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Inmate Perceptions of Mental Health Services

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With the increasing rise in the U.S. prison population, meeting the mental health needs of inmates before, during, and after incarceration remains an obstacle. What are the mental health experiences of inmates? For what types of problems are inmates willing to seek help, and what are the barriers to their service utilization? This study investigated inmates' attitudes and perceptions toward mental health services and examined whether these attitudes and perceptions vary with respect to ethnic group membership or among inmates of differing security levels. Implications of these findings for psychologists, including psychologists not employed in correctional settings, are highlighted.

Much has been written about the provision of mental health services in correctional settings, including psychologists' roles and responsibilities in such settings (Boothby & Clements, 2000; Farrington, 1972; Morrissey, Swanson, Goldstrom, Rudolph, & Manderscheid, 1993; Pallone & LaRosa, 1979); however, there is a paucity of information about inmates who seek mental health services. What type of mental health service providers do inmates prefer to see? For what types of problems do inmates seek services? What are the barriers inhibiting inmates' willingness to seek mental health services? These questions must be addressed to ensure appropriate service delivery.

Of particular relevance for psychologists are the therapeutic needs of these clients. Inmates are a culturally diverse population, and with training focused on an awareness and appreciation of multicultural issues, psychologists are already prepared for working with many of the issues presented by this population. However, much more information about the needs and service utilization of this special population is needed.

A variety of mental health services (e.g., individual psychotherapy, group psychotherapy and psychoeducational groups, substance abuse programs) is available to incarcerated offenders (Adams, 1985; Osofsky, 1996; Pallone & LaRosa, 1979). These services appear to respond to a wide variety of mental health problems, such as depression, anger management, psychotic symptoms, anxiety, and institutional adjustment issues, exhibited by inmates (Boothby & Clements, 2000); however, inmates' mental health needs are typically identified from investigations of the types of problems most frequently treated by mental health professionals. In other words, no research elucidates the types of problems for which inmates state they would be most willing to seek mental health services. Thus, it is possible that inmates need (or want) services that mental health professionals in correctional settings are not currently providing. Unfortunately, only one investigation of inmates' service utilization was found in the literature. This study concluded that inmates with greater levels of disability were more likely to receive mental health services (Steadman, Holohean, & Dvoskin, 1991); however, this study did not address inmates' perceptions and attitudes toward mental health services, nor did it investigate the types of services for which inmates are most likely to seek help.

Nevertheless, it has been speculated that inmates' attitudes toward rehabilitation programs tend to be negative (Rappaport, 1982), as inmates do not want to expose their vulnerabilities or experience ridicule from others (Kupers, 2001). It is further speculated that suspiciousness is prominent (e.g., Mathias & Sindberg, 1985) because inmates view therapists as cops and treatment sessions as snitch sessions (Mobley, 1999). They may also be fearful of how documentation of mental health services may be used against them as they progress through the criminal justice system (Kupers, 2001). Although clients' perceptions of treatment services may have a direct impact on the effectiveness of such services (e.g., Palmer, 1991), the accuracy of these speculations regarding inmates' perceptions of and attitudes toward mental health services remains uninvestigated. Certainly, an identification of incarcerated offenders' reported barriers (i.e., biases, negative

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perceptions) to mental health services would enable providers to target these barriers in efforts to reach a larger number of inmates.

Furthermore, little is known about inmates' willingness to seek mental health services. New Zealand inmates who had prior helpful counseling experiences were more likely to utilize prison mental health services (Deane, Skogstad, & Williams, 1999), but little additional information is available. Of particular concern in correctional mental health, given security issues and demographic variability, is that perceptions of mental health services by inmates across varying security levels, as well as ethnic groups, remains unexplored.

Of interest for mental health providers in correctional facilities of differing security levels or restrictiveness is the potential conflict between therapists' goal of providing rehabilitative services versus their goal of providing general mental health services (Morgan, 2003; Morgan, Winterowd, & Ferrell, 1999). General mental health services in correctional environments focus on "specific emotional distress and adjustment difficulties" (p. 604), whereas rehabilitation is geared toward the reduction of recidivism and societal reintegration (Morgan et al., 1999). Although inmates in varying levels of environmental restrictiveness value differing therapeutic factors (MacDevitt & Sanislow, 1987), it remains unclear what inmates across differing security levels perceive as their mental health needs.

Of possibly greater significance are the attitudes and perceptions toward mental health services among inmates of various ethnic groups. For example, it is commonly understood that African Americans frequently underutilize mental health services (O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Snowden, 1999). Of particular relevance for inmate populations is that correctional settings do not foster feelings of trust and security, as previously alluded to, nor do they facilitate self-disclosure (e.g., Halleck, 1960), issues compounded by recent findings regarding cultural mistrust, especially for African American clients (e.g., Whaley, 2001a). Cultural mistrust impacts the attitudes and behaviors of African Americans, including mental health services utilization (Whaley, 2001b), an issue that may be even more prominent given that the majority of mental health professionals in correctional settings are Caucasian (Ferrell, Morgan, & Winterowd, 2000). Thus, it is essential to identify specific barriers experienced by ethnically diverse inmates that will inhibit their willingness to seek mental health services.

The purpose of the present study was to describe male inmates' attitudes and perceptions of mental health services. It seems reasonable to suggest that inmate biases toward mental health services may reduce the likelihood of voluntary treatment participation. Therefore, we anticipated that this study would provide useful information for assisting mental health professionals in addressing inmate biases (e.g., during new inmate orientation sessions), so that inmates would be more comfortable accessing services when needed. More specific hypotheses were that inmates of differing security levels and ethnicities would seek services for differing reasons (e.g., maximum-security inmates would be more interested in general mental health services, whereas minimum-security inmates would be more interested in rehabilitative services) and would identify different barriers to their willingness to seek services (e.g., maximum-security inmates would report more concern than lower security level inmates about barriers to counseling, such as concern about being seen as a snitch).

Inmates' Attitudes and Perceptions of Mental Health Services Survey

A two-page survey was developed to assess inmates' previous experiences with, and attitudes and perceptions toward, mental health services. The survey was written at a sixth-grade reading level and queried a range of mental health related issues, including types of previous experiences related to mental health both before and after adulthood (i.e., age 18 years), participation status (i.e., voluntary or involuntary/mandated), and quantity of services received. Participants were asked to respond to some questions (e.g., "After age 18, approximately how many hours of counseling have you received during any incarceration?") with open-ended responses and were asked to respond to others with a checklist and ranking of responses. For example, when asked, "What type of mental health services have you participated in during your adult life (since age 18)?" they were provided with several response options (e.g., "voluntary individual counseling while incarcerated") and instructed to check all that applied. In addition, participants were asked about their preferences regarding the types of mental health services available to them, as well as the types of mental health providers they would prefer to see, and were asked to respond using a rank-order response format.

Inmates were also queried about the types of problems for which they would consult a mental health professional and the barriers or concerns that would influence their decisions about whether to seek mental health services. Inmates were asked to respond, using a 5-point Likert-type scale (from 1 = *very likely* to 5 = *very unlikely*), to questions about the likelihood of their consulting a mental health professional for a variety of concerns under four broad categories: (a) relationship issues (e.g., problems with other inmates, divorce or relationship problems), (b) emotional issues (e.g., stress or anxiety regarding their incarceration, sad or depressed feelings), (c) health related issues (e.g., problems sleeping too much or too little, problems with serious or chronic disease), and (d) other mental health issues frequently a focus of treatment in correctional settings, such as substance use problems, lifestyle or criminal-behavior problems, severe mental illnesses, or sexual problems. Inmates were also asked, using a 5-point Likert-type scale (1 = *very influential*, 3 = *unsure*, and 5 = *very uninfluential*), about 15 potential reasons that they might not seek mental health services (e.g., "unsure how to access mental health services," "concerned about being seen as a 'snitch,' " "concerned about being seen as weak").

Three correctional facilities representing differing security levels (i.e., maximum, minimum, and a reception and diagnostic unit [RDU] for newly admitted inmates) from a department of corrections in one Midwestern state were used in this study. Participants were recruited at their respective facilities through a verbal invitation to participate in a study that assessed their perceptions of mental health services. The only participation criterion placed on inmates was that they be able to read and write in English. Data collection for this study was completed in accordance with institutional research guidelines as approved by the Texas Tech University Institutional Review Board for the Protection of Human Subjects as well as the Evaluation and Research Division of the state department of corrections in which this study was completed.

A total of 418 inmates completed surveys, with an estimated 70% participation rate among those inmates offered an opportunity

to participate. Of these, 148 (35.4%) were from the maximum-security correctional facility; 123 (29.4%) were from the minimum-security correctional facility; and 147 (35.2%) were from the RDU. The inmates had a mean age of 33 years (SD = 10.08) and were predominantly Caucasian (n = 196; 46.9%) and African American (n = 128; 30.6%). Approximately half of the participants were single or nonpartnered (n = 196; 46.9%), whereas approximately one third were in a significant relationship (n = 120; 28.7%), and the remainder were divorced (n = 75; 17.9%), separated (n = 17; 4.1%), or widowed (n = 5; 1.2%). The average length of education was 11.76 years (SD = 2.03). Inmates were incarcerated for a variety of crimes including the following: drug- or alcohol-related crimes, such as possession or distribution (n = 79; 18.9%); robbery or theft (n = 73; 17.5%); multiple violent crimes (n = 56; 13.4%); murder or manslaughter (n = 41; 9.8%); sex crimes (n = 35; 8.4%); multiple nonviolent crimes (n = 31; 7.4%); assault or battery (n = 18; 4.3%); aggravated assault or aggravated battery (n = 12; 2.9%); and other types of offenses (n = 38; 9.1%). Participants were serving a median sentence of 51 months, with a life sentence being the modal sentence. At the time of this study, the inmate participants had served a mean total of 77 months (SD = 79.2) of their adult life in prison and/or jail. The inmate participants in this study are grossly representative of all U.S. inmates. More specifically, inmates in our study were roughly equivalent with regard to age and the crime for which they were convicted when compared with all inmates incarcerated in federal and state facilities; however, the participants in our study included an overrepresentation, by approximately 10%, of White inmates compared with Black inmates when compared with national averages (Harrison & Beck, 2002).

Before reporting the results of this study, a few limitations should be noted. This study was limited to adult male inmates in state correctional facilities; thus, the generalizability of the results to other incarcerated offenders is unknown. More specifically, these results may not generalize to female or federal inmates. In addition, this study assessed inmates' perceptions during a time of incarceration, and it is unknown how offenders' perceptions of mental health services may differ during times when they are not incarcerated. Last, although attempts were made to record response rates, a data-collection error limited the utility of this data; thus, only an estimated response rate is available.

Prison Security Level and Inmate Differences

Preliminary analyses were conducted to determine if inmates in correctional facilities of differing security levels (i.e., maximum security, minimum security, RDU) are in fact different or unique in several respects. For example, it was anticipated that inmates in maximum-security settings would have been incarcerated for more violent crimes and would be serving longer sentences than inmates in the minimum-security and RDU settings. It was also anticipated that maximum-security inmates would have served more time in adult correctional facilities than either of the other two groups, that they would tend to be older, and that they would report, on average, fewer partnered relationships because of the duration of their incarceration. As hypothesized, results indicated that maximum-security inmates were indeed convicted of more violent crimes, $\chi^2(2, N = 383) = 33.77$, $p < .001$, and were serving longer sentences, $F(2, 397) = 44.74$, $p < .001$. We also found that Black inmates were incarcerated for longer sentences than their White counterparts, $F(1, 309) = 4.42$, $p = .036$, but there were no differences between Black and White inmates' security level placements ($p > .05$).

Results also indicated that maximum-security inmates were less likely to be partnered or married, $\chi^2(2, N = 413) = 18.5$, $p < .001$. Maximum-security inmates had also spent, on average, more of their adult lives incarcerated than had newly incarcerated inmates ($p < .001$), but not more than the minimum-security inmates ($p = .078$). There was no significant difference ($p > .05$) with regard to the age of inmates, regardless of security level. These differences indicate that it will be meaningful to analyze inmates' perceptions of mental health services from the perspective of the differing inmate groups, as mental health professionals may be working with different offender typologies, depending on the type of correctional environment in which they are employed.

Inmates' Mental Health Histories

The results of this study indicated that 36% (n = 149) of inmates received mental health services prior to adulthood, including individual or group counseling (n = 138; 33%) and/or family counseling (n = 89; 21.3%). There was a statistically significant relationship between institutional placement and mental health counseling prior to adulthood, $\chi^2(2, N = 417) = 7.357$, $p = .025$, as well as between racial differences and mental health counseling prior to adulthood, $\chi^2(1, N = 324) = 21.77$, $p < .001$. In other words, inmates incarcerated in the maximum-security setting were most likely to have received either individual, group, or family counseling during childhood (43%) compared with minimum-security inmates (36%) and newly admitted inmates (28%). Furthermore, White inmates were more likely to have received counseling prior to adulthood (44%) than were Black inmates (19%).

Twenty-five percent (n = 105) of inmates participating in this study received some type of voluntary mental health treatment as an adult when they were not incarcerated (i.e., when they were free in the community). Of these inmates, 79 (75%) participated in individual counseling, 29 (28%) participated in group counseling, and 36 (34%) participated in family counseling. On the basis of chi-square analyses, there were no significant differences ($p > .05$) between inmates' security level or race and their voluntary participation in mental health counseling in the community, with the exception that White inmates were more likely to volunteer for individual counseling than were Black inmates, $\chi^2(1, N = 324) = 15.095$, $p < .001$. Furthermore, 31% (n = 129) of the participants volunteered for mental health services at some time during their incarceration as an adult (it should be noted that there is some overlap between those inmates who volunteered for treatment while not incarcerated and those who volunteered for counseling services during their incarceration). Of these 129 inmates, 103 (80%) received individual counseling services, 65 (50%) participated in group counseling, and 9 (7%) participated in family counseling. On the basis of chi-square analyses, inmates in maximum-security settings (41%) were significantly more likely to volunteer for individual counseling compared with minimum-security inmates (24%) and newly admitted inmates (8%), $\chi^2(2, N = 417) = 43.383$, $p < .001$. Maximum-security inmates were also more likely to volunteer for group counseling (25%, 13%, and 8%, respectively), $\chi^2(2, N = 417) = 16.611$, $p < .001$, but were not

more likely to volunteer for family therapy, $\chi^2(2, N = 417) = 0.445$, $p = .801$. No significant differences ($p > .05$) were found between race (i.e., Black or White) and voluntary counseling while incarcerated on the basis of chi-square analyses.

Of the inmates participating in this study, 77 (18%) had been, at some time in their adult lives, mandated to participate in mental health counseling during a time when they were not incarcerated. Fifty (65%) of these inmates received individual counseling services, 37 (48%) received group counseling services, and 17 (22%) received family counseling services. Significant differences were noted: Maximum-security inmates (7%) were more likely to have been mandated to attend family counseling while in the community than were minimum-security inmates (2%) or newly incarcerated inmates (3%), $\chi^2(2, N = 417) = 6.818$, $p = .033$. No significant differences ($p > .05$) were found for institutional security level and mandated individual or group treatment in the community. Furthermore, White inmates (13%) were more likely to have been mandated to attend group counseling in the community than were their Black counterparts (5%), $\chi^2(1, N = 324) = 4.922$, $p = .027$, but were not differentially mandated to attend individual counseling $\chi^2(1, N = 324) = 0.771$, $p = .380$, or family therapy, $\chi^2(1, N = 324) = 1.186$, $p = .276$.

While incarcerated as adults, 90 (22%) of the inmates had participated in mandatory mental health services, such that 68 (76%) participated in individual counseling, 53 (59%) participated in group counseling, and 5 (6%) participated in family counseling. We found no significant relationships ($p > .05$) among race, security level, and involuntary treatment during incarceration, with the exception that maximum-security inmates (22%) were more likely to be mandated to attend individual counseling than were minimum-security inmates (19%) or inmates in the RDU (8%), $\chi^2(2, N = 417) = 10.686$, $p = .005$, with a similar trend for mandated group counseling, $\chi^2(2, N = 417) = 5.576$, $p = .062$.

Inmates were asked about the total number of hours of mental health treatment they had received as adults, during both incarcerated and nonincarcerated times. As a result of variability in reporting (e.g., outliers, narrative descriptors), these data were collapsed into categories in 25-hour increments (i.e., 0 hours, 1–25 hours, 26–50 hours, 51–75 hours, 76–100 hours, and greater than 100 hours). Table 1 presents the number of hours of mental health treatment inmates had received as adults during their incarceration and during times when they were not incarcerated.

Table 1
Hours of Mental Health Treatment Received as Adults

	Incarcerated ($N = 362$)		Not incarcerated ($N = 383$)	
Number of hours	*N*	%	*N*	%
0	195	54	239	62
1–25	130	36	67	17
26–50	0	0	29	8
51–75	0	0	12	3
76–100	0	0	18	5
>100	37	10	18	5

Inmates' Service and Provider Preferences

Inmates participating in this study overwhelmingly reported a preference for individual counseling ($n = 254$; 61%) over group counseling ($n = 28$; 7%) or some other form of mental health service ($n = 20$; 5%) if they were in need of treatment. Ninety-eight (23%) inmates reported no preference for the type of mental health services they would seek if they were in need of mental health services.

Approximately 44% ($n = 185$) of the inmates participating in this study indicated a preference for the type of mental health professional they would work with if they needed mental health services. According to their median rank order of mental health professionals, inmates would most prefer to work with psychologists or professional counselors (median rank = 2 for both categories), followed by psychiatrists (median rank = 3), addiction counselors (median rank = 4), social workers (median rank = 5), students or other professionals (median rank = 6 for both categories), and nonprofessionals (median rank = 7).

As previously indicated, inmates were asked about the likelihood of their consulting a mental health professional for a variety of concerns under four broad categories including the following: relationship issues, emotional issues, health related issues, and other mental health issues. Inmates, on average, reported that they were generally neutral about their likelihood for consulting a mental health professional for relationship issues ($M = 3.5$, $SD = 1.1$), emotional issues ($M = 3.2$, $SD = 1.2$), health related issues ($M = 3.4$, $SD = 1.2$), or other mental health issues, ($M = 3.3$, $SD = 1.2$). Furthermore, results of a one-way multivariate analysis of variance (MANOVA) procedure resulted in no significant differences among inmates housed in maximum-security facilities, those in minimum-security facilities, or newly incarcerated inmates, $\Lambda(8, 696) = 1.27$, $p = .25$. Therefore, inmates with differing levels of security classification and in differing phases of their incarceration did not report differences with regard to those issues for which they would be most likely to seek mental health services. In addition, a one-way MANOVA for race also resulted in no significant differences, $\Lambda(4, 262) = 0.884$, $p = .474$; thus, whether an inmate is Black or White does not negatively influence their likelihood to seek mental health services for differing problems.

Barriers to Mental Health Consultation

As seen in Table 2, on average, inmates indicated that the potential reasons for not seeking mental health services presented to them were not generally barriers that heavily influenced their decision of whether to seek mental health services. Although these potential barriers to service utilization do not appear to prohibit inmates from seeking services, there were significant differences among inmate perceptions of these barriers depending on their security placement. More specifically, a one-way MANOVA procedure resulted in statistically significant between-group differences, $\Lambda(28, 670) = 2.98$, $p < .001$ on the questions of interest, and Table 2 presents the follow-up univariate and Scheffé post hoc analyses. In summary, newly incarcerated inmates (those in the RDU group) considered questions such as when and how to access mental health help, the potential length of treatment, the quality of services they would receive (i.e., concern about seeing nondoctoral-level providers), and perceptions of other inmates (e.g.,

Table 2
Means, Standard Deviations, and Analyses of Inmate Ratings for the Influence of Various Issues on Their Decision to Seek Mental Health (MH) Services

	RDU		Minimum		Maximum		
Type of issue	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*(2, 351)
Unsure how to access help	3.15	1.32_{a}	3.83	1.20_{b}	3.86	1.33_{b}	11.38***
Unsure when to seek help	3.06	1.25_{a}	3.65	1.18_{b}	3.78	1.34_{b}	11.49***
MH is for crazy people	3.54	1.30_{a}	3.82	$1.23_{a,b}$	4.01	1.23_{b}	4.25*
Length of treatment	3.22	1.33_{a}	3.68	1.17_{b}	3.84	1.35_{b}	7.61***
Lack of confidentiality	3.30	1.38_{a}	3.79	1.20_{b}	3.65	$1.46_{a,b}$	3.91*
Seen as a snitch	3.44	1.50_{a}	3.98	1.28_{b}	4.13	1.34_{b}	8.43***
Seen as weak	3.41	1.50_{a}	3.87	1.28_{b}	3.99	1.39_{b}	5.99**
MH groups are rat groups	3.85	1.26_{a}	4.07	1.15_{a}	4.05	1.28_{a}	1.09
Information will be used against me	3.47	$1.45_{a,b}$	3.60	1.42_{a}	3.08	1.61_{b}	3.84*
People should deal with their own problems	3.19	1.30_{a}	3.35	1.35_{a}	3.30	1.39_{a}	0.44
Prefer to talk to friends/family	2.76	1.37_{a}	2.83	1.31_{a}	3.19	1.50_{a}	3.28*
No access to a doctor	3.49	1.25_{a}	3.80	1.21_{a}	3.69	1.38_{a}	1.70
Have to see a training or master's level professional	3.24	1.29_{a}	3.64	$1.27_{a,b}$	3.98	1.30_{b}	10.31***
Previous bad counseling experience	3.75	1.30_{a}	4.08	1.20_{a}	3.86	1.46_{a}	1.76

Note. Responses were based on a Likert-type scale: 1 = *very likely*, 2 = *somewhat likely*, 3 = *neutral*, 4 = *somewhat unlikely*, 5 = *very unlikely*. Values in a row with dissimilar subscripts are significantly different at $p < .05$, as assessed by Scheffé post hoc procedures. RDU = reception and diagnostic unit.
* $p < .05$. ** $p < .01$. *** $p < .001$.

seeing them as weak or a snitch) as more influential in their decision to seek mental health services than did either the minimum-security or maximum-security inmates. In addition, newly admitted inmates placed significantly greater emphasis (regarding their decision to seek mental health services) on a perception that mental health services are for crazy people. Last, newly admitted inmates' decisions to seek mental health services were more influenced by concern about lack of confidentiality than inmates in the minimum-security facility, whereas maximum-security inmates were more influenced than minimum-security inmates by a concern that the information presented in counseling would be used against them by prison officials. Race (i.e., Black or White) was not a factor in reasons that inmates would chose not to seek mental health services, $\Lambda(14, 251) = 1.562$, $p = .09$.

Implications for Correctional Psychologists

Given previous findings by Boothby and Clements (2000), inmates in this study somewhat unexpectedly indicated no greater likelihood for seeking counseling for any of the issues or problems presented in this study compared with any other issues or problems. Thus, it appears that inmates who would seek mental health services would do so for any number of issues or concerns, and those that would not seek mental health services would not do so, regardless of the nature of the problem, their institution's security level, or their ethnicity. Therefore, consistent with current training in correctional psychology (Ax & Morgan, 2002), psychologists need to practice as generalists because they are likely to work with offenders with varying presenting problems. It is not surprising then that psychology or mental health departments in correctional settings appear to be moving toward a community mental health center model where the majority of inmates are self-referred, with a smaller percentage being mandated to attend counseling services.

The effectiveness of mandated treatment for inmates has been debated for some time; nevertheless, a sizeable number (approximately 20%) of inmates continue to be mandated to attend mental health services, either in the community or while incarcerated. When asked what type of mental health services they would prefer, the inmates participating in this study overwhelmingly indicated a preference for individual counseling services and, in fact, received most of their therapeutic services through this modality. This finding is consistent with reports from correctional psychologists, who spend approximately 60% of their treatment time in individual therapy compared with approximately 15% of their time providing group treatment (Boothby & Clements, 2000). This preference, however, does not appear to be related to issues of confidentiality or possible negative perceptions from other inmates because inmates did not endorse these items as barriers to treatment.

Although inmates continue to prefer individual treatment in spite of the availability and prevalence (e.g., Morgan et al., 1999), as well as the effectiveness (Morgan & Flora, 2002), of group counseling services in correctional facilities, the continued increase in the prison population without a parallel increase in staffing (Clements, 1999) may necessitate increased utilization of group therapy as the primary means of service delivery. Therefore, it may be beneficial for inmates to be educated not only about the availability of group counseling services, but also about the utility and efficacy of such services. Certainly, individual counseling will remain an essential treatment modality offered to incarcerated inmates; however, the potential of group counseling to offer an effective therapeutic approach to a larger number of inmates may result in increasing usage.

As previously discussed, it is commonly believed that inmates are reluctant to access mental health services because of a variety of concerns, including confidentiality concerns, the potential for

information to be used against them by prison officials (e.g., security classification, parole board recommendations, etc.), the belief that mental health services are snitch sessions, and the belief that inmates requiring mental health services are weak. However, inmates may be less concerned about social pressures and potential misuses of information than has historically been the case. That is, inmates participating in this study, on average, reported minimal concern about these issues and indicated that these were generally not barriers to their willingness to seek mental health services. This suggests a potential change in the zeitgeist of the prison environment where inmates are now more willing to access services with less concern over the social implications.

Differences existed among inmates of differing security levels; however, the differences were the opposite of those expected. We hypothesized that maximum-security inmates, being incarcerated in stereotypically more machismo settings, would be the most likely to endorse these items as barriers to their willingness to seek mental health services. However, it was the newly incarcerated inmates who reported these types of concerns. One possible explanation for this finding is that newly incarcerated inmates have preconceived ideas about the social structure within a penitentiary setting and only later learn that at least some of these stereotypical perceptions are, in fact, inaccurate. It is also possible that current prison structures are experiencing a transformation, as inmates become less concerned about the perceptions of their fellow inmates than in years past and are willing to trust mental health professionals in an attempt to receive therapeutic services. In any event, correctional mental health professionals need to understand that newly incarcerated inmates may not self-refer for mental health services because of these biases. Thus, a system for monitoring newly incarcerated inmates must be in place to identify those inmates in need of services.

Also of note was the finding that maximum-security inmates were more influenced than minimum-security inmates by concerns about how prison officials would use information disclosed in counseling. Several possible explanations exist for this finding, and correctional psychologists employed in maximum-security settings need to focus on issues of confidentiality as they relate to prison officials whenever possible. This could occur early in the inmates' orientation process (e.g., during the orientation to mental health services that most systems offer) and should also be a focus of early treatment sessions.

It is also of no surprise to correctional psychologists that inmates incarcerated in maximum-security settings have spent more of their adult life incarcerated, are currently serving longer sentences for more violent crimes, and are less likely to have the support of a significant partner. Thus, psychologists and other mental health professionals providing correctional mental health services should be cognizant of the particular needs of the inmates with whom they work.

The results of this study also have implications for mental health procedures in correctional settings. Orientation procedures for newly admitted inmates need to include increased focus on how and when to access mental health services as newly incarcerated participants in this study indicated these as barriers to seeking mental health services. As previously indicated, newly admitted inmates are also concerned about others' perceptions of them if they seek mental health services (i.e., perceived as weak or as a snitch). Although this concern appears to dissipate once they are acclimated to the correctional environment, addressing this issue during orientation procedures may reduce the delay of service utilization. Similarly, inmates may benefit from orientation presentations that deemphasize the focus on mental illness (or craziness) and include the information that services can be brief.

Inmates in maximum-security settings, on the other hand, may require increased reassurance about the confidentiality of services they receive, because they are particularly concerned about how correctional administrators utilize information disclosed during counseling sessions. This issue can be addressed directly during the intake process; however, astute clinicians may also want to revisit this issue periodically during counseling sessions. Last, maximum-security inmates appear to be the population in greatest need of services, given that they were most likely to have received childhood services, and they were the most likely to both request and be mandated to receive individual and group counseling services. Thus, increased efforts should focus on the mental health programming needs of these individuals. More specifically, psychologists should identify the particular needs (e.g., criminogenic issues such as antisocial beliefs, work skills deficits, or anger/hostility) that contribute to recidivism (Andrews et al., 1990) in these individuals so that mental health services can be tailored to match those needs. In fact, this is a critical issue in the effectiveness of correctional treatment programs as programs should target high-risk offenders (Andrews et al., 1990; Gendreau, 1996).

Finally, employment strategies in correctional settings may need to be reevaluated. Inmates in RDUs appear to be more reluctant to request services from non-doctoral-level providers. Furthermore, inmates indicated an overall preference for seeking services from psychologists (or professional counselors), which contradicts the "emerging trend of hiring nondoctoral-level practitioners to provide direct client services" (Morgan et al., 1999, p. 603). Thus, prison and mental health administrators may need to reevaluate hiring practices with a particular focus on increasing the presence of doctoral-level providers, particularly in RDUs.

Implications for All Psychologists

The results of this study should be of interest to correctional as well as noncorrectional psychologists and mental health professionals. Of particular interest to noncorrectional psychologists is the finding that at least one fourth of the inmates participating in this study participated in either voluntary or mandated counseling services during a time when they were not incarcerated (i.e., community-based mental health services). Therefore, it is likely that psychologists, regardless of settings (e.g., correctional, psychiatric, or community), will at various times during their practice provide therapeutic services to offender clients. Thus, it seems appropriate that training programs begin to include experiences for working with this specialized population.

Training implications are further supported by the recent finding that 6% of California psychologists work in correctional facilities (Pingitore, Scheffler, Haley, Sentell, & Schwalm, 2001), a relatively large number given that master's-level therapists may be correctional administrators' mental health providers of choice (Morgan et al., 1999). In addition, the interface between psychology and law (including corrections) provides a growth opportunity for psychologists; therefore, it is fortunate that psychology training programs are already largely prepared for the inclusion of such

training opportunities because it may be argued that working with offender populations is analogous to working with other culturally diverse clients. In fact, offenders may be one of the most ethnically diverse client populations in this country, a problem confounded by the overrepresentation of minorities (especially Blacks) in the U.S. criminal justice system (see Haney & Zimbardo, 1998; Snell, 1995). It should be noted that ethnicity is only one of several cultural issues that must be dealt with when working with this population given issues of the "criminal code" and prison culture more generally.

Given this heterogeneity of prison populations, it is no surprise that offenders present with unique problems and challenges that necessitate specialized skills and knowledge (e.g., impact of systemic punishments on mental illnesses, crisis management for segregated inmates lacking social support, facilitation of treatment gains in a punitive correctional environment). Undoubtedly, psychologists are well trained for dealing with issues of diversity in general and would appear particularly qualified for dealing with the unique issues and problems presented by offender clients. This issue appears particularly salient, given that inmates would prefer to work with psychologists (or professional counselors) rather than other mental health professionals. Therefore, the inclusion of training experiences related to treatment of offenders as a diverse population may prove beneficial to psychologists who find themselves working with offender clients.

Although not the focus of this study, the results highlighted the fact that Black inmates are disproportionately incarcerated and for longer sentences compared with their White counterparts. As the discipline of psychology considers its role in advocacy (Dobson, 2002; Fouad, 2002; Levant et al., 2001; Miller, 2002; Safarjan, 2002), psychologists should note that the U.S. legal system is clearly one governing body that continues to marginalize minorities and thereby warrants the advocacy efforts of psychologists. Of additional concern is the finding that White inmates were more likely to have received mental health counseling as children than were their Black counterparts. This finding is consistent with that of Herz (2001), who found that White juvenile offenders were more likely to receive a mental health placement, whereas Black juvenile offenders were more likely to receive a criminal justice placement. Although alternative explanations exist for this finding (e.g., an issue of financial disparity rather than biased placement), clearly advocacy efforts aimed at affording equal mental health services to all children are warranted.

Psychologists are likely to be sought out for mental health services by offenders both inside and outside of the correctional environment; thus, correctional and noncorrectional psychologists alike need to be familiar with the mental health experiences, attitudes, and perceptions of this population. The results of this study highlight the benefits and the possible necessity of increased training opportunities and advocacy efforts directed toward offender populations.

References

Adams, K. (1985). Addressing inmate mental health problems: A new direction for prison therapeutic services. *Federal Probation, 49,* 27–33.

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology, 28,* 369–404.

Ax, R. K., & Morgan, R. D. (2002). Internship training opportunities in correctional psychology: A comparison of settings. *Criminal Justice and Behavior, 29,* 332–347.

Boothby, J. L., & Clements, C. B. (2000). A national survey of correctional psychologists. *Criminal Justice and Behavior, 27,* 716–732.

Clements, C. B. (1999). Psychology, attitude shifts, and prison growth. *American Psychologist, 54,* 785–786.

Deane, F. P., Skogstad, P., & Williams, M. W. (1999). Impact of attitudes, ethnicity and quality of prior therapy on New Zealand male prisoners' intentions to seek professional psychological help. *International Journal for the Advancement of Counseling, 21,* 55–67.

Dobson, K. S. (2002). A national imperative: Public funding of psychological services. *Canadian Psychology, 43,* 65–75.

Farrington, J. (1972). Utilization of psychological constructs by group therapy participants. *Psychological Record, 22,* 387–394.

Ferrell, S. W., Morgan, R. D., & Winterowd, C. L. (2000). Job satisfaction of mental health professionals providing group therapy in state correctional facilities. *International Journal of Offender Therapy and Comparative Criminology, 44,* 232–241.

Fouad, N. A. (2002). Dreams for 2010: Making a difference. *Counseling Psychologist, 30,* 158–166.

Gendreau, P. (1996). Offender rehabilitation: What we know and what needs to be done. *Criminal Justice and Behavior, 23,* 144–161.

Halleck, S. L. (1960). The criminal's problem with psychiatry. *Psychiatry, 23,* 409–412.

Haney, C., & Zimbardo, P. (1998). The past and future of U.S. prison policy: Twenty-five years after the Stanford Prison Experiment. *American Psychologist, 53,* 709–727.

Harrison, P. M., & Beck, A. J. (2002, July). Prisoners in 2001. *Bureau of Justice Statistics Bulletin* (NCJ 195189). Washington, DC: Office of Justice Programs, U.S. Department of Justice. Retrieved April 10, 2003, from http://www.ojp.usdoj.gov/bjs/pub/pdf/p01.pdf

Herz, D. C. (2001). Understanding the use of mental health placements by the juvenile justice system. *Journal of Emotional and Behavioral Disorders, 9,* 172–181.

Kupers, T. A. (2001). Psychotherapy with men in prison. In G. R. Brooks & G. E. Glenn (Eds.), *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches* (pp. 170–184). San Francisco: Jossey-Bass.

Levant, R. F., Reed, G. M., Ragusea, S. A., DiCowden, M., Murphy, M. J., Sullivan, F., et al. (2001). Envisioning and accessing new roles for professional psychology. *Professional Psychology: Research and Practice, 32,* 79–87.

MacDevitt, J. W., & Sanislow, C., III. (1987). Curative factors in offenders' groups. *Small Group Behavior, 18,* 72–81.

Mathias, R. E., & Sindberg, R. (1985). Psychotherapy in correctional settings. *International Journal of Offender Therapy and Comparative Criminology, 29,* 265–275.

Miller, D. (2002). Advancing mental health in political places. *Professional Psychology: Research and Practice, 33,* 277–280.

Mobley, M. J. (1999). Psychotherapy with criminal offenders. In A. K. Hess & I. B. Weiner (Eds.), *The handbook of forensic psychology* (2nd ed., pp. 603–639). New York: Wiley.

Morgan, R. D. (2003). Basic mental health services: Services and issues. In T. Fagan & R. K. Ax (Eds.), *Correctional mental health handbook* (pp. 59–71). Thousand Oaks, CA: Sage.

Morgan, R. D., & Flora, D. B. (2002). Group psychotherapy with incarcerated offenders: A research synthesis. *Group Dynamics: Theory, Research, and Practice, 6,* 203–218.

Morgan, R. D., Winterowd, C. L., & Ferrell, S. W. (1999). A national survey of group psychotherapy services in correctional facilities. *Professional Psychology: Research and Practice, 30,* 600–606.

Morrissey, J. P., Swanson, J. W., Goldstrom, I., Rudolph, L., & Manderscheid, R. W. (1993). *Overview of mental health services provided by*

state adult correctional facilities: United States, 1988 (Mental Health Statistical Report No. 207). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Osofsky, H. J. (1996). Psychiatry behind the walls: Mental health services in jails and prisons. *Bulletin of the Menninger Clinic, 60,* 464–479.

O'Sullivan, M. J., Peterson, P. D., Cox, G. B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology, 17,* 17–30.

Pallone, N. J., & LaRosa, D. S. (1979). Mental health specialists and services in correctional facilities: Who does what? *Journal of Offender Counseling, Services, and Rehabilitation, 4,* 33–41.

Palmer, T. (1991). The effectiveness of intervention: Recent trends and current issues. *Crime and Delinquency, 37,* 330–346.

Pingitore, D., Scheffler, R., Haley, M., Sentell, T., & Schwalm, D. (2001). Professional psychology in a new era: Practice-based evidence from California. *Professional Psychology: Research and Practice, 32,* 585–596.

Rappaport, R. G. (1982). Group therapy in prison. In M. Seligman (Ed.), *Group psychotherapy and counseling with special populations* (pp. 215–227). Baltimore: University Park Press.

Safarjan, B. (2002). A primer for advancing psychology in the public sector. *American Psychologist, 57,* 947–955.

Snell, T. L. (1995). *Correctional populations in the United States, 1993* (No. NCJ-156675). Annapolis Junction, MD: U.S. Department of Justice.

Snowden, L. R. (1999). African American service use for mental health problems. *Journal of Community Psychology, 27,* 303–313.

Steadman, H. J., Holohean, E. J., Jr., & Dvoskin, J. (1991). Estimating mental health needs and service utilization among prison inmates. *Bulletin of the American Academy of Psychiatry and the Law, 19,* 297–307.

Whaley, A. L. (2001a). Cultural mistrust: An important psychological construct for diagnosis and treatment of African Americans. *Professional Psychology: Research and Practice, 32,* 555–562.

Whaley, A. L. (2001b). Cultural mistrust and mental health services for African Americans: A review and meta-analysis. *Counseling Psychologist, 29,* 513–531.

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