehabilitation ideal” (Allen, 1981) in criminal justice has been broad. The migration of individuals with mental illness to U.S. jails and prisons in the wake of disappearing public mental health resources has been widely covered in the media (Kim et al., 2015). Lamb and Weinberger (2005) found correctional settings have surpassed psychiatric hospitals in the total population of individuals with mental illness within them. Correctional settings have become the “new asylum” for individuals with mental illness despite being a poor fit for the servicing of their needs. Community-based juvenile justice programs and various diversion programs seeking to prevent adolescents from falling victim to the pernicious effects that “mere exposure” to correctional programming can have on their identities and future development are on the rise (Annie E. Casey Foundation, 2013). Low and moderate risk adolescents are diverted from locked settings and their treatment and management is shifted to the community. The civil commitment of Sexually Dangerous Persons has called for the development and implementation of innovative treatment approaches for sexual offenders, such as the Good

Lives Model (Ward et al., 2007), a strength-based treatment approach that seeks to build healthy relationships and positive coping skills in sexual offenders. The net result of these various trends and initiatives in the criminal justice and corrections systems is the increased need for mental health professionals with specialized training and experience working with these populations.

Recent surveys of correctional practicums for psychologists-in-training report that these training programs provide broad clinical training in assessment and treatment (Magaletta et al., 2013, 2017). Early participation in clinical training within a correctional setting is associated with an increased probability of a decision to work in a correctional setting as an early career choice (Magaletta et al., 2012). Magaletta et al. (2017) in their survey of 47 psychology students in correctional practicum sites reported that 93.8% received direct treatment and clinical intervention experience in individual treatment, 83.3% in psychoeducational groups or classes, 64.6% in process groups, and 62.5% in crisis intervention. Their exposure to various forms of screening and assessment ranged from 74.5% for the diagnosis of mental illness to 23.4% for risk of recidivism. The opportunity for early exposure to clinical training within a correctional program is an important contribution to the professional identity of the developing clinician.

As clinical mental health counseling (CMHC) seeks to unify and consolidate its professional identity under the national accreditation of training programs (CACREP, 2016; Field, 2017; Pistole & Roberts, 2002), it is an opportune time to investigate the current state of the role of CMHCs in correctional settings and to document the training priorities and needs of students participating in practicum training positions at correctional mental health training sites. Norton (1990) proposed a model of supervision for trainees

in mental health counseling and psychology in correctional settings but did not provide survey data from directors, supervisors, or students about their clinical roles and training priorities or needs. While there has been several reviews of practicum and internship training for CMHCs (Bjornestad et al., 2014; Cannon & Cooper, 2010; Gaubatz & Vera, 2006; Neukrug et al., 2013; Sayers & Carroll, 1996), as far as we are aware, there has not been a published survey documenting the clinical functions and training needs of CMHC in correctional settings.

This study surveyed a sample of directors of public-sector adult and juvenile forensic and correctional placements in a New England state including court clinics, forensic mental health units in public hospitals, prisons, juvenile detention centers, and juvenile secure and community residential programs. The results provide data about the prevalence of CMHCs employed in these sites along with a detailed description of their clinical activities and duties within these settings and their level of professional independence. We also surveyed the directors about the training and experience domains they assess as most important when considering the recruitment and hiring of mental health staff for their respective programs. Several research questions guided this survey:

1. What are the major clinical duties and functions of CMHCs within these varied correctional and forensic settings?
2. How do CMHC's proportion their time to the various clinical functions and duties?
3. How much clinical supervision is provided by CMHCs and how often do they function in leadership roles within these programs?
4. What are the most important domains of training/experience for prospective staff within these settings?

5. What are the hiring preferences of clinical directors for various clinical duties within their respective programs?

This survey represents the first of its kind: A survey of forensic and correctional mental health facilities regarding the clinical duties and responsibilities of CMHCs. It is hoped that the results can be used to help guide curriculum development, practicum training and supervision, and research areas within forensically oriented CMHC programs across the country.

## **Method**

### **Participants and Procedure**

One hundred thirty-six mental health programs, servicing adults and adolescents in the criminal and juvenile justice systems, were identified by the first and third authors. An email invitation with a link to the survey on Survey Monkey was sent to the clinical directors. A brief introduction to the project greeted the participants along with instructions about how to complete the survey if they elected to participate. Participants who did not respond to the first email were emailed a follow-up request after a few weeks. The Human Subject Review Board at Roger Williams University approved the research project and survey form.

### **Survey Form**

The survey instrument contained four major domains of inquiry: (a) demographic and professional information about the respondent, (b) information about the forensic mental health facility where the respondent worked and its clinical staffing, (c) information about the clinical duties and responsibilities of CMHCs, and (d) the respondent's ratings of training priorities for trainees and preferences for prospective job applicants. The survey

consisted of 70 questions. Participants were not asked to respond to all items as some questions were nested and participants were instructed to skip sections that did not apply to them. The response format varied: some questions required a dichotomous response (i.e., yes-no); some allowed respondents to check multiple boxes; some asked respondents for a rating on a 7-point Likert scale; and some allowed respondents to elaborate descriptively with text. The full survey was estimated to take about 15-20 minutes to complete. A copy of the instrument is available from the first author upon request.

### **Analytic Strategy**

Frequencies, percentages, chi square tests of independence, and paired-sample *t*-tests were performed to determine significant differences on respondent demographic variables. An alpha level of .05 was used for the demographic variables. Chi square tests of independence were computed for survey respondents' identification of the clinical duties of CMHCs within adolescent and adult programs. Bonferroni's correction was used when multiple chi-square tests were calculated to set a more conservative alpha level and control for the risk of a Type I error. The Bonferroni correction was calculated by dividing the number of comparisons (9) by an alpha level of .05 ( $9/.05 = .005$ ). A more conservative alpha level of .005 was utilized for the multiple chi-square comparisons.

Paired-sample *t*-tests were computed to determine significant differences in the time CHMCs devoted to assessment, treatment and supervision duties and the respondent's ratings of six knowledge-experience domains for prospective applicants for a staff position. An alpha level of .05 was used as for the comparisons of the time estimates and a more conservative alpha level of .008 ( $6/.05$ ) was applied to the respondent ratings of the importance of six knowledge-experience domains for prospective applicants.

To determine whether each mean rating for the knowledge domains was significantly different than the overall mean across all the ratings, an overall mean using all the knowledge domains except the knowledge domain under investigation, was computed. The knowledge domain under investigation and the overall mean were compared through a series of paired-samples *t* tests for all the items. The overall computed means minus the domain under investigation had a similar mean and standard deviation and are not separately reported. They served as the comparison point against the target domain. Cohen's *d* was calculated to estimate the magnitude of the difference between the target knowledge domain and the overall mean of the other five domains. As recommended by Cohen (1988), values under .20 are small effect sizes, .20 - .50 are medium effect sizes, and above .50 are large effect sizes.

A 3 X 3 mixed between-within ANOVA was performed with professional identity (social worker, psychologist, and CMHC) serving as the between group independent variable. Preference ratings of the respondents across assessment, treatment and supervision clinical duties for social work, psychology and CMHC prospective job applicants served as the within group independent variable. All data were analyzed using SPSS 19.0 for Windows.

## **Results**

### **Survey Participant Characteristics**

Sixty clinical directors returned the survey form for a total response rate of 44.1%. Five survey forms had significant missing information and could not be used, leaving 55 (40.4%) completed survey forms.

Clinical directors oversaw mental health services in 21 programs (38.2%) that serviced adult offenders while 34 (61.2%) programs serviced adolescent offenders. Females respondents comprised 63.6% ( $n = 35$ ) of the sample and were more highly represented in adolescent programs (73.5%) than adult programs (47.6%),  $\chi^2 = 3.77$ ,  $p = .05$ ,  $\phi = .26$  (medium effect size). A higher proportion of male respondents were clinical directors in adult programs (52.4%) than adolescent programs (26.5%).

About a quarter (23.5%) of the respondents identified as non-white and there was not a significant difference in the proportion of non-white clinical directors in adult (14.3%) and adolescent (32.3%) programs. Nearly two-thirds of the respondents were social workers (63.0%;  $n = 29$ ), psychologists made up 14.5% ( $n = 8$ ) of the sample, 16.4% ( $n = 9$ ) were CMHCs, and 16.4% ( $n = 9$ ) identified as other (i.e., nurse, psychiatrist).

The average age of the respondents was 41.1 years ( $SD = 9.9$ ). Their average years of employment was 5.4 years ( $SD = 6.3$ ) and 4.2 years ( $SD = 6.0$ ) as directors. Three-quarters (75.0%,  $n = 45$ ) of the respondents were licensed in their respective discipline and 86.7% ( $n = 52$ ) provided direct clinical services to their client population.

### **Clinical Duties of CMHC**

The survey respondents were asked about the clinical and professional duties of the CMHCs within their respective programs. CMHCs conducted intake assessments in 74.5% of the programs ( $n = 41$ ). CMHCs conducted intake assessments in 90.5% of the adult programs ( $n = 19$ ) and within 64.7% ( $n = 22$ ) of the adolescent programs. The difference did not reach statistical significance,  $\chi^2 = 4.54$ ,  $p = .033$ , using a more conservative alpha level of .005, but the magnitude of this difference was moderate ( $\phi = .29$ ). Psychological testing was relatively rare for CMHCs with only 14.5% of the respondents indicating that

CMHC's conducted psychological testing within their program. Psychological testing by CMHCs was higher in adult programs (28.6%) than adolescent programs (5.9%) but the difference was not statically significant,  $\chi^2 = 5.38, p = .02$ , using a more conservative alpha level. The magnitude of this difference, however, was also estimated to be within the medium range ( $\phi = .31$ ). CMHC performed discharge summaries in about half of the programs (52.6%) and treatment plans in about two-thirds of the programs (66.0%). There was not a significant difference in the percentage of discharge summaries between adult versus adolescent programs.

CMHCs were well-represented in the provision of therapy in adult and adolescent programs. Over three-quarters of the respondents indicated that CMHCs provided individual and group therapy (78.6%). They provided more than half of the total therapy sessions within adult and adolescent programs (54.4%). The respondents identified a wide range of individual and group psychotherapy within their programs including cognitive-behavioral therapy, Dialectical-Behavioral Therapy, family therapy, Multisystemic Treatment, substance use treatment, violence relapse prevention training, social skills group, life skills group, and sex offender treatment. Almost half of the programs employ CMHCs as clinical supervisors (44.4%) and over a third of the programs have CMHCs functioning as team or unit leaders. A professional license was required in 59.1% of the programs. The results for CMHCs for assessment, treatment, and leadership positions are contained in Table 1.

**Table 1***Clinical Duties of Mental Health Counselors (MHC)*

Program type	Adult		Adolescent		Total		Phi ( $\phi$ )
	%	( <i>n</i> )	%	( <i>n</i> )	%	( <i>n</i> )	
<b>Assessment</b>							
Intake Assessments	90.5%	(19)	64.7%	(22)	74.5%	(41)	.29 <sup>a</sup>
Psychological Testing	28.6%	(6)	5.9%	(2)	14.5%	(8)	.31 <sup>a</sup>
Discharge Plans	40.9%	(9)	60.0%	(21)	52.6%	(30)	.19
Treatment Plans	73.7%	(14)	60.7%	(17)	66.0%	(31)	.13
<b>Treatment</b>							
Programs with CMHC Therapists	85.7%	(18)	74.3%	(26)	78.6%	(44)	.14
Clients with CMHC Therapists	62.4%	(14)	50.1%	(26)	54.4%	(40)	.10
<b>Leadership</b>							
Clinical Supervisor	38.1%	(8)	48.5%	(16)	44.4%	(24)	.10
Team/Unit Leader	40.0%	(8)	36.4%	(12)	37.7%	(20)	.04
License required	64.7%	(11)	55.6%	(15)	59.1%	(26)	.09

<sup>a</sup> medium effect size

**Time CMHCs Devote to Clinical Duties**

Respondents were asked to estimate the percentage of time CMHCs devoted to various clinical duties and task. Therefore, the percentage estimates are a continuous variable with a mean and a standard deviation. They are not based on frequencies as typically is the case for percentage estimates. The provision of individual and group counseling is the most significant clinical function of the CMHC, comprising nearly half of their professional time ( $M = 43.5\%$ ,  $SD = 18.2$ ). Followed by administrative duties/documentation ( $M = 27.1\%$ ,  $SD = 13.1$ ), assessment ( $M = 24.7\%$ ,  $SD = 18.2$ ), and clinical supervision ( $M = 4.9\%$ ,  $SD = 7.9$ ). CMHCs in adolescent programs spend significantly more time supervising clinical staff ( $M = 7.36\%$ ,  $SD = 9.4$ ) than CMHCs in

adult programs ( $M = 1.56, SD = 3.5$ ),  $t(28.46) = -2.66, p = .013, d = 1.33$  (large effect size). There was no statistically significant difference between adult and adolescent programs regarding time devoted to assessment, therapy, and administrative task such progress notes, service documentation, and billing. The mean percentage of time devoted to each of the major professional functions are presented in Table 2.

**Table 2**

*Percentage of Time CMHC Devoted to Various Clinical Duties*

Program type	Adult	Adolescent	Total
	$M$ ( $SD$ ) ( $n = 16$ )	$M$ ( $SD$ ) ( $n = 22$ )	$M$ ( $SD$ ) ( $n = 38$ )
Assessment	21.6% (24.9)	26.9% (11.9)	24.7% (18.2)
Therapy	51.6% (25.5)	37.6% (19.1)	43.5% (22.8)
Supervision	1.6% <sup>a</sup> (3.5)	7.4% <sup>a</sup> (9.4)	4.9% (7.9)
Administrative/ Documentation	26.6% (12.0)	27.4% (14.0)	27.1% (13.1)

*Note:* Percent (%) of time is the mean of the respondents' estimate of the percentage of time CMHCs devoted to various tasks and duties. It is a continuous variable with a mean and standard deviation.

<sup>a</sup>  $t(28, 46) = -2.66, p = .013, d = 1.33$

### **Rankings and Ratings of Knowledge Domains for Job Applicants**

The survey asked respondents to rate the importance of six knowledge domains when considering job applications for a clinical staff position. The knowledge domains included theoretical knowledge, familiarity with the empirical literature, assessment experience, counseling experience, knowledge of law and ethics, and knowledge of research methodology.

Counseling experience was the top ranked knowledge domain. The mean rating for counseling experience ( $M = 6.39, SD = 1.08$ ) was significantly higher than the mean rating for the other five knowledge domains ( $M = 4.71, SD = .92$ ),  $t(43) = 7.65, p < .001$ .

The effect size for this difference was large ( $d = 1.15$ ). Theoretical knowledge was ranked second ( $M = 5.59, SD = 1.15$ ),  $t(43) = 4.37, p > .001$ ) with a medium effect size ( $d = .66$ ) from the mean of the other five knowledge domains ( $M = 4.87, SD = 0.82$ ). Knowledge of the empirical literature was ranked fifth in importance by the clinical directors and it had a significantly lower mean rating ( $M = 4.43, SD = 1.50$ ) than the mean of the other five domains ( $M = 4.87, SD = 0.80$ ) with a moderate effect size,  $t(43) = -2.75, p = .008, d = -.41$ ). Knowledge of research methodology was ranked sixth (last) with a mean rating significantly lower ( $M = 3.20, SD = 1.32$ ) than the mean rating for the other five domains ( $M = 5.63, SD = .73$ ),  $t(43) = -12.24, p < .001$  and the difference between the means was large ( $d = -1.84$ ).

The results of the knowledge domain rankings and rating comparisons with the overall mean ratings are provided in Table 3.

**Table 3**

*Ratings, Descriptive Statistics, and Paired-Sample t-Test Results Comparing Each of the Six Knowledge Domains to the Overall Mean of the Other Five*

Variable	rank	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	<i>d</i>
Counseling Experience	1	6.39	1.08	7.65	<.001	1.15*
Theoretical Knowledge	2	5.59	1.15	4.37	<.001	0.66*
Law and Ethics	3	5.34	1.36	0.67	.504	0.10
Assessment Experience	4	5.02	1.63	0.79	.433	0.12
Empirical Literature	5	4.43	1.50	-2.75	.008*	-0.41*
Research Methodology	6	3.20	1.32	-12.24	<.001*	-1.84*

\* medium to large effect size

### **Hiring Preferences of Clinical Directors**

A 3 X 3 mixed between-within subject's ANOVA was performed to test the effect of the professional identity of the responding clinical director (social worker, psychologist,

and CMHC) on preference ratings for assessment, treatment, and supervision functions for prospective social worker, psychologist and CMHC applicants. In the analysis, the professional identity of the respondent served as a between-subjects independent variable (social worker, psychologist, and CMHC) and the preference ratings of prospective social work, psychology, and CMHC applicants within the domains of assessment, treatment and supervision served as the within-subjects independent variable.

The analysis did not produce a main effect for the between-subjects independent variable, professional identity. Clinical directors did not significantly prefer their own professional group as demonstrated in their preference ratings for social workers, psychologists, or CMHCs when considering them for positions requiring skills in assessment, treatment and supervision.

The within-subjects (repeated measures) independent variable revealed a main effect for preference rating for treatment. The respondents, regardless of their own professional identity, preferred social workers and CMHCs over psychologists for treatment, Wilks' Lambda = 0.68,  $F(2, 27) = 6.91, p = .004, \eta^2 = 0.32$ . There was a trend for respondents, regardless of their professional identity, to prefer social workers for supervision over CMHCs, Wilks' Lambda = 0.75,  $F(2, 28), p = .019, \eta^2 = 0.25$ ). There was not a significant interaction between the professional identity of the rater and their preferences for assessment, treatment and supervision. The results of the comparison of the preference ratings for social worker, psychology and CMHC candidates by the respondents are provided in Table 4.

**Table 4**

*Hiring Preferences for Assessment, Treatment and Supervision by Professional Identity of Clinical Director*

Preference Rating	Clinical Director (rater)			Total <i>M (SD)</i>
	Social Worker <i>M (SD)</i>	Psychologist <i>M (SD)</i>	CMHC <i>M (SD)</i>	
Assessment	( <i>n</i> = 18)	( <i>n</i> = 9)	( <i>n</i> = 5)	( <i>n</i> = 29)
Social worker	6.06 (1.55)	4.17 (2.48)	5.20 (2.49)	5.52 (2.01)
Psychologist	5.14 (2.40)	5.67 (1.51)	3.80 (2.68)	5.02 (2.08)
CMHC	5.36 (1.54)	5.92 (1.43)	5.80 (0.67)	5.55 (1.39)
Total	5.52 (1.83)	5.25 (1.81)	4.93 (1.97)	
Treatment	( <i>n</i> = 21)	( <i>n</i> = 6)	( <i>n</i> = 6)	( <i>n</i> = 33)
Social worker	6.62 (0.74)	6.17 (1.17)	5.67 (2.39)	6.36 <sup>a</sup> (1.25)
Psychologist	5.00 (1.97)	4.25 (2.19)	3.67 (2.71)	4.62 <sup>a, b</sup> (2.15)
CMHC	5.21 (1.73)	5.92 (1.31)	5.67 (0.68)	5.42 <sup>b</sup> (1.53)
Total	5.61 (1.48)	5.47 (1.56)	5.00 (1.93)	
Supervision	( <i>n</i> = 19)	( <i>n</i> = 7)	( <i>n</i> = 6)	( <i>n</i> = 32)
Social worker	6.53 (1.17)	5.57 (2.30)	6.50 (0.84)	6.31 (1.45)
Psychologist	5.37 (2.09)	5.50 (1.61)	4.58 (2.25)	5.25 (1.99)
CMHC	4.92 (2.20)	4.57 (1.90)	5.67 (0.98)	4.98 (1.95)
Total	5.61 (1.15)	5.21 (1.94)	5.58 (1.36)	

*Note:* Identical superscripts are significantly different from each other

<sup>a, b</sup>*p* = .001

## **Discussion**

The return of a rehabilitation focus within the criminal and juvenile justice systems will likely increase the demand for properly trained and experienced mental health professionals to provide high quality evidenced-based assessment and treatment to adults and children in forensic and correctional programs. The clinical practicum and internship in a forensic setting is a formative experience for the mental health clinician-in-the-making, often leading to choosing forensic mental health as a career path (Magaletta et al., 2013).

Recent surveys of clinical internships for doctoral students in professional psychology has established that psychology interns are exposed to broad range of clinical experiences and training in assessment and treatment in correctional settings. A similar survey of forensic and correctional settings offering practicum and internships for CMHC students has not been conducted. We report on the results of a comprehensive survey of clinical directors of forensic and correctional mental health programs in a New England state who offer practicum and internship experiences for students working toward becoming licensed CMHCs.

The results of the survey revealed that CMHCs are involved in a broad range of clinical activities and duties within forensic and correctional mental health programs. They have a large stake in the performance of intake assessments (74.5%), particularly in adult programs (90.5%), treatment plans (66.0%) and discharge summaries (52.6%); although psychological testing is a less frequent clinical duty for the CMHC (14.5%). These findings are inconsistent with prior research reporting a reluctance on the part of counseling students to become involved in diagnostic assessment (Davis et al., 2005; Neukrug et al., 2013;

Wood & D'Agostino, 2010). These results also challenge the findings of prior research indicating that CMHCs do not perceive assessment as a defining focus of their professional identity and feel poorly prepared in this area of professional practice (Ekstrom et al., 2004; Fischer & Chambers, 2003; Mellin et al., 2011; Villalba et al., 2005).

Assessment is a prevalent and critical role for the CMHC within these forensic and correctional programs, highlighting the need for CMHC students to receive evidenced-based training in assessment, diagnostic interviewing, treatment planning, and case conceptualization. Assessment is a key component to the delivery of mental health services within forensic and correctional settings and is a critically important component to a treatment program.

Notwithstanding the importance of assessment for the CMHC, the provision of psychotherapy and counseling is the main clinical service provided by the CMHC and their role as therapist or counselor may be the primary identity of the CMHC. Over three-quarters (78.6%) of the programs have CMHC conducting individual and group psychotherapy and CMHCs provide about half (54.4%) of the total psychotherapy and counseling within these surveyed forensic and correctional programs. In fact, counseling experience was ranked as the most important knowledge/experience domain, rated more than a standard deviation unit ( $d = 1.18$ ) above the mean rating for the other five knowledge/experience domains. The provision of counseling and psychotherapy comprise almost half of their professional time (43.5%). The centrality of psychotherapy and counseling for the CMHC strongly highlights the need for students to be trained in the provision of evidenced-based treatment in forensic and correctional settings.

CMHCs often assumed leadership positions within these programs with nearly half of the programs (44.4%) indicating that CMHCs function as clinical supervisors and that more than a third (37.7%) function as team or unit leaders. CMHCs were preferred about equally to social workers and psychologists when considering assessment skills and were rated higher than psychologists and about the same as social workers when considering therapy skills and abilities. CMHCs fared about as well as the other professionals when the survey respondents were in the market for a clinical supervisor.

### **Implications of the Study**

The results of this survey have important implications for educational and training programs for CMHCs who offer specialty training tracks or practicum and internship experiences in forensic and correctional programs. Assessment and treatment emerged as central clinical duties and activities for CMHCs within these programs, according to the responding clinical directors, providing a strong argument for offering training in evidence-based assessment and treatment models specifically designed for forensic and correctional programs.

Counseling experience and theoretical knowledge emerged as the highest rated skills that clinical directors look for in applicants for staff positions. The findings argue for the development of course curriculum that include teaching the broad spectrum of theoretical models for counseling and providing opportunities for students in training to apply various theoretical models of counseling within supervised practicum placements. The clinical directors endorsed a broad range of individual and group therapies, including CBT, Dialectical Behavior Therapy, substance-use treatment, and violence reduction groups.

Clinical directors report that their CMHCs carry a large share of the treatment load within these programs and that they decidedly prefer staff that have counseling experience and theoretical knowledge. CMHC training programs are advised by the results of this survey to develop course curriculum and supervised practicum placements to meet this demand in the field.

### **Limitations and Further Research**

The major limitation of this survey was the small sample size and it was limited to a single state system. Future research should expand the geographic representation of the survey results so that regional comparisons across the country can be made. It is unclear if the results of this survey would generalize to other states or other parts of the country, outside of New England. While the recruitment of clinical directors as survey respondents was a strength of this survey, future research should also survey CMHC trainees within forensic and correctional practicum and internship programs regarding their training experience with these programs.

### **Conclusions**

The results of this survey of clinical directors resoundingly supports the large professional stake that CMHCs have in adult and juvenile forensic and correctional mental health programs. While they are identified as having an important role in assessment and clinical supervision, their main clinical identity centers on the provision of mental health intervention and risk-reducing treatment to offenders within these settings. These results have important implications for the curriculum and clinical supervision of students training to be CMHCs in a forensic or correctional setting. Evidence-based assessment and treatment services for individuals in forensic and correctional settings have advanced in

recent years. Given the major role CMHCs play within these settings, it is vital that students training to be CMHCs in forensic and correctional settings receive coursework and supervision within these evidence-based assessment and treatment models to better prepare them for future work within these settings.

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