Correctional Officers' Mental Health Literacy and Attitudes Toward Offenders with Mental Illness

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CORRECTIONAL OFFICERS’ MENTAL HEALTH LITERACY
AND ATTITUDES TOWARD OFFENDERS WITH MENTAL
ILLNESS

A Dissertation
Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The School of Social Work

by
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May 2020
This dissertation is dedicated to Patricia Hebert Landwehr, my beautiful sister, my educational muse.

My social work heart must also acknowledge all of the people involved in the criminal justice system for whom I advocate and work to empower. My passion for social work was cemented as I watched them suffer, struggle, recover, and live. I am a better social worker because of those tough lessons. I promise to fight for social justice and believe that every person has dignity and worth.
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ABSTRACT

Overrepresentation of people with mental illness in the criminal justice system is a major societal problem. According to the Bureau of Justice Statistics, nearly three quarters of people housed in local jails report having symptoms suggestive of mental illness. Individual consequences to incarceration for people diagnosed with a mental illness include disruption in treatment, increase in symptomology, exposure to violence, and victimization. Correctional officers are an important component to the criminal justice system but their role in the lives of offenders with mental illness has been understudied. The current study explored the mental health knowledge, attitudes, and personal experiences of Louisiana jail correctional officers. Cross-sectional data was collected in a self-report survey from June 2019 until August 2019. The sample consisted of jail correctional officers (n=214) from 11 parishes in Louisiana. The average age of the sample was 36.1 years. A majority of the sample were male (69%), Caucasian (76.5%), and had a high school diploma (48.7%). The mean number of months as a correctional officer was 81.2.

The multiple regression analysis tested the hypotheses that (H1) work experience, (H2) educational attainment, and (H3) contact with persons with mental illness predicted attitudes toward offenders with mental illness; (H4) mental health literacy predicted the level of negatively held stereotypes of mentally ill offenders; and (H5) that attending CIT training is predictive of mental health literacy. Work experience in months (H1) and contact with people with mental illness (H3) were not found to be predictors of attitude toward offenders with mental illness. However, educational attainment (H2) was found to be a significant predictor of attitude. Mental health literacy was found to be a predictor of negative stereotypical views of offenders with mental illness. Attending CIT training (H5) was not a predictor of mental health literacy.
Further research is needed to determine if improved attitudes toward offenders with mental illness translate to improved outcomes for offenders with mental illness.
CHAPTER 1. INTRODUCTION

Overrepresentation of persons diagnosed with mental illness in the criminal justice system, and those detained in jails, in particular, is a major societal problem. Despite the attention to this issue over the last two decades, negative personal and criminal justice outcomes for offenders with mental illness remains higher than for offenders without a mental illness (Lamb & Weinberger, 2011; Ringhoff, Rapp, & Robst, 2012). The problem has negatively affected persons with mental illness and contributes to continued alienation, stigmatization, and social difficulties. Possible factors contributing to the poor outcomes for offenders with mental illness are the attitudes and lack of mental health knowledge of correctional officers who work within the criminal justice system. Correctional officers are responsible for the daily care of all offenders and have decision making authority that directly relate to offender outcomes. The current study explored the mental health knowledge, attitudes, and personal experiences of jail correctional officers to identify associations between these variables.

The consequences of incarceration for many people with mental illness are harsh (Biswas, 2017; Fezel, Hayes, Bartellas, Clerici, & Trestman, 2016; Treatment Advocacy Center, 2016). Findings from a systematic international review of studies on prisoner mental health from 2003-2015 indicate that rates of suicide, self-harm, violence, and victimization are significantly higher than for people without mental illness (Fezel et al., 2016). In the United States, offenders with mental illness housed in jail facilities are often delayed treatment and suffer from untreated symptoms; subsequently, they experience behavior management problems as a result of the untreated symptoms (Biswas, 2017; Treatment Advocacy Center, 2016). Behavior problems often lead to disciplinary actions, including isolative housing assignments, which exacerbate symptoms and compound consequences (Biswas, 2017). The Treatment Advocacy Center (2016)
reports that offenders with mental illness remain in jail longer, are costlier, and are more likely to commit suicide while incarcerated.

Although prevalence rates vary, researchers have consistently noted that people with mental disorders are overrepresented in correctional facilities nationwide (Henrichson, Rinaldi, & Delaney, 2015; Restum, 2005). The most recent national data reports that 44% of all jail offenders have been told by a mental health professional that they have a mental disorder (Bronson & Berzofsky, 2017). Due to the prevalence of mental illness among incarcerated populations, correctional staff is likely to encounter offenders with mental illness and view responsibility for offenders with mental illness as an added stressor to an already demanding job (Berkeley Journal of Criminal Law, 2009). Under the 8th Amendment to the U.S. Constitution, jails are mandated to provide appropriate and adequate mental health care for offenders under their supervision (Dvoskin & Spiers, 2004). The goal of jail authorities is to ensure the security and safety of staff and offenders, but the correctional staff is increasingly responsible for providing rehabilitation and treatment-type services to offenders, simultaneously serving punitive, protective, and rehabilitative functions (Dvoskin & Spiers, 2004).

**Mental Health Literacy**

Mental health literacy encompasses an individual's knowledge and beliefs about mental illness (O'Connor, Casey, & Clough, 2014). Researchers have scantly studied correctional officers' mental health literacy and knowledge about mental health despite the rise in the prevalence of offenders with mental illness. Attributes of mental health literacy include the ability to recognize specific disorders, knowledge of how to seek information, knowledge of risk factors, knowledge of causes of mental illness, knowledge of self-treatment, knowledge of professional help available, and attitudes that promote recognition or application of help-seeking
behaviors (Jorm et al., 1997). The Crisis Intervention Team (CIT) training model can be used to increase correctional officers’ knowledge about mental disorders and expose them to people with mental illness. The National Institute of Corrections (NIC, 2010) states that benefits of CIT for correctional staff include a reduction in officer and offender injuries, an increased chance for offenders to connect with mental health services, an increase in officer confidence in their skill (i.e., self-efficacy), a reduction in agency liability, a reduction in unnecessary use of force, and a reduction in costs by way of fewer probation violations. Although CIT is widely studied in non-criminal justice settings (i.e., patrol-based law enforcement), this researcher could find only three empirical studies that investigated outcomes for CIT in the correctional environment (Center for Health Policy, Planning, and Research, 2007; Davidson, 2016; Public Health Research Institute, 2011). Although findings from these studies indicate that CIT training is beneficial in the short-term, a lack of longitudinal research prevents any claims of the long-term benefits of the training in a correctional setting (Davidson, 2016). Some researchers have investigated correctional officer outcomes related to mental health training (i.e., self-efficacy when responding to mental health crisis and verbal de-escalation skills; Davidson, 2016; Petrecek, 2012), few have measured knowledge of mental disorders (Davidson, 2016; Podkova, 2013) and none have measured mental health literacy among correctional officers employed in jails. The proposed research study intends to address this gap in the literature.

**Attitudes Toward Offenders with Mental Illness**

Because stigma is a process by which individuals with mental disorders are distinguished and labeled, stereotyped, and ultimately devalued (Bechteler, 2015; Corrigan, Kerr, & Knudsen, 2005), the attitudes held by correctional officers toward offenders with mental illness is important. According to Corrigan and Watson (2002), negative attitudes and stigmatizing views
of people with mental illness can lead to discriminatory practices. Discriminatory behavior, resulting from stigmatizing attitudes toward people with mental illness, includes avoidance, minimizing interactions, withholding help, and coercive treatment (Corrigan & Watson, 2002; Overton & Medina, 2008; West, 2015). Often the stereotyping and discrimination are as harmful as the disease itself, hindering the quality of life and ability to pursue goals of people diagnosed with mental illness (Corrigan et al., 2005; Overton & Medina, 2008).

**Purpose of this Study**

The purpose of this exploratory study was to examine the level of mental health literacy and attitudes of jail correctional officers toward offenders with mental illness and to evaluate whether experience with persons with mental illness is associated with those findings. This study aims to contribute to the knowledge base and to explore what, if any, factors mitigate the identified relationships. The findings will inform correctional administrators on training jail staff in such a way to contribute to a safer, more effective correctional staff. The study sought to test the following hypotheses:

Hypothesis 1: Correctional officers with more work experience will have more positive attitudes toward offenders with mental illness.

Hypothesis 2: Correctional officers with higher educational attainment will have more positive attitudes toward offenders with mental illness.

Hypothesis 3: Correctional officers with more frequent contact with persons with mental illness will have more positive attitudes toward offenders with mental illness.

Hypothesis 4: Correctional officers with high mental health literacy will have fewer negative stereotypes of offenders with mental illness.
Hypothesis 5: Correctional officers in a jail setting who report attending CIT training will have high levels of mental health literacy.
CHAPTER 2. LITERATURE REVIEW

The literature review provides a background for the proposed study by identifying relevant historical and empirical research related to the incarceration of people with mental illness, mental health literacy among correctional officers, and attitudes toward offenders with mental illness. This chapter includes a theoretical and historical perspective, the current state of the literature, as well as identified gaps in the literature.

Theoretical Perspective

Theories are used to make sense of the world in an organized and expected way. For social workers, theories align practice with informed systematic models (Payne, 2016). Clinical decisions are informed by theoretical models based on research and empirical evidence (Payne, 2016). Chapter two presents three theories to explain the social problems associated with incarceration of people with mental illness. Specifically, this section addresses the rise of incarceration rates for offenders with mental illness, the stigmatization of offenders with mental illness, and correctional officers’ attitudes toward those offenders.

Structural discrimination

Structural discrimination models are used by social scientists to describe the stigmatization of people diagnosed with mental illness (Corrigan et al., 2005: Corrigan, Markowitz, & Watson, 2004). The models are based on structural discrimination theory, which asserts that race, ethnicity, and gender-neutral laws and policies have an unintended harmful effect on minority groups (Pincus, 2000). Although structural discrimination theory is typically applied to racial discrimination, such as the use of Jim Crow laws to discriminate against African-Americans in the southern U.S., this theory may include other stigmatized, vulnerable,
and less empowered groups, including people with mental illness (Bechteler, 2015; Corrigan, et al. 2005; Scannell & Nagai-Rothe, 2011).

Borrowing the concepts of structural discrimination theory, simultaneous changes in mental health delivery and the criminal justice system over the last 50 years may explain the rise in the number of people with mental illness in U.S. jails. Although structural discrimination is primarily defined to include unintended negative consequences, Corrigan et al. (2005) include laws that intentionally restrict opportunities of people with mental illness as well as unintended consequences of institutional policies. Intentionally restrictive laws include ineligibility to hold a government office, laws that limit parenting custody due to mental illness, and restricted voting laws (Corrigan et al., 2004). Government efforts to trim budgets and reallocate funding during deinstitutionalization paved the way for the current system of healthcare, which has arguably contributed to the lack of treatment opportunities for people with mental illness (Lurigio, 2011).

The well-intended deinstitutionalization policies meant to provide people a chance to live and receive treatment in the community were successful for a large portion of people diagnosed with mental illness. However, the unintended consequence of deinstitutionalization for some people with severe and persistent mental illness is homelessness, poor treatment outcomes, addiction, and incarceration (Davis, Fulginiti, Kriegel, & Brekke, 2012).

**Mere Exposure Theory**

Mere Exposure Theory posits that familiar stimuli, those stimuli to whom the person has been exposed, are more likable than unfamiliar stimuli (i.e., those stimuli to whom the person has never been exposed; Harmon-Jones & Allen, 2001). Further, Harmon-Jones and Allen (2001) state that repeated exposure to nonreinforced stimuli increases a person’s positive affective reactions to those stimuli. Harmon-Jones and Allen (2002) identify multiple models to
explain the mere exposure effect (i.e., positive responses following exposure to a stimulus). First, affective models use evolutionary theory to explain that unfamiliar stimuli may be associated with a more negative attitude because of the unfamiliar stimuli’s association with potential danger. Cognitive models propose that brief exposures to stimuli produce memory representations that lack contextual reference. Perceptual fluency/attributional models suggest that familiar stimuli are more comfortable to perceive, encode and process than unfamiliar stimuli and thus have increased perceptual fluency. Perceptual fluency/attribution models attribute the reported increased liking as a product of the experimental questions rather than a genuine fondness of the stimuli. Finally, an affective-perceptual fluency model posits that as stimuli become more familiarized, they become more perceptually fluent, and this increase in fluency may then increase positive affective response. In other words, the positive affect caused by mere exposure may result from an increased ease of cognitive processing.

Research on mere exposure theory studies the phenomenon that stimulus ratings are more favorable after participants are exposed to the stimulus (i.e., the exposure effect). The exposure effect is a complex phenomenon that is based on nonreinforced exposure (Bornstein, 1989). A meta-analysis of research from 1968-1987 found that stimulus type, stimulus complexity, presentation sequence, exposure duration, stimulus recognition, age of the subject, the delay between exposure and rating, and the maximum number of stimulus presentations all influence the magnitude of the exposure effect (Bornstein, 1989). Social interactions have been used as exposure in research and have been determined to increase positive affect toward a stimulus. The present research is interested in correctional officer experiences that are more complex and represent a higher level of relationships than is tested in mere exposure research. Mere exposure to stimuli can significantly enhance liking for those stimuli, including social targets; however,
reduction in uncertainty about an object is an important mechanism to the phenomenon (Harmon-Jones & Allen, 2001; Pettigrew, Tropp, Wagner, & Christ, 2011). Unfortunately, the relationships that build and will be tested in this research study are likely more intense and complex than social encounters identified in mere exposure research.

**Intergroup Contact Theory**

Intergroup contact theory suggests that intergroup exposure reduces stigmatizing attitudes and discriminatory behavior among groups (Pettigrew, et al., 2011). Intergroup exposure consists of personal contact with members of a negatively stereotyped group. Additionally, intergroup exposure is believed to improve attitudes toward members of the negatively stereotyped group based on the type of relationship a person has with an individual with a disability (Barr & Bracchitta, 2015). Intergroup contact theory asserts that intimate relationships between members of groups can lead to healthy, positive attitudes toward the outgroup that are resistant to change (Pettigrew et al., 2011).

Intergroup contact may promote positive emotions towards outgroup members, such as empathetic feelings, which may improve attitudes toward the outgroup as a whole (Anagnostopoulos & Hantzi, 2011). Graves, Chandon, and Cassisi (2011) report that groups with high levels of intergroup contact reported significantly lower negative affect toward people diagnosed with mental disorders as compared to participants with lower levels of contact.

Intergroup contact between correctional officers and people with mental illness can include offenders with mental illness (i.e., professional contact) or family and friends (i.e., personal contact). The relationship dynamics that exist for correctional officers with personal and professional relationships with people diagnosed with mental illness are complicated and challenge the tenants of the Intergroup Contact theory. Allport (1954) stressed the importance of
optimal conditions during contact, along with a relationship that discourages stereotypes and promotes equal status. Because a power differential exists between correctional officers and offenders, this relationship does not fit Allport’s (1954) identified conditions of the theory. Negative outgroup contact (e.g., sometimes experienced between jail correctional officers and offenders diagnosed with mental illness), may occur when participants feel threatened or did not choose to have the contact. Negative intergroup contact has received less attention in the research, but Pettigrew, Tropp, Wagner, and Christ (2011) found that even with negative intergroup contact, the cumulative effect of positive and negative contacts resulted in less prejudice than participants with only positive contacts. This research seeks to explore whether correctional officers with personal relationships or professional exposure to offenders with mental illness is associated with a reduction in negative attitudes and stereotypes.

**Historical Perspective**

**Deinstitutionalization**

Before the introduction of psychotropic medications in the 1950s, individuals suffering from mental disorders were housed in large, often untherapeutic, psychiatric facilities. Advances in the treatment of mental illness, along with legislation that promoted community treatment for mental disorders, spurred the deinstitutionalization of individuals diagnosed with a range of mental disorders. In 1963 the Community Mental Health Act established community mental health centers to promote and support community treatment of persons with mental illness. In 1966 the U.S. Government introduced the Medicaid and Medicare programs, which changed funding sources and encouraged states to dehospitalize older adults previously housed in mental health institutions (Grob, 1995; Raphael & Stoll, 2013). During the 1960s and 1970s, the first wave of dehospitalization occurred, and patients released from long-term psychiatric care
included individuals who were unlikely to become criminalized or engage in criminal behavior, such as older persons and women (Druhn, 2007; Raphael & Stoll, 2013).

The second wave of dehospitalization occurred in the 1980s, following legislation that tightened restrictions on involuntary commitments (Druhn, 2007; Grob, 1995) along with a federal policy change that shifted responsibility for mental health treatment from the federal government to state entities (Helms, Gutierrez, & Reeves-Gutierrez, 2016). In 1975 the U.S. Supreme Court decision on *O’Connor v Donaldson* stated that a diagnosis of mental illness alone was not sufficient to involuntarily commit a person to a psychiatric facility (Grob, 1995). Subsequent legislation limited the ability to involuntarily commit a person to only those instances where an individual poses a danger to self, to others, or was gravely disabled (i.e., unable to provide food, clothing, and shelter for self; Druhn, 2007). The Supreme Court ruling, along with expanded community mental health funding, effectively slowed the admission of individuals into state psychiatric hospitals, and the populations of these institutions further declined.

Deinstitutionalization began with the systematic dehospitalization of people with mental illness and later was characterized by the widespread closing of hospitals across the county. The number of available public hospital beds for people with mental illness was reduced from 558,239 in 1955 to 52,539 in 2005, a decrease of 95% (Torrey, Entsminger, Geller, Stanley, & Jwaffe, 2008). At present, the shortage of public inpatient treatment and inadequate community resources place persons with mental illness at risk for homelessness and incarceration (Raphael & Stoll, 2013). A review of literature on the post-deinstitutionalization living conditions found that approximately 13% of persons with mental illness are living with family or friends, 6% of persons with mental illness are homeless, 2.6% of persons with mental illness are in prison, and
2.1% are residing in nursing homes. Jails (n=187,500), state hospitals (n=189,000), and residential care facilities (n=183,000) each house 1.8% of the population of persons with mental illness. Five percent of all persons with mental illness are incarcerated in either jails or prisons (Davis et al., 2012). The review highlighted the difficulties in tracking the living conditions of persons with mental illness, noting that the living conditions of 71% of people with mental illness were unknown during the data collection period (Davis et al., 2012; Frank & Glied, 2006).

**Criminal Justice System Changes**

Preceded by 50 years of stability, the incarceration rates in state and local correctional facilities quadrupled between 1970 and 2006 (Stemen & Rengifo, 2011; Tonry, 2009). Scholars cite overemphasis on punishment, policy reforms, and shifts in political climate to explain the rise in incarceration rates (Tonry, 2009). A conservative political environment that promoted crime control, tough-on-crime agendas, and the philosophy of Just Deserts contributed to a soaring incarceration rate in the 1990s (Nicholson-Crotty, 2004; Stemen & Rengifo, 2011; Tonry, 2009). Beginning in the 1970s, lawmakers began using fear of crime as a political tool and succumbed to political pressure to pass legislation reflecting increasingly punitive responses to deviant human behavior (Jacobs, 2007; Tonry, 2009). Laws are frequently proposed and passed based on public anxiety and moral panic, and for many elected officials, supporting contemporary sentencing reform is tantamount to political suicide (Eversman & Bird, 2017; Luna & Cassell, 2010). Luna and Cassell (2010) warn that when policymakers pass legislation that is not supported by objective empirical data, the new laws may inadvertently cause public harm despite good intentions. For example, the War on Drugs stipulated harsh criminal consequences for individuals convicted of drug offenses, including crack cocaine, relative to
those convicted of drug offenses for powder cocaine. The disproportionately severe criminal penalties did nothing to curb the use of crack cocaine but contributed significantly to the mass incarceration of people of color (Eversman & Bird, 2017; Tonry, 2009). Eversman and Bird (2017) observe that expanding the reach of the criminal justice system following the crack cocaine moral panic was more advantageous from a political standpoint than addressing the underlying urban poverty and unemployment that they believe contributed to the epidemic.

In an essay on American punishment policies, Tonry (2009) outlined four possible explanations for the increase in incarceration rates in the United States. First, he described a paranoid political climate that used crime and substance use to provoke a moral panic and insecurity among middle-class Americans. Second, Tonry (2009) pointed to the rise of Protestant fundamentalism and increasing intolerance of behaviors believed to threaten political conservatives and religious majorities. Examples of issues that polarized the U.S. political climate include LGBT rights, abortion, and capital punishment, described in the essay as dichotomous issues of right or wrong, or good and evil. Third, Tonry (2009) pointed out that the U.S. Constitution was written to address 18th-century issues that are not relevant to social problems present in the 21st century. The current system, according to Tonry (2009), is susceptible to political bias and public moral panic, thus making unpopular social policy changes unlikely to occur. Lastly, institutionalized racism in the U.S. has contributed to the increase in incarceration rates after the 1970s (Tonry, 2009). Racial disparities continue to plague the criminal justice system and are a critical factor influencing the rise in incarceration rates. In conclusion, Tonry (2009) asserts that U.S. punishment policies are harsh because the system of government allows politicians to play on the fears of the general public and pass stringent and
biased laws without supportive empirical evidence indicating that the regulations would have the desired impact.

**Criminalization of Persons with Mental Illness**

Scholars agree that the substantial increase in the incarceration of people with mental illness followed the process of dehospitalization (Knoll, 2006); however, debate exists regarding the exact mechanisms by which the rates increased (Engel & Silver, 2001). High prevalence rates may be rooted in deinstitutionalization, but also include other factors, such as legislative changes in civil commitment procedures, lack of adequate community support systems for persons with mental illness, as well as shifting public policy on crime and punishment (Tonry, 2009).

Proponents of the criminalization hypothesis argue that the large proportion of offenders with mental illness in jails is a direct result of deinstitutionalization. Additionally, proponents suggest that law enforcement bears responsibility for inappropriately responding to deviant behavior with arrest and detainment rather than a referral to mental health treatment (Perez, Leifman, & Estrada, 2003; Ringhoff et al., 2012). In the wake of deinstitutionalization and the increased presence of persons with mental illness in communities, law enforcement officers were ill-equipped to handle calls related to individuals with mental illness (Helms et al., 2016). Before the 1960s, law enforcement officers had few encounters with persons diagnosed with mental illness, and long-term psychiatric hospitalization was a viable residential option when such encounters occurred (Helms et al., 2016).

Literature that emerged following the first significant phase of deinstitutionalization focused on law enforcement officers unfairly targeting persons with mental illness. This view of the criminalization hypothesis asserted that connecting individuals with community-based mental health treatment would result in a reduction in the number of people with mental illness
in jails (Druhn, 2007; Ringhoff et al., 2012). It also assumed that treatment opportunity would result in treatment compliance, and eventually lead to a reduction in arrests and recidivism. Evidence does not support this assumption (Wolff et al., 2013). The systematic problem of high incarceration rates of people with mental illness cannot solely be explained by law enforcement unfairly targeting people with mental illness because of overt symptomology (Silver, 2006).

Lamb and Weinberger (2011) identified specific characteristics that place some persons with mental illness at higher risk for arrest and incarceration, including poor insight into their illness, noncompliance with psychotropic medication, a history of arrests and substance abuse, and susceptibility to aggression and violence. General risk factors are those factors that are unrelated to mental illness and include criminal history, education and employment, social networks, family and marital status, and anti-social personality traits (Skeem, Winter, Kennealy, Louden, & Tatar, 2013). Clinical risk factors are those variables that are directly related to symptoms of mental illness (i.e., principle diagnosis, delusions, hallucinations, substance abuse, victimization; Ballard & Teasdale, 2016). Persons with mental illness often have an increased number of general risk factors, in addition to clinical risk factors, that contribute to arrest (Ringhoff et al., 2012; Skeem et al., 2013). Having a history of arrests, which is a nonclinical risk factor, is more predictive than clinical risk factors for arrest. This is inconsistent with the major tenets of the criminalization hypothesis (Helms et al., 2016; Ringhoff et al., 2012). Persons with mental illness who demonstrate such traits are often difficult to treat and have lapses in formal treatment, both in jail and in the community (Lamb & Weinberger, 2011). The lapses in mental health services typically can be attributed to poor treatment engagement, not to a lack of treatment opportunity (Lamb & Weinberger, 2011). People with a criminal history, history of poor treatment adherence, and high clinical needs are difficult to maintain in
community treatment because the bulk of community treatment is designed to treat individuals with less severe symptomology and no criminogenic needs (Ballard & Teasdale, 2016; Helms et al., 2016). Teplin (1990) found that limited social support rendered individuals with mental illness vulnerable to imprisonment. Greenberg and Rosenheck (2014) used multivariate regression analysis to identify correlates of incarceration in a national sample and found that having a history of incarceration (identified as “ever having been incarcerated”), being male, experiencing homelessness, and having a history of substance abuse or dependence were significantly related to incarceration among adults with mental illness.

**Incarceration of People with Mental Illness**

The Bureau of Justice Statistics uses stratified probability sampling, based on census data, to estimate the number and characteristics of jail offenders for the Annual Survey of Jails (ASJ). Information garnered from the survey includes the number of offenders housed in local jails across the county, the occupancy rate of jails, the average length of stay for each offender, as well as jail turnover rates (Zeng, 2018). Incarceration rates in the United States peaked in 2008, with 785,000 people incarcerated in local jail facilities (Zeng, 2018). After 2008, the number of people housed in jails began a slow decline to 740,700 at midyear 2016 (Zeng, 2018). The latest survey, using data collected in 2016, included a sample of 876 of the 2,851 jail jurisdictions nationwide. Jurisdictions were grouped into ten strata based on their average daily population, then a random selection of jails was chosen in 8 of the ten strata for inclusion in the survey. Using 2016 data, the ASJ determined that 85% of jail offenders were male, 48.1% were white, 34.4% Black or African American, and 15.2% were Hispanic. Two in five jail offenders were held in jails with a capacity of at least 1,000 offenders, and the ratio of offender to correctional officer was four to one. Smaller jurisdictions had a higher weekly turnover rate and
shorter lengths of stay than larger jails; the average length of stay per offender in U.S. jails was 25 days. According to the Bureau of Justice Statistics, U.S. jails had 10.9 million admissions in 2015, and an estimated 721,300 offenders were confined in local jails on a typical day that same year (Minton & Zeng, 2016).

According to Steadman, Osher, Robbins, Case, and Samuels (2009), the escalating prevalence rates of mental illness among jail offenders began to attract attention in the early 1990s, with landmark studies conducted by Abram and Teplin (1991) and Teplin (1990). Teplin (1990) found that 9.48% of 627 jail offenders booked into the Cook County Department of Corrections, Chicago, Illinois reported a diagnosis of major depression, mania, or schizophrenia in their lifetime, as compared to 4.41% of a non-jail sample (n=3,654). Data collected from a nationally representative sample of 6,982 jail offenders in 2002 indicated substantially higher rates of mental illness than previously reported (Binswanger et al., 2010). Although the overall rate of mental illness for the combined sample of men and women was not reported, researchers found that women had significantly higher rates of mental illness than men, at 43.6% and 21.6% respectively (Binswanger et al., 2010). The Bureau of Justice Statistics (BJS; James & Glaze, 2006) published a comprehensive report on the health care of jail and prison offenders that is frequently cited in the literature. Data collected in 2005 indicated that 76% of jail offenders reported symptoms suggestive of mental illness, and 14% reported taking psychiatric medications while incarcerated (James & Glaze, 2006). In 2009, a study examining the prevalence of mental illness in Maryland and New York jails determined that 14.5% of men and 31.0% of women were diagnosed with mental illness (Steadman et al., 2009).

In addition to the ASJ, the Bureau of Justice Statistics conducts surveys to gather information on offender characteristics. The 2011-2012 National Inmate Survey (NIS-3) was
held in 358 jails with 61,351 offenders and is the most recent offender data available (Bronson & Berzofsky, 2017). In addition to demographic data, two mental health indicators were assessed in the medical section of the offender questionnaire: prevalence of severe psychological distress (SPD) in the 30 days before the interview and the percentage of offenders who were told by a mental health professional that they had a mental health disorder. The Kessler 6 (K6), a 6-item self-report instrument, was administered to determine SPD. The history of mental health problems was determined by response to a single question about the offenders' history of mental health diagnosis (i.e., bipolar disorder, depression, psychotic disorder, post-traumatic stress disorder, other anxiety disorder, personality disorder, or emotional condition not listed). The two mental health indicators were not mutually exclusive and factored into the study results. Twenty-six percent of jail offenders surveyed were positive for SPD, and 44.3% reported a history of a mental health problem. Depression (30.6%) was the most prevalent disorder identified; bipolar disorder (24.9%), anxiety disorder (18.4%), post-traumatic stress disorder (15.9%), and schizophrenia and other psychotic disorders (11.7%) were less prevalent. The percent of jail offenders with SPD in the previous 30 days (26%) was five times higher than the comparison group (5%; e.g., adults in the U.S general population with no criminal history). Jail offenders who met the threshold for SPD (10%) or had a history of mental illness (10%) were more likely to have been written up for assaultive behavior than those who had not (4%).

**Correctional Environment**

**Jail Environment**

Jails are one component of the correctional branch of the criminal justice system and often serve as the entry point into the criminal justice system (Marks & Turner, 2014; Travis, 2012). The primary purpose of jail facilities is to detain individuals awaiting disposition of
criminal proceedings. Although the terms jail and prison are sometimes used interchangeably, jails are local detention facilities operated by local government or law enforcement agencies; they primarily provide housing for pretrial detainees or short-term sentenced offenders. Prisons are detention facilities where state or federally convicted offenders are housed (Hall, 2006). Jails have quick population turnover, and offenders are more likely to enter the facility from the community rather than from other correctional institutions, as is the case with prisons (Regenstein & Rosenbaum, 2014). For this proposal, jail refers to any detention facility operated by local government or law enforcement agency that houses pretrial detainees along with sentenced local, state, and federal offenders.

The processes of incarceration and criminal procedures are complex and include multiple agencies. The process often begins with an arrest conducted by law enforcement (i.e., local police agencies, probation or parole officers, state police, federal or tribal agencies) based on the accusation that a law has been violated.

The 8th Amendment to the U.S. Constitution guarantees that offenders have access to adequate care by qualified mental health professionals while housed in jail facilities. In order to comply with the 8th Amendment requirements, jails are required to implement a basic system for identification, treatment, and supervision of offenders with mental illness, including those with suicidal ideation or behaviors (Fellner, 2006). The structure and delivery of mental health treatment in U.S. jails vary with the size and function of each facility. The most common treatment services include screening during the intake process and additional evaluation for mental disorders based on screening outcomes, crisis intervention, and suicide prevention, and the prescription of psychotropic medications (Young, 2002). A systematic review of 26 empirical studies examining treatment outcomes of offenders with mental illness found that
interventions targeting psychiatric and criminal justice needs of offenders with mental illness were effective for reducing symptoms of distress, as well as improving offenders' adjustment, level of functioning, and coping skills (Morgan, Flora, Kroner, Mills, Varghese, & Steffan, 2012). Further, the interventions were associated with a decrease in both psychiatric and criminal recidivism. Results of the review are directly relevant for policymakers and service providers of individuals with both mental illness and a history of criminal justice involvement.

Roles of Correctional Officers

The predominant goal of correctional authorities is to ensure the security and safety of staff and offenders (Fellner, 2006; Lambert & Paoline, 2008). The correctional workforce began to be professionalized after the 1970s when riots and affirmative action drew attention to the predominantly white, male workforce. The expansion of the correctional workforce, in both jails and prisons, to include women and minorities was meant to address the culture gap between offenders and staff (Maahs & Pratt, 2001). The role of the professional correctional officer is to maintain order in the facility and to protect the civil and legal rights of offenders (Dvoskin & Spiers, 2004). Professional ethics for correctional officers are established on the state and local level and include the prohibition of offender exploitation, the establishment or development of personal relationships with offenders, and the development of personal feelings or bias that interfere with order and safety in the facility (Simmons, 2017). Correctional officers must be prepared to deal with a variety of situations at any given time, including offenders experiencing drug or alcohol abuse, mental disorder, medical issues, poverty, homelessness, and suicidal behavior (Dvoskin & Spiers, 2004; Simmons, 2017).

Correctional officers supervise offenders in housing units, assist with routine cleaning and hygiene, conduct regular checks of offenders’ housing units and work areas, conduct counts
of offenders, conduct cell and work area searches for contraband, patrol inside and the facility perimeter to ensure security, as well as monitor offender visitation (Simmons, 2017). The level of supervision and chain of command is established by each facility or government entity but will usually include correctional officer, corporal, sergeant, lieutenant, captain, and major (Simmons, 2017). A corporal or sergeant typically supervises correctional officers. Jail facilities are operational 24-hours per day and require correctional staff to work in shifts to cover assigned tasks. At the beginning of each shift, correctional officers are assigned a designed post (e.g., specific housing unit, recreation, laundry, kitchen, transportation) for their shift and receive a summary of activities from the prior shift. Tasks for correctional officers during a shift may include delivery of meals to housing units, escorting offenders to medical or other treatment appointments within and outside the facility, and providing first responder, life-sustaining interventions in the case of a medical emergency (Simmons, 2017). The scope of authority and tasks for each post (i.e., post orders) are designated and maintained by the agency based on facility needs and are reviewed annually (Simmons, 2017). Accrediting bodies, state, and federal agencies provide standards of practice for jail facilities that dictate the post orders.

The jail environment can be unpredictable, unstable, and unsafe due to the purpose and nature of the facility (Lowder, Ray, & Gruenewald, 2019). Jail correctional work can be overwhelming and is often viewed as a lesser occupation within the law enforcement community (Lambert & Paoline, 2008). Daily exposure to a hostile and stressful environment (i.e., extremes of noise, temperature, filth, and fear) are often inescapable realities of life inside an institution (Dvoskin & Spiers, 2004). Little research is conducted on officers at the local level (Farkas, 1999), and much of the existing literature is focused on job stress and job satisfaction (Butler,
The impact of working directly with offenders with mental illness is under-researched (Lowder et al., 2019; Maahs & Pratt, 2001). Correctional officers are an integral part of ensuring the safety and security of the facilities as well as serving as part of multidisciplinary teams that carry out mental health services (Appelbaum, Hickey & Parker, 2011; Fellner, 2006; Weaver, Lee, Choi, Johnson, & Clements, 2019). A collaborative approach between mental health staff and correctional staff, joint training, and use of multidisciplinary treatment teams are methods recommended for improving overall outcomes for offenders with mental illness (Dvoskin & Spiers, 2004; Weaver et al., 2019). Offenders with mental illness often behave in ways that correctional institutions consider punishable misconduct (i.e., disruptive behavior, belligerence, aggression, and violence) and thus have higher than average disciplinary rates (Fellner, 2006). Correctional officers function like police within the facility, tasked to maintain order and have discretion in deciding which infractions receive disciplinary action when offenders violate facility rules (Fellner, 2006). Evidence shows that well-trained and experienced officers utilize discretion when responding to crises such as these with patience, care, and common sense (Dvoskin & Spiers, 2004).

Training and education requirements for correctional officers standardize correctional practices and improve outcomes for staff and offenders (Dvoskin & Spiers, 2004). Training of line-staff on interpersonal skills equips them to deal with crises. Without training, correctional officers may be more likely to punish disruptive behaviors than to reward positive behaviors (Dvoskin & Spiers, 2004). Field training programs, often part of correctional new hire training, cover a variety of topics and range depending on agency and size of the facility (e.g., standards of conduct, use of force, safety procedures, emergency procedures, offender rights, supervision of offenders, and code of ethics; Simmons, 2017). Lavoie, Connolly, and Roesch (2006) found that
despite the high rate of training reported by correctional officers, they did not report feeling prepared to work with offenders diagnosed with a mental illness.

Mental Health Literacy

Health Literacy

Health literacy is an individual’s ability to make sense of health-related information and make informed choices about personal health needs. It is a complex construct that is defined by the skills needed to understand, promote, and maintain good health (Kutcher, Wei, & Coniglio, 2016) as well as the services required to make appropriate health decisions (Berkman et al., 2011). Health literacy research was informed by observations that low levels of functional literacy were associated with poor health outcomes (Kickbusch, Pelikan, Apfel, & Tsouros, 2013). Systematic literature reviews conducted in 2004 and 2011 on literacy and health outcomes concluded that low literacy is associated with a range of adverse outcomes, including reduced influenza and pneumonia immunizations, increased risk of hospitalization, poorer global measures of health, and poor outcomes related to chronic disease (e.g. heart disease, asthma, and diabetes; Berkman et al. 2011; DeWalt, Berkman, Sheridan, Lohr, & Pignone, 2004). As the construct of health literacy developed, researchers and healthcare providers focused on a patient’s ability to read prescription labels and appointment reminders, to understand the health care environment and to adhere to medical recommendations (Kutcher et al., 2016). Health literacy has broadened even further to include decreased disparity among populations, enhancing health systems, and the development of health policy (Kutcher et al., 2016).

Mental Health Literacy

Mental health literacy (MHL), introduced in 1997, is an extension of health literacy and includes seven components: ability to recognize specific disorders, knowledge of how to seek
information, knowledge of risk factors, knowledge of causes of mental illness, knowledge of self-treatment, knowledge of professional help available, and attitudes that promote recognition or application of help-seeking behaviors (Kutcher et al., 2016). Another conceptualization of MHL includes only four components which differ slightly from the initial definition: knowledge about how to obtain and maintain good mental health, knowledge about mental disorders and their treatments, decreasing stigma against those living with mental disorders, and enhancing help-seeking efficacy (Wei, McGrath, Hayden, & Kutcher, 2016). MHL is an evolving construct that includes the relationships between mental health knowledge and stigma and is increasingly informed by developing a more comprehensive approach to health literacy (O'Connor et al., 2014).

Mental health knowledge is one component of MHL. Compton and colleagues (2011) developed the Multiple-choice Knowledge of Mental Illness Test (MC-KOMIT) as an instrument to measure general knowledge about mental illness in police officers who participated in Crisis Intervention Training (CIT; n=74) compared to a group of officers who did not participate in CIT (n=125). Although the development of the MC-KOMIT provided initial support for the psychometric properties, Wei et al. (2016) rated the internal consistency and responsiveness of the instrument as "poor," reliability was rated "good," and content validity was rated as "excellent." O'Connor, Casey, and Clough (2014) conducted a systematic review of scale-based measures that investigate MHL. They concluded that although some measures of mental health knowledge existed, no scales existed that accounted for all seven components of Jorm et al.'s (1997) definition of MHL. Although the MC-KOMIT measured ability to recognize disorders, knowledge of risk factors, knowledge of causes of mental illness, and knowledge of professional help available, the MC-KOMIT did not measure knowledge of how to seek information,
knowledge of self-treatment, nor did it measure attitudes that promote recognition or appropriate help-seeking behavior (O’Connor et al., 2014).

**Correctional Officer Mental Health Literacy**

Despite the empirical evidence that mental health training for patrol-based law enforcement improves outcomes when law enforcement officers encounter people with mental illness (Franz & Borum, 2011; Watson, 2010), sparse evidence exists that demonstrates increased mental health knowledge improves outcomes for correctional officers or offenders with mental illness during similar encounters in a correctional environment. The CIT training model provides an opportunity for knowledge building about mental health disorders, learning through interactions with people diagnosed with mental disorders, and skill-building via experiential learning interactions (i.e., role play; NIC, 2010). In 2010 the NIC developed the *CIT for Corrections: A Frontline Response to Mental Health in Corrections* curriculum. The intervention’s training handbook reports the benefits of CIT in corrections as increased officer safety, reduced officer injuries, reduced offender injuries, increased chance for offenders to connect with mental health services, increased officer confidence in their skill, reduced liability, reduced unnecessary use of force, and avoidance of costs to criminal justice system by way of reduction in probation violations (NIC, 2010). No studies were identified that measured correctional officers' level of knowledge before or following CIT training. Petrack (2012) examined correctional officers’ perceptions of offenders with mental illness following CIT training but did not measure the correctional officers' knowledge about mental illness, either pre or post-training.

Jail correctional officers’ mental health literacy, including knowledge of mental disorders, is largely unstudied. One dissertation study measured mental health knowledge
among correctional officers (Podkova, 2013). Studies that measure perceptions of people with mental illness (Misis, Kim, Cheeseman, Hogan, & Lambert, 2013; Petrack, 2012; Shannon & Page, 2014) or stigma associated with mental illness (Hansson & Markström, 2014; Lowder et al., 2019) were more abundant, but none measured knowledge of mental health disorders. Knowledge of mental disorders was measured in a study that explored the relationship between mental health knowledge and self-efficacy (Podkova, 2013). The study used the MC-KOMIT and a researcher-constructed self-efficacy measure to test the hypothesis that a positive, significant relationship exists between correctional officers’ level of knowledge of mental illness and self-efficacy when working with offenders diagnosed with mental illness. Researchers found no significant correlation between the two variables. Tomar et al. (2017) investigated the relationship between knowledge of mental health and stigma among probation officers. The survey included probation officers (n=368) in a statewide web-based training program. The findings supported the hypothesis that as officers’ knowledge of mental illness increased, they also demonstrated lower levels of stigma toward probationers with mental illness.

**Attitudes toward Offenders with Mental Illness**

**The Stigma of Mental Illness**

Stigma is a process of distinguishing and labeling characteristics, applying negative stereotypes, and devaluing individuals with attributes that are perceived as undesirable, including mental illness (Link & Phelan, 2001). Stigmatization includes negative connotations, false assumptions, and is deeply discrediting of the object or person who is stigmatized (Kennedy, Abell, & Mennicke, 2017; Overton & Medina, 2008). Individual-level stigma can include ascribing negative attitudes and beliefs to a group and then conducting overt discrimination against a person in that group (Link & Phelan, 2001; Overton & Medina, 2008). An example of
individual-level stigma would be a correctional officer placing a person in a segregated housing unit based on the correctional officer’s belief about mental illness and dangerousness. Structural discrimination is the accumulation of actions that result in poor outcomes for a stigmatized group (Link & Phelan, 2001). The consequences of stigma include lack of employment opportunities, limitations on finding shelter, barriers to treatment, and financial barriers (Overton & Medina, 2008).

Popular beliefs about people with mental illness include that they are dangerous, that mental health difficulties are self-inflicted, and that individuals with mental illness have difficulty communicating (Simmons, 2017). Findings from research on mental health stigma suggest that stigma does not generalize from one diagnosis to another (Reavley & Jorm, 2011; Simmons, 2017). In a survey of 1,737 adults in the United Kingdom, 70% of respondents viewed persons with schizophrenia, alcohol abuse, and substance abuse as dangerous, and 80% of respondents viewed the same persons as unpredictable. The survey also found that 62% of respondents thought that people with depression are difficult to talk to, 19% of respondents thought that people with depression could pull it together, and 23% of respondents say that people with depression will eventually recover (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). In a national survey of Australians (n=6,019), schizophrenia is associated with dangerousness and unpredictability, consistent with previous research (Reavley & Jorm, 2011).

**Contact with Persons Diagnosed with a Mental Illness**

Consistent with the intergroup contact theory, Corrigan, Green, Lundin, Kubiak, and Penn (2001) note that familiarity and social distance are significantly related to stigma. Mitigation of stigma includes education to improve familiarity and personal contact between the person with mental illness and the person with stigmatizing attitudes (Alexander & Link, 2003;
Corrigan et al., 2001; Lee & Seo, 2018; Simmons, Jones, & Bradley, 2017). People with knowledge of mental illness or who have contact with persons diagnosed with mental illness are less likely to endorse stigmatizing attitudes (Corrigan et al., 2001). The type of contact (i.e., indirect contact, public contact, or personal contact; Lee & Sea, 2018) is not as predictive as the level of contact (ranging from “never observed a person with mental illness” to “has a serious mental illness”; Corrigan et al., 2001). Recent research on criminal justice professionals’ attitudes toward offenders with mental illness indicate that “scholars have yet to fully explore how criminal justice professionals’ own contact with persons with mental behavioral health disorders might shape their attitudes toward mental illness and substance abuse” (Lowder et al., 2019, p. 429).

Corrigan et al. (2001) found that the more familiar a study participant was with mental illness, the less dangerous that person was believed to be (n= 208). Research conducted in Korea found that the anti-stigma effect of contact varies based on the type of mental illness and not on the type of contact (Lee & Seo, 2018). The research found that participants perceived people with alcoholism as more dangerous than those diagnosed with schizophrenia, and lastly, persons with depression were perceived as the least dangerous among the three diagnoses. Lee and Seo (2018) identified two types of contact (i.e., direct and indirect). Examples of indirect contact are public service announcements and watching a television program on mental illness (Lee & Seo, 2018). The findings from the Korean study indicate that indirect contact may be equally effective at decreasing stigmatizing attitudes as direct contact.

Weaver et al. (2019) included the variable “personally knowing someone with a mental illness” in a study investigating future criminal justice and social work students’ perceptions of offenders diagnosed with mental illness. The findings indicated that both social work and
criminal justice majors were less likely to have negative stereotypes toward offenders with mental illness if they personally knew someone with a mental illness. Although few studies have included this variable in the analysis, Petracek (2012) included the presence of a personal relationship in a scale, and Powers-Magro (2016) included the question in the study's qualitative analysis. Neither study directly addressed the association between personal relationships and other variables within the study results. Lowder et al. (2019) included personal contact between criminal justice professionals and offenders with mental illness as a moderator of attitude differences among different criminal justice professional positions. Among all professionals surveyed (i.e., community corrections officers, prosecutors, defense attorneys, jail correctional officers, judges, and administrative professionals; n= 610), daily contact with offenders with mental illness was associated with significantly more positive attitudes toward mental illness than monthly contact.

**Correctional Officer Attitudes toward Offenders with Mental Illness**

Although some research exists on correctional officers’ attitudes toward offenders in general, limited research exists on jail correctional officers' attitudes toward offenders with mental illness. Petracek (2012) conducted a study that investigated correctional officers' perceptions of working with offenders with mental illness and the effectiveness of training on their self-efficacy for working with this population. The online survey (n=70) utilized an instrument developed by the NAMI-Maine chapter to assess the effectiveness of CIT training. The survey did not find that CIT-trained officers had a more positive view of offenders with mental illness, but that they felt more prepared to work with that population. Additionally, Petracek (2012) found that correctional officer age, gender, and race were not significantly related to perceptions of offenders diagnosed with mental illness. The study’s self-described
limitations included a small sample size extracted from an agency that promotes a culture of rehabilitation. A second study that investigated correctional officer perceptions of offenders with mental illness used a qualitative design (Powers-Magro, 2016). The study revealed that officers working in a dedicated psychiatric unit found job satisfaction in mental health training, building rapport with offenders, and being able to observe offenders’ mental health stabilize. The research indicated that officers working in this specialized unit were able to “humanize” and relate to the offenders’ struggles in a way that working in the jail’s general population did not. Both studies highlighted the dearth of research on correctional officers and offenders with mental illness.

Lowder et al.’s (2019) study on the differences in attitudes across criminal justice positions explored whether personal contact with offenders with mental illness moderated the relationship between attitude and position. Major findings suggest that 1. defense attorneys and community corrections officers reported having a more positive attitude toward offenders with mental illness relative to correctional officers and prosecutors and 2. high contact, versus low contact, was associated with more positive attitudes among correctional staff. In two different studies, the Attitude toward Offenders with Mental Illness Scale (ATMIO) was used to investigate the attitudes toward offenders with mental illness among college students in both social work and criminal justice (Church, Baldwin, Brannen, & Clements, 2009; Weaver et al., 2019). Findings in Weaver et al. (2019) note that criminal justice students are more likely to endorse negative stereotypes than social work students. Church et al. (2009) found that attitudes toward mentally ill offenders became more tolerant and less negative as the level of social work education increased.

Hansson and Markström (2014) conducted a comparison group study of Swedish police officers to determine the effectiveness of anti-stigma training. Data were collected at the start
and termination of the three-week intervention designed to improve knowledge, behavior, and attitudes toward people with mental illness. Four measures were used to assess stigma-related mental health literacy, attitudes toward mental illness, and reported and intended behavior when interacting with people with serious mental illness. No measure of mental health knowledge was included in the study. The results indicate that the intervention group (n=46) showed a significant improvement in attitudes toward people with mental illness. Additionally, the intervention group was significantly more willing to work with people with mental illness following the intervention. Noteworthy is that the post-test and 6-month follow-up indicated that the intervention group showed improvement in intentional behavior, as well as attitudes toward people with mental illness.

Tomar et al. (2017) researched probation officers' attitudes toward offenders with mental illness. The survey of 316 probation officers included a standardized 11-item measure of stigma, and a 15-item researcher developed a measure for knowledge of mental illness. The survey was electronically mailed to participants in a statewide mental health training program designed to assist probation officers with probationers with mental illness. Due to problems with email firewalls, not all of the intended recipients received the request for participation, which decreased the anticipated sample size. The pre-test post-test design revealed that mental health knowledge increased significantly, and scores on the stigma measure were significantly lower following the training. The finding suggests that increasing knowledge among probation officers is associated with a decreased level of stigma toward probationers with mental illness.

**Summary**

The overrepresentation of persons with mental illness in jails is a serious social problem (Treatment Advocacy Center, 2016). Despite the documented and accepted recognition of this
problem, little research is published on jail correctional officers and mental health-related topics. The individual consequences to incarceration include disruption in treatment, an increase in symptomology, violence, and victimization (Biswas, 2017; Fezel et al., 2016). Additionally, housing persons with mental illness in local jails is costly for communities, both financially and socially (Treatment Advocacy Center, 2016). A review of theory and relevant empirical literature suggests the exploration of correctional officers’ level of mental health literacy and attitudes toward persons diagnosed with mental illness is warranted due to the dearth of research in this area. Although limited studies have been conducted with jail correctional officers investigating mental health knowledge and attitudes toward offenders with mental illness, empirical studies on allied law enforcement professions exist that suggest similar findings for jail correctional staff are likely.

The significant role of correctional officers in providing for the welfare of offenders with mental illness is underrepresented in the literature (Butler et al., 2019; Dowden & Tellier, 2004). Correctional officers are responsible for the safety and well-being of offenders and have daily and consistent contact with offenders with mental illness. Research shows they are empathetic toward the plight of offenders with mental illness, yet do not wish to be responsible for rehabilitative or counseling tasks (Cook & Lane, 2014). The literature is lacking information on how the correctional officers’ personal bias and stigmatization of offenders with mental illness impact their role as daily caretakers. Therefore, the current study explored the gaps in the literate by examining the following hypotheses.

Hypothesis 1: Correctional officers with more work experience will have more positive attitudes toward offenders with mental illness.
Hypothesis 2: Correctional officers with higher educational attainment will have more positive attitudes toward offenders with mental illness.

Hypothesis 3: Correctional officers with more frequent contact with persons with mental illness will have more positive attitudes toward offenders with mental illness.

Hypothesis 4: Correctional officers with high mental health literacy will have fewer negative stereotypes of offenders with mental illness.

Hypothesis 5: Correctional officers in a jail setting who report attending CIT training will have high levels of mental health literacy.
CHAPTER 3. METHODOLOGY

Chapter three provides a detailed description of the research methodology used in this study. The chapter includes the purpose of the study, research objectives, and research design. The chapter also includes operational definitions of key terms and variables, participant selection and protection of human subjects, psychometric properties of each instrument, sampling and data collection procedures, as well as the data analysis techniques used in the study.

Purpose

This exploratory study investigated the relationships between demographic factors, work experience, education, mental health literacy, and attitudes towards offenders with mental illness in correctional officers working in jails throughout Louisiana. The survey data were collected by the researcher using written surveys. The cross-sectional data were analyzed using a variety of statistical techniques, including descriptive statistics, and multiple regression.

Research Hypotheses

The following research hypotheses guided the study:

Hypothesis 1: Correctional officers with more work experience will have more positive attitudes toward offenders with mental illness.

Hypothesis 2: Correctional officers with higher educational attainment will have more positive attitudes toward offenders with mental illness.

Hypothesis 3: Correctional officers with more frequent contact with persons with mental illness will have more positive attitudes toward offenders with mental illness.

Hypothesis 4: Correctional officers with high mental health literacy will have fewer negative stereotypes of offenders with mental illness.
Hypothesis 5: Correctional officers in a jail setting who report attending CIT training will have high levels of mental health literacy.

Research Design

This exploratory research used a cross-sectional survey to investigate the relationships among attitudes toward offenders with mental illness, work experience, educational attainment, contact with a person diagnosed with mental illness, mental health literacy, and demographic characteristics. This study did not investigate causal relationships among the variables but did gather information that contributes to the knowledge base surrounding correctional officers' role in the lives of offenders with mental illness. Louisiana State University's Institutional Review Board (IRB) approved the study prior to the beginning of data collection procedures (see Appendix A for IRB approval).

Participants

Louisiana jail correctional officers were the population under study. Correctional officers are also referred to as correctional deputies and may include other security staff who are responsible for the care, custody, and control of offenders housed in jail facilities. Jail support staff, such as mental health professionals, nurses, and clerical staff, were not included in the sample. The sample was obtained using non-probability, convenience sampling methods. The researcher sent requests to each sheriff in Louisiana and additionally contacted jail administrators in each Parish jail to elicit their interest in participation in this study. Eleven jail facilities participated in the survey for a total sample of 213 jail correctional officers.

Protection of Human Subjects

The data collection procedures allowed voluntary participants to remain anonymous. The substantive focus of the study pertains to correctional officers' knowledge about mental health
and attitudes toward offenders with mental illness. Before completing the survey, participants were provided written informed consent forms and allowed to ask questions about the survey. Information about the study was also included in the first section of the survey instrument, as well. Participants were notified that their participation was voluntary, that minimal psychological risk was involved with the survey, and no penalties existed for not participating in the study. As part of the informed consent, participants were notified that if the results are published at a future date, no personal or agency identifying information will be revealed. Data were collected in a self-report survey instrument.

As an incentive for participation, jail jurisdictions were offered a one-hour training on mental illness for their staff. One facility requested and received the one-hour training following the survey. The researcher also provided snack items to participants during and after survey administration.

Survey Instrument

A 69-item questionnaire, consisting of 3 major sections, was used to measure the key constructs. The survey includes two standardized scales, the Mental Health Literacy Scale (MHLS) and the Attitudes Toward Mentally Ill Offenders scale (ATMIO), and one demographic section. The demographic section included the Level of Contact Report. (See Appendix C for full survey instrument).

MHLS

Mental health literacy was measured with the standardized 35-item MHLS, developed to assess all seven attributes of mental health literacy (O'Connor & Casey, 2015). The MHLS includes 35-Likert type responses that include very unlikely (1) to very likely (4), strongly disagree (1) to strongly agree (5), and definitely unwilling (1) to definitely willing (5). The
measure achieved acceptable internal consistency in previous applications ($\alpha = .873$; O'Connor & Casey, 2015). The current study obtained an acceptable reliably coefficient as well ($\alpha = .825$). Scoring consists of totaling the responses to each question, for a total score range of 35-160. Because the first section of the measure included a 1-4 Likert type response and the second section of the measure included a 1-5 Likert type response, all 35 responses were converted to a score between zero and one for a total score of 0 to 35 for this study. Higher scores were indicative of higher levels of mental health literacy. Item numbers 10, 12, 15, 20-28 were reverse scored. Results of an initial factorability assessment indicated that a univariate structure was the most statistically and theoretically appropriate (O'Connor & Casey, 2015). The MHLS was developed using a community sample of 94 male and 278 female Australian first-year university students and a sample of six male and 37 female Australian mental health professionals (O'Connor & Casey, 2015). The MHLS has also been used to measure mental health literacy on 237 Christian clergies in the United States (Vermaas, Green, Haley, & Haddock, 2017).

**ATMIO**

The ATMIO is a 23-item scale used to elicit both general and specific attitudes about mental illness (Church et al., 2009; Weaver et al., 2019). Each item was scored on a 6-point Likert scale, ranging from disagree strongly (A=0) to agree strongly (F=5). The items are summed, with 13 items reverse-scored, to determine an overall attitudinal score. Higher scores indicate a more tolerant attitude toward offenders with mental illness (Church et al., 2009). The scale includes four factors: Negative Stereotypes, Rehabilitation/Compassion, Community Risk, and Diminished Responsibility (Weaver et al., 2019). Scale reliability was reported at .73 during development (Weaver et al., 2019) and subsequently at .88 (Church et al., 2009). Weaver et al. (2019) report Cronbach's alpha for Negative Stereotypes, Rehabilitation/Compassion,
Community Risk, and Diminished Responsibility as .86, .70, .61, and .56, respectively. The current study obtained acceptable coefficients for both the ATMIO ($\alpha = .825$) and Negative Stereotypes subscale ($\alpha = .831$). According to Weaver et al. (2019), the lower Cronbach's alphas for the Rehabilitation/Compassion, Community Risk, and Diminished Responsibility subscales are a reflection of the small number of items in those subscales. Only the Negative Stereotypes subscale was used in the current study. The ATMIO has been used to measure attitudes in social work students, law students, mental health professionals, and legal professionals (Church et al., 2009; Lohmann, 2016; Weaver et al., 2019).

The ATMIO has been used to assess the perceptions of future social work and criminal justice professionals but has not been used to measure the attitudes of current correctional staff. The current survey included educational-related items for analysis. Previous research found that clinical professionals and line staff from a maximum-security prison held fewer negative stereotypes than college students (Weaver et al., 2019).

**Demographic, Work History, and Educational Attainment**

Participants were asked questions about their demographic, work history, and educational characteristics. Demographic characteristics included age, sex, race, and ethnicity. Work history consisted of the length of time employed as a correction officer, measured in years and months. The survey requested participants to provide the number of years and months they have worked as a correctional officer. The participants’ work history was converted to the continuous variable representing the total months worked for analysis. Level of education was measured using the response options: did not complete high school (0), graduated high school or obtained a GED (1), some college but did not graduate (2), associate degree (3), bachelor's degree (4), master's degree or higher (5), or other (6). Level of education was treated as an
ordinal variable during analysis. The demographic section allowed the researcher to describe the sample, to assess the generalizability of the findings, and identify potential mediating variables in the data analysis.

**Contact with a Person Diagnosed with Mental Illness**

A personal relationship with a person with mental illness was measured with a single no (0) or yes (1) item on the questionnaire. Two items about contact with persons diagnosed with mental illness were below the demographic, work history, and educational items in the survey. The first item asks, "Do you personally know someone with a mental illness?" The response options are no (0) or yes (1). The second asks how often the participant has contact with offenders with mental illness, responses options were never (0), less than once per month (1), once per month (2), two to three times per month (3), once per week (4), two to three times per week (5) and daily (6).

**Level-of-Contact Report**

The level of contact report listed 12 situations in which the intensity of contact with people diagnosed with mental illness varies (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). Participants were asked to place a checkmark next to each of the situations in which they have experience. Examples of items include, "I have observed, in passing, a person I believe may have had a mental illness," (2), "I have worked with a person who had a severe mental illness at my place of employment" (6), and "I live with a person who has a severe mental illness" (11). The least intimate situation is "I have never observed a person that I was aware had a severe mental illness," and receives a score of one. The most intimate situation is "I have a severe mental illness," and receives a score of 12. The index for contact in this study was the rank score between 0 and 12 of the most intimate situation indicated by the participant (Holmes et al.,
Situation ranked at eight is, "My job involves providing services/treatment for persons with a severe mental illness."

**Operationalization of Key Variables**

**Attitude toward mentally ill offenders.** Attitude refers to a set of emotions, beliefs, and behaviors toward an object, person, thing, or event (Chaiklin, 2011). In this study, attitude toward mentally ill offenders referred to the general attitude for an individual diagnosed with a serious mental illness that may require inpatient hospitalization, treatment, and medication, and who has committed a crime (Brannen, Clements, Kirkley, Gordon, & Church, 2004). The dependent variable was measured using the Attitude Toward Mentally Ill Offenders scale (ATMIO; Church et al., 2009). The study used the negative stereotypes subscale from the ATMIO during multivariate analysis as well.

**Work experience.** Participants' work experience was measured in years and months. The survey item is, "How long have you served as a correctional officer (at this or any other location)?" The responses were converted to months and coded as a continuous variable. Participants were also asked to indicate if they have attended a Crisis Intervention Training, coded as (0) no or (1) yes.

**Educational attainment.** The survey included three self-report items related to education. The first item asked, “What is the highest level of education you have received?” The response was ordinal level and included the following options: did not complete high school (0), graduated high school or obtained GED/HiSET diploma (1), some college (2), associate's degree (3), bachelor's degree (4), master's degree (5), other (specify; 6). The second education item is, "If you attended college, but did not graduate, how many semesters did you complete?" The last
education item asks if the participants' major was criminal justice; the response was coded as no (0) or yes (1).

**Contact with persons diagnosed with mental illness.** The level of contact with a person with mental illness is measured using the Level of Contact Report (Holmes et al., 1999). Participants are asked to identify which of 12 situations they have experience with a person with mental illness; the situations are ranked in order of one (least intimate) to 12 (most intimate). The highest score is recorded to indicate the most intimate relationship that exists for the participant. An additional measure of contact was the item that asked whether the participants self-identified as personally knowing someone with a mental illness. The response was coded as no (0) or yes (1). Lastly, participants were asked to identify their frequency of contact with offenders with mental illness using an ordinal scale with response options range from never (0) to daily (6).

**Mental health literacy.** Mental health literacy is the knowledge and attitudes regarding mental health that aid in the recognition, management, and prevention of mental health issues (O'Connor & Casey, 2015). Mental health literacy consists of seven attributes, including the ability to recognize specific disorders, knowing how to seek mental health information, understanding risk factors and causes, knowledge of self-treatment, knowledge of professional help, and attitudes that promote recognition and appropriate help-seeking behavior (O'Connor & Casey, 2015). Mental health literacy was assessed with the 35-item MHLS (O'Connor & Casey, 2015).

**Age.** The participants’ self-reported age is measured in years as a continuous variable.

**Sex.** The participants' self-reported gender is recorded as male (0) or female (1).

**Race.** Participant's race was self-reported as one of the following options: black or African American, non-Hispanic (1); American Indian or Alaska Native (2); Asian (3); Hispanic
origin (includes Mexican, Mexican American, Cuban, Puerto Rican/Caribbean, Central/South American Spanish, and other Spanish; 4); White, non-Hispanic (5); Native Hawaiian or other Pacific Islander (6); and all other races (specify; 7). A series of dichotomous variables were created from the nominal level survey options. For multivariate analysis, dichotomous variables were created for white, non-Hispanic (n=163) and black or African American (n=39) variables; all other observations were included in the "all other races" group (n=5).

**Procedures**

The current study was a cross-sectional, exploratory study. The participation solicitation included contacting jail wardens directly via telephone and email. This initial request elicited a low response rate. Letters were mailed to the sheriff in each of 64 Louisiana parishes producing a total of nine participants. A second letter to each sheriff was sent requesting participation with further explanation of the project. See Appendix B for both letters. Although fifteen facilities agreed to participate in the study, only eleven facilities scheduled and participated in the study. This researcher traveled to each of the eleven facilities for data collection between June 12, 2019, and October 10, 2019. In nine of the eleven facilities, correctional officers were offered an opportunity to voluntarily participate in the study during, before, or after their regularly scheduled shifts. One facility requested that survey be conducted on a Friday afternoon when all staff were present for a meeting during which their paychecks were disseminated; most of the staff were off duty during this visit. One facility requested that the study be conducted during a regularly scheduled training of correctional officers. The correctional officers present during the training (n=9) were from the facility’s Correctional Emergency Response Team (CERT). CERT officers receive specialized training and are considered elite members of the correctional staff.
**Statistical Analyses**

All data were managed, statistically described, and statistically analyzed using Stata® statistical software. Univariate and multivariate analyses were conducted to test the research hypotheses.

**Data Screening**

Descriptive statistics of all key variables were assessed for data accuracy. Ranges were evaluated to determine whether values existed in the data that were outside the range of possible scores for each variable. Summary statistics were used to evaluate the extent of missing data. The scale scores were calculated using only complete data for each scale; partial data was dropped. The extent of the missing data is discussed in the results section.

**Descriptive Statistics**

Univariate statistics, including percentages, means, and standard deviations, were calculated to describe each key variable. Scale scores, standard deviations, and ranges for MHLS, ATMIO, and negative stereotypes subscale were calculated and are presented in the results section. Findings from the descriptive statistics were used to address research objectives and inform inferential statistics.

**Inferential Statistics**

Ordinary Least Squares (OLS) multivariate regression analysis was used to test the research hypotheses. OLS regression was chosen for the analysis based on the hypotheses and characteristics of the variables. The three dependent variables are continuous variables and independent variables are continuous, ordinal, and binary. The analysis included tests for violations of assumptions. Tabachnick and Fidell (2013) suggest the examination of residuals scatterplots as a test of normality, linearity, and homoscedasticity between predicted scores and
errors of prediction. Variance inflation factors (VIF) were calculated to assess multicollinearity (Acock. 2018).

Hypothesis 1: Correctional officers with more work experience will have more positive attitudes toward offenders with mental illness. OLS regression was used to determine the model that best explains the direction and degree of relationship between work experience and attitudes toward offenders with mental illness, controlling for the effects of age, gender, and race.

Hypothesis 2: Correctional officers with higher educational attainment will have more positive attitudes toward offenders with mental illness. OLS regression was used to determine the model that best explains the extent and direction of the relationship between work experience and attitudes toward offenders with mental illness, controlling for the effects of age, gender, and race.

Hypothesis 3: Correctional officers with more frequent contact with offenders with mental illness will have more positive attitudes toward offenders with mental illness. The independent variable, frequency of contact, is measured using an ordinal Likert scale from never (0) to daily (6). Although this is an ordinal scale, the independent variable will be treated as a continuous variable for analysis (Johnson & Creech, 1983; Norman, 2010; Sullivan & Artino, 2013). The model specification will assume the predictor has a linear impact across the increments. OLS regression was used to determine the model that best explains the extent and direction of the relationship between the frequency of contact and positive attitudes, controlling for the effects of age, gender, race, and contact with persons with mental illness.

Hypothesis 4: Correctional officers with high mental health literacy will have fewer negative stereotypes of offenders with mental illness. OLS regression was used to determine the model that best explains the extent and direction of the relationship between mental health
literacy and negative stereotypes, controlling for the effects of age, gender, race, educational characteristics, CIT and personal relationship with people with mental illness.

Hypothesis 5: Correctional officers in a jail setting who report attending CIT training will have high levels of mental health literacy. The hypothesis was tested using OLS regression to determine if those officers who have attended CIT training have higher levels of mental health literacy, controlling for the effects of age, gender, race, educational characteristics, attitudes toward offenders with mental illness, work experience, and contact with persons with mental illness.
CHAPTER 4. RESULTS

The purpose of this study was to investigate the relationships between mental health literacy, attitudes toward offenders with mental illness, and personal relationships with persons with mental illness. Descriptive statistics are provided in the first section of the chapter for reference. Following the presentation of descriptive statistics on the variables, each research hypothesis is addressed with results of statistical analysis.

Characteristics of Correctional Officers in Louisiana Jails

The characteristics investigated include age, sex, race and ethnicity, level of education, participation in Crisis Intervention Team (CIT) training, and experience and contact with persons with mental illness.

Demographics

The descriptive analysis included correctional officers (n= 213) who participated in this survey data collection period between June 2019 and October 2019. As seen in Table 1, a majority of the participants identified as white (78.7%) and male (69.0%). The mean age of participants was 36.11 years (SD = 13.05).

Table 1. Demographic characteristics (N= 205-210)

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Range</th>
<th>Frequency</th>
<th>Valid %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>36.1</td>
<td>13.05</td>
<td>18-66</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>145</td>
<td>69.0</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td>65</td>
<td>30.9</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>-</td>
<td></td>
<td>-</td>
<td>163</td>
<td>76.5</td>
</tr>
<tr>
<td>African-American</td>
<td></td>
<td>39</td>
<td></td>
<td>18.8</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>2.3</td>
</tr>
</tbody>
</table>
Educational Characteristics

Table 2 shows the descriptive statistics and frequencies for participants’ educational background characteristics, the frequency of participants that have attended CIT training, and the months worked as a correctional officer.

Table 2. Educational characteristics and work experience (N=197-205)

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
<th>Frequency</th>
<th>Valid %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not Complete HS</td>
<td>2</td>
<td>.98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduated HS</td>
<td>100</td>
<td>48.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>59</td>
<td>23.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate Degree</td>
<td>18</td>
<td>8.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>23</td>
<td>11.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>1</td>
<td>.49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>.98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIT Trained</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>146</td>
<td>74.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>51</td>
<td>25.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months worked as CO</td>
<td>81.2</td>
<td>82.2</td>
<td>1-384</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CO = Correctional Officer

Contact with Persons with Mental Illness

Participants most frequently reported having contact with offenders with mental illness on a daily basis (n= 112, 54.63%). Eighty-two percent (n=170) of correctional officers reported knowing someone with a mental illness. Findings from the level of contact report and frequency of offender contact are presented in Tables 3 and 4, respectively.

Mental Health Literacy

The mean score on the MHLS was 24.3 (SD=3.12) from a possible range of 15.25 to 32.16. According to O’Connor and Casey (2015), higher scores indicate increased mental health literacy. During the MHLS development, O’Connor and Casey (2014) generated descriptive statistics for the measure. The community sample mean for the scale using the original range of 35 to 160 was 127.38 (SD-12.63). Because the current study standardized the responses to a 0-1
score, comparing the two samples is not appropriate. Questions one through 15 were intended to measure participants’ ability to recognize specific disorders (i.e., mental health knowledge; O’Connor & Casey, 2015). Among questions about mental health knowledge, participants scored lowest on question number 12, which asked specifically about anxiety and avoidant behavior ($M=.43$, $SD=.27$). Question numbers nine ($M=.53$, $SD=.58$) and ten ($M=.52$, $SD=2.3$) also asked about anxiety and scored among the lowest three questions as well. Participants’ mean scores were highest on questions 14 (limits of confidentiality; $M=.83$, $SD=.22$), seven (bipolar disorder; $M=.83$, $SD=.19$), and eight (addiction; $M=.80$, $SD=.244$). Question 12 also scored lowest among all question on the scale. Appendix D includes the mean and standard deviation for each question in the MHLS.

**Attitudes Toward Offenders with Mental Illness**

The mean score on the ATMIO was 70.6 ($SD=12.46$) out of a possible range from 0 to 138. Higher scores indicate more tolerant attitudes toward offenders with mental illness (Brannen et al., 2004). The negative stereotypes subscale mean score was 33.9 ($SD=7.32$) out of a possible range from 0 to 50. Items are scored between zero (disagree strongly) and five (agree strongly); thirteen items are reverse scored. The item scoring lowest, indicating the least tolerant item in the scale, was item number 5, “You should be constantly on your guard with mentally ill offenders” ($M=1.6$, $SD=1.23$). The highest mean response was item number 23, “Mentally ill offenders deserve to be helped” ($M=4.12$, $SD=.85$). Among the items on the negative stereotypes subscale, item 20 scored lowest (i.e., indicating less tolerant responses; $M=2.72$, $SD=1.27$) and item number nine scored the highest (i.e. indicating more tolerant responses; $M=3.85$, $SD=1.02$). Appendix E includes the mean and standard deviations for each question on the ATMIO and Negative Stereotypes subscale.
Table 3. Level of contact report (n=204)

<table>
<thead>
<tr>
<th>Coded Score</th>
<th>Description</th>
<th>Frequency</th>
<th>Affirmative responses %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have never observed a person that I was aware had a severe mental illness.</td>
<td>20</td>
<td>9.85</td>
</tr>
<tr>
<td>2</td>
<td>I have observed, in passing, a person I believe may have had a severe mental illness.</td>
<td>149</td>
<td>73.04</td>
</tr>
<tr>
<td>3</td>
<td>I have watched a movie or television show in which a character depicted a person with mental illness.</td>
<td>161</td>
<td>78.92</td>
</tr>
<tr>
<td>4</td>
<td>I have watched a documentary on the television about severe mental illness.</td>
<td>109</td>
<td>53.69</td>
</tr>
<tr>
<td>5</td>
<td>I have observed persons with a severe mental illness on a frequent basis.</td>
<td>138</td>
<td>67.65</td>
</tr>
<tr>
<td>6</td>
<td>I have worked with a person who had a severe mental illness at my place of employment.</td>
<td>64</td>
<td>31.53</td>
</tr>
<tr>
<td>7</td>
<td>My job includes providing services to persons with a severe mental illness.</td>
<td>123</td>
<td>60.59</td>
</tr>
<tr>
<td>8</td>
<td>My job involves providing services/treatment for persons with a severe mental illness.</td>
<td>129</td>
<td>63.24</td>
</tr>
<tr>
<td>9</td>
<td>I have a friend of the family has a severe mental illness.</td>
<td>100</td>
<td>49.26</td>
</tr>
<tr>
<td>10</td>
<td>I have a relative who has a severe mental illness.</td>
<td>95</td>
<td>46.80</td>
</tr>
<tr>
<td>11</td>
<td>I live with a person who has a severe mental illness.</td>
<td>36</td>
<td>17.73</td>
</tr>
<tr>
<td>12</td>
<td>I have a severe mental illness.</td>
<td>12</td>
<td>05.91</td>
</tr>
</tbody>
</table>

**Multivariate Analysis**

Ordinary least squares (OLS) multiple regression was used to test each of the five research hypotheses using the simultaneous entry method. The power analysis, using STATA software, indicated that the estimated sample size for multiple linear regression with a medium
effect size ($f^2=.13$), alpha level ($\alpha=.05$), and desired power (.80) with nine predictor variables is 114 participants. A sufficient number of cases are available to ensure adequate statistical power for this study.

Table 4. Frequency of contact with offenders with mental illness ($N=205$)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>112</td>
</tr>
<tr>
<td>2-3 times per week</td>
<td>45</td>
</tr>
<tr>
<td>Once per week</td>
<td>15</td>
</tr>
<tr>
<td>More than once per month</td>
<td>15</td>
</tr>
<tr>
<td>2-3 times per month</td>
<td>13</td>
</tr>
<tr>
<td>Once per month</td>
<td>3</td>
</tr>
<tr>
<td>Never</td>
<td>2</td>
</tr>
</tbody>
</table>

Hypothesis 1, 2, and 3

An OLS multivariate regression was used to test if correctional officers with more work experience, educational attainment, and more frequent contact with offenders with mental illness will have more positive attitudes toward offenders with mental illness. The model was found to be significant ($R^2=.34$, $F(10,136)=7.24$, $p<0.000$). The model accounted for approximately 35% of the variance in attitudes toward offenders with mental illness. A summary of the regression coefficients is presented in Table 5. A review of the missing data indicated that an adequate number of observations ($n=147$) exist in this model to ensure statistical power. Multicollinearity was not a problem in this model, the mean VIF score (1.31) was within the acceptable range.
The regression model included 10 predictor variables, three of which have coefficients that were statistically significant: educational attainment, race, and mental health literacy. Standardized coefficients indicate that mental health literacy has the strongest effect on attitudes toward offenders with mental illness (β= .520). The magnitude of effects for each independent variable on the dependent variable can be calculated by multiplying the predictor variables’ coefficient by the range for each variable. The maximum effect that the MHLS can have on ATMIO scores is 37.2, roughly 26% of the range of the ATMIO. Educational attainment represents a maximum effect of 10.2 on the ATMIO score. These results indicate that mental health literacy and educational attainment contribute significantly to the correctional officers’ attitudes and have the largest impact on the ATMIO scores for correctional officers. The coefficients for the demographic predictor variables, age and gender, were not significant and represented a maximum possible effect on ATMIO of 4.5 and .441, respectively.

**Hypothesis 4**

An OLS multiple regression was used to test the hypothesis that correctional officers with high mental health literacy will have fewer negative stereotypes of offenders with mental illness while controlling for other variables. Recall that higher scores on the negative stereotype subscale indicate fewer negative stereotypes. The model was significant and predicted 33.78% of the variance (R²=.337, R²_adj=.289, F(10,141)=7.15, p<.001). The coefficients for mental health literacy, educational attainment, frequency of contact, and race were significant at p<.05. A review of the missing data indicated that an adequate number of observations (n=152) exist in this model to ensure statistical power. Multicollinearity was not a problem in this mode, the mean VIF score (1.29) was within the acceptable range.
Table 5. OLS regression coefficients for general model of determinants of attitude toward offenders with mental illness

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>$\beta$</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work experience</td>
<td>0.004</td>
<td>0.028</td>
<td>0.33</td>
<td>0.743</td>
</tr>
<tr>
<td>Educational attainment</td>
<td>1.70</td>
<td>0.151</td>
<td>2.06</td>
<td>0.021*</td>
</tr>
<tr>
<td>Level of Contact Report</td>
<td>-0.687</td>
<td>-0.113</td>
<td>-1.45</td>
<td>0.148</td>
</tr>
<tr>
<td>Personal relationship</td>
<td>1.09</td>
<td>0.030</td>
<td>0.38</td>
<td>0.706</td>
</tr>
<tr>
<td>Frequency of Contact</td>
<td>-0.186</td>
<td>-0.022</td>
<td>-0.28</td>
<td>0.779</td>
</tr>
<tr>
<td>Mental health literacy (MHLS)</td>
<td>2.20</td>
<td>0.520</td>
<td>7.19</td>
<td>0.000*</td>
</tr>
<tr>
<td>CIT</td>
<td>-1.76</td>
<td>-0.058</td>
<td>-0.79</td>
<td>0.433</td>
</tr>
<tr>
<td>Age</td>
<td>0.094</td>
<td>0.091</td>
<td>1.01</td>
<td>0.313</td>
</tr>
<tr>
<td>Gender</td>
<td>0.441</td>
<td>0.015</td>
<td>0.21</td>
<td>0.832</td>
</tr>
<tr>
<td>Race</td>
<td>-4.91</td>
<td>-0.149</td>
<td>-1.94</td>
<td>0.027*</td>
</tr>
</tbody>
</table>

*sig. at p<.05

Table 6 represents a summary of the regression coefficients for the general model. The negative stereotype subscale has a possible range of 50 points, with the current sample scoring between 7-49. The standardized regression coefficients suggest that among the variables in this model, a correctional officer’s mental health literacy has the strongest effect on their negative stereotypes ($\beta=0.495$). Educational attainment, contact, and race share similar effects on the dependent variable, $\beta=0.158$, $\beta=-0.135$, and $\beta=0.169$ respectively. As with the previous three hypothesis, mental health literacy has the largest substantive effect on negative stereotypes. The MHLS has a possible effect (20.79) that represents roughly 40% of the negative stereotype range. Educational attainment’s maximum effect on the negative stereotype subscale is 6.42, contact is 2.95, and race is 3.38.
Table 6. OLS regression coefficients for model of the effects of mental health literacy on negative stereotypes toward offenders with mental illness

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work experience</td>
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</tr>
<tr>
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<td>.032*</td>
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<td>6.74</td>
<td>.000*</td>
</tr>
<tr>
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<td>.910</td>
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<td>-2.23</td>
<td>.027*</td>
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</table>

*sig. at p<.05

**Hypothesis 5**

An OLS multivariate regression was used to test if correctional officers in a jail setting who report attending CIT training will have high levels of mental health literacy while controlling for other variables. The model was not significant and predicted 9% of the variance in mental health literacy ($R^2=.09$, $F(9,152)$, $p=.06$). The coefficient for CIT attendance was not significant, while the coefficient for having a personal relationship with a person diagnosed with mental illness and gender were significant at $p<.05$. A review of the missing data indicated that an adequate number of observations ($n=162$) exist in this model to ensure statistical power. Multicollinearity was not a problem in this model, the mean VIF score (1.31) was within the acceptable range.
Table 7 represents the summary of coefficients for the general model. The hypotheses states that attending CIT training will have an effect on mental health literacy, the coefficients and substantive effect suggest that this is not the case with this sample. Additionally, only one of the variables included in the model contributes substantively to the officers’ mental health literacy: having a relationship with a person diagnosed with a mental illness. The range of possible scores for the MHLS is 0-35, this sample’s range was 15.25-32.17. The maximum effect of CIT attendance was .07, representing 4% of the MHLS range. Personal relationship has a maximum effect representing 11% of the MHLS range (1.95). The gender coefficient had a maximum effect representing 6.8% of the MHLS range (1.15).

Table 7. OLS Regression coefficients for model of the effects of attending crisis intervention training on mental health literacy

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<th>B</th>
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*sig. at p<.05
Summary

The multivariate analyses included three general models to determine what, if any, factors contribute to attitudes, negative stereotypes, and mental health literacy of correctional officers working in Louisiana jails. The first two models represent attitudes toward offenders with mental illness, model two’s dependent variable is a subscale of the dependent variable in model one. In both of the first two models, educational attainment, mental health literacy, and race coefficients were significant and each of the predictor variables substantively contributed to the officers’ attitudes and stereotypes (see Table 5 and Table 6). In all three models, race had a negative coefficient, indicating that being white tends to decrease scores in all three dependent variables. Coefficients for work experience and CIT training were not significant in either of the three models, suggesting that the duration of time spent working in the correctional environment and attending CIT training does not contribute to attitudes, negative stereotypes, or mental health literacy in this sample. Further discussion on the results are discussed in Chapter 5.
CHAPTER 5. DISCUSSION AND CONCLUSIONS

This study examined the relationships between correctional officer mental health literacy, attitudes toward offenders diagnosed with mental illness, as well as contact and relationships between officers and persons with mental illness. In this chapter, a discussion of the results and significant findings are provided along with conclusions derived from the findings. Limitations and merits of the study are described, as well as directions for future research and implications for social work practice.

Attitudes toward Offenders with Mental Illness

Much of the research conducted on jail correctional officers explores job satisfaction and professional orientation toward punitive or rehabilitative views. Little is known about correctional officers’ perceptions and attitudes toward offenders with mental illness (Lavoie, Connolly, & Roesch, 2006). The current study explored correctional officers’ attitudes toward offenders with mental illness as predicted by work experience, educational attainment, and contact with offenders with mental illness. Multiple regression analyses revealed that work experience and contact with persons with mental illness are not significant predictors of attitude. Educational attainment, mental health literacy, and race were found to be significant predictors of attitudes toward offenders with mental illness.

Work Experience

The sample included correctional officers of varying rank, including wardens, supervisors, and line staff. The range of work experience was one month to 384 months. Hypothesis one states that work experience enhances positive attitudes toward offenders diagnosed with mental illness. The hypothesis posited that correctional officers’ work experiences increase the opportunity to learn through natural exposure and training opportunities
resulting from extended employment in the field. Correctional officers are required to have
annual training on mental health issues; thus, the increased work experience includes increased
opportunities for training. According to Dvoskin and Spiers (2004), both formal training and
experiential learning during years of employment benefit correctional officers and offenders
alike. They point out that inexperienced staff may partake in behaviors that undermine safety
within the facility as well as the mental health of offenders in their care. For example, Dvoskin
and Spiers (2004) note that inexperienced or unaware staff may belittle or humiliate offenders to
exert power, not realizing the consequences of such behavior. Humiliation is one stressor that
Dvoskin and Spiers (2004) connect to violent behavior, thus connecting the humiliating
experience at the hands of the officer with the potential for offender violence.

The results of this study do not support the hypothesis that work experience is a predictor
of attitudes toward offenders with mental illness, nor does it support that work experience is a
significant predictor for negative stereotypes and mental health literacy. The results indicate that
although the correctional officers in this sample have an average of 81.2 months (6.8 years) of
correctional experience, the experience is not a predictor of attitudes toward offenders diagnosed
with mental illness. Further information on the rank and training of each participant may have
provided further insight into the findings of this analysis. In addition to supplementary
information on the participants, a larger sample size would have allowed for advanced analysis
into the relationship between work experience and attitudes toward offenders with mental illness.

Although work experience may provide learning opportunities, working in a correctional
environment can be daunting and includes little opportunity for positive reinforcement. Lavoie et
al. (2006) researched jail correctional officers’ perceptions about offenders with mental illness
and opined that officers’ negative attitudes toward offenders with mental illness are due to
burnout among correctional officers. Burnout includes emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (Lavoie et al., 2006). Although this study did not inquire about symptoms of burnout among the sample, future research would benefit from exploring the dynamics of work experience, job satisfaction, and attitudes toward offenders diagnosed with mental illness. Inquiring about burnout may shed light on why some correctional officers gain insight and improve professionally with experience, and others experience burnout, cynicism, and emotional exhaustion (Lavoie et al., 2006).

**Education**

Research supports the hypothesis that educational attainment is positively correlated with positive attitudes toward people diagnosed with mental illness and less stigmatized views of the population (Simmons et al., 2017). The findings from the current study are consistent with previous research and supported the hypothesis that educational attainment is associated with more tolerant attitudes toward offenders diagnosed with mental illness. Roughly 78% of the sample earned less than an associate's degree, while 8.78% earned an associate's degree, and 11.22% earned a bachelor's degree. This sample's educational attainment was lower than the 32.3% of correctional officers who earned bachelor's degrees in a study conducted in a single midwestern state (Lowder et al., 2019). In this midwestern state, Lowder et al. (2019) found that correctional officers are the least likely of all criminal justice professionals to hold a college degree. Given the frequency with which correctional officers interact with offenders and the research findings that knowledge and education improve stigmatizing attitudes, hiring and retention of correctional officers with higher educational attainment should be among priorities for facilities wanting to address issues related to offenders with mental illness. Lavoie et al. (2006) indicated that higher education is associated with a rehabilitative orientation, versus
punitive orientation, and influences how officers interact with offenders. Church et al. (2009) found that as educational attainment increased in social work students, so did tolerant attitudes toward offenders with mental illness. Research related to stigma often refers to mental health knowledge as a mechanism to mitigate stigmatizing attitudes and discriminatory behavior, rather than educational attainment. Mental health knowledge is a component of mental health literacy and will be addressed in the analysis of hypothesis four.

**Contact with Persons with Mental Illness**

Consistent with findings from previous research, correctional officers in this sample have frequent interactions with people diagnosed with mental illness both personally and professionally (Corrigan et al. 2001). A majority of correctional officers (54.6%) in the current study reported having contact with offenders diagnosed with mental illness at least daily, and 82% reported knowing someone diagnosed with a mental illness. Further, 46.8% reported having a family member with mental illness, and 17.73% reported living with a person diagnosed with a mental illness. Lastly, 5.91% of the sample reported having a mental illness themselves. Lowder et al. (2019) found that daily contact with offenders diagnosed with mental illness was associated with more positive attitudes, as compared to monthly contact. Using the ATMIO to measure attitude, Weaver et al. (2019) found that criminal justice and social work students who knew someone with a mental illness were less likely to endorse negative stereotypes of offenders with mental illness. The current study hypothesized that correctional officers' attitudes would also be less negative as contact with persons diagnosed with mental illness increased. Using three measures of contact (i.e., the level of contact report, the frequency of contact item, and the question regarding personal contact), the study did not find that attitudes were significantly predicted by any of the three measures of contact.
In the general population, personal relationships are associated with more tolerant attitudes toward people with mental illness (Alexander & Link, 2003). However, little is known about how personal relationships shape attitudes toward offenders with mental illness (Lowder et al., 2019; Weaver et al., 2019). Negative intergroup contact may explain the inconsistency in findings between correctional officers’ attitudes toward offenders with mental illness and other population samples, including students (Árnadóttir, Lolliot, Brown, & Hewstone, 2018). Although correctional officers have personal relationships with people diagnosed with mental illness, their exposure to offenders with mental illness does not qualify as Allport’s key situational conditions for contact theory to be relevant (Pettigrew et al., 2011). The relationship between correctional officers and offenders is not always positive and supportive. Correctional officers are responsible for disciplinary as well as caretakers of offenders among their job duties (Simmons, 2017). Offenders with mental illness who are involved in the criminal justice system are often symptomatic and do not conform to facility rules (Lamb & Weinberger, 2011). Given the duties of correctional officers and the difficulties placed on them when offenders are symptomatic and acting-out, the potential for adverse interactions is high. One could speculate, based on the findings of this study, that negative intergroup contact between correctional officers and offenders with mental illness outweigh any positive contact that correctional officers are exposed to outside of the correctional environment (Árnadóttir et al., 2018). The survey did not inquire about the quality of interactions between correctional officers and people with mental illness; therefore, this explanation is speculative and warrants additional investigation. The findings from this study suggest that the relationship between correctional officers’ contact with people with mental illness and the officers’ attitude toward offenders with mental illness is complicated and nuanced. An additional perspective is that correctional officers generalize the
behavior of all offenders and do not differentiate between those with or without mental health diagnoses. The relationship between correctional officers and attitudes toward offenders with mental illness is complicated by the existence of both personal and professional relationships with people diagnosed with mental illness (Lowder et al., 2019).

**Mental Health Literacy**

Although evidence supports the hypothesis that more mental health knowledge is associated with less stigmatizing attitudes, scant information exists on the mental health literacy and the level of knowledge about mental illness of correctional officers (Simmons et al., 2017). This study explored whether mental health literacy contributes to negative stereotypes and attitudes toward offenders with mental illness. Mental health knowledge has been measured among correctional officers to a limited extent, and the findings support the assertion that higher levels of mental health literacy are associated with improved perceptions of offenders with mental illness (Petracek, 2012). Consistent with findings that education is associated with tolerant attitudes, this study found that high mental health literacy is a significant predictor of positive attitude toward offenders with mental illness. Research consistently found that those correctional officers who attended formal training on mental health are less likely to endorse stigmatizing attitudes toward people with mental illness. (Kutcher et al., 2016; Lavoie et al., 2006; Tomar et al., 2017).

**Negative Stereotypes**

Hypothesis four was supported and found that mental health literacy, educational attainment, and race were significant predictors of negative stereotypes. The study participants with higher scores on the MHLS and higher educational attainment were less likely to have
negative stereotypical views of offenders with mental illness. As discussed previously, education is a significant predictor of attitudes toward offenders with mental illness as well.

Link and Phelan (2001) define stigma as a process by which people are labeled, stereotyped, separated and devalued, and discriminated against in a circumstance in which a power structure that allows it to happen. Holding negative stereotypes does not necessarily lead to the open engagement of discrimination but can contribute to the accumulation of micro-level interactions that ultimately result in poor outcomes (Link & Phelan, 2001; Tomar et al., 2017). The labels offender and person with mental illness are both linked to undesirable characteristics and status loss (West, 2015). As noted previously, inexperienced or poorly trained correctional officers may display outward discriminatory behavior, but may also contribute to poor outcomes without an overt act of discrimination (Dvoskin & Spiers, 2004). Other negative labels and stereotypes that contribute to the downward placement of offenders with mental illness on the social hierarchy include poverty, homelessness, substance abuse, and victimization. Multiple layers of stigma and discrimination throughout the criminal justice system contribute to the poor outcomes for offenders with mental illness (Link & Phelan, 2001; West, 2015).

Stigmatizing attitudes have a major impact on the lives of the people who are stigmatized (Alexander & Link, 2003; Simmons et al., 2017). Negative stereotypes were specifically investigated in this study because they are a component of stigma that can offer insight into the complicated relationship between correctional officers and offenders diagnosed with mental illness (Link & Phelan, 2001). The population of incarcerated people who are diagnosed with mental illness carries the burden of multiple labels that lead to discriminatory treatment and unequal outcomes (West, 2015). This was evident during the administration of the survey for this study. On multiple occasions, the researcher fielded questions from correctional officers that
elucidated their view that offenders with mental illness were not treated differently from other offenders despite any special needs related to their diagnosis. Specifically, question five on the ATMIO states, "You should be constantly on your guard with mentally ill offenders.” The officers were asked to rate the item on a scale from disagree strongly to agree strongly, but reflected that as a correctional officer, they are on guard with all offenders and that their response is independent of the offender having a mental illness. The response would be the same whether the offender had a mental illness or not; they communicated that they are on guard with every offender. Their candor regarding this item is evidence of the multiple labels that offenders with mental illness carry. The culture of correctional environments is driven by staff and offender safety. Because some offenders act out and become violent, independent of any mental health diagnosis, correctional officers treat all offenders as though they are violent as a matter of general facility safety. The acculturation and socialization of new correctional officers within an agency often determines how offenders with mental illness are treated and the extent to which they are stigmatized. The process of separating “them” from “us” includes the labeling of the person as an offender as well as a person diagnosed with mental illness; correctional officers are trained to view “them” as dangerous (Pettigrew et al., 2011; Simmons, 2017). Further investigation into correctional officers’ stereotypical views of offenders with mental illness and whether they demonstrate differential treatment of those offenders is warranted. Most importantly, research on whether any differential treatment impacts outcomes for the offenders is necessary to connect correctional officers’ mental health literacy and attitudes to offender outcomes.

Stigma impacts behavior when decisions are made on false assumptions or negative stereotypes (Corrigan & Watson, 2002; Overton & Medina, 2008). An example is the false,
negative stereotype that people with mental illness are dangerous (Simmons, 2017). If correctional officers accept the dangerousness myth as true, they will make decisions that impact the offenders based on this false assumption. The daily discretion used by correctional officers impacts the offenders' ability to socialize with other offenders, gain access to recreation and religious services, and face disciplinary actions, for example (Fellner, 2006: Dvoskin & Spiers, 2004). Correctional officers’ use of discretion can minimize environmental stressors and optimize conditions that assist with emotional needs and coping mechanisms. The belief system of correctional officers will determine if they make decision believing that offenders with mental illness are worthy and valued human beings, capable of healing, growth, and recovery or if they are dangerous, and of a lesser status not deserving of assistance.

**Crisis Intervention Training**

Although the overall model for hypothesis five was significant, attending CIT training in the past was not significantly related to mental health literacy scores. According to the model, significant predictors of mental health literacy among the included variables are having a personal relationship with a person diagnosed with a mental illness and gender. Age, race, education, work experience, level of contact, and frequency of professional contact were not significant predictors of mental health literacy. Simmons et al.’s (2017) findings provide the support that mental health knowledge mitigates mental health stigma. Education was a significant predictor of attitudes toward offenders with mental illness but was not a significant predictor of mental health literacy.

CIT training includes modules to improve knowledge about mental illness as well as experiential learning with persons diagnosed with mental illness (Public Health Resource Institute, 2011). Experiential learning in the CIT model includes contact between trainees and
persons from the community diagnosed with mental illness (NIC, 2010). The purpose of this portion of the training is to personalize people diagnosed with mental illness because offenders with mental illness are often depersonalized in the correctional environment (Lavoie et al., 2006). The experiential contact may influence the belief that mental illnesses are treatable, and thus the officers may change behavior based on the new belief that the person with mental illness is capable of stability and improved behavior (Lavoie et al., 2006). Well trained and knowledgeable correctional staff can provide necessary crisis intervention techniques that deescalate situations when mental health staff is not available (Dvoskin & Spiers, 2004). The correctional officers’ ability to deescalate situations when offenders diagnosed with a mental illness are involved requires a specific skill set, but also requires officers to use discretion. Dvoskin and Spiers (2004) stressed the importance of formal training along with informal communication and experiences within the correctional environment.

The relationship between gender and attitudes toward offenders with mental illness among correctional officers is understudied and has produced mixed results (Barr & Bracchitta, 2015; Davidson, 2016). Females are generally more accepting of individuals with disabilities (Barr & Bracchitta, 2015). However, results from research on correctional officers are mixed on whether gender is associated with more punitive attitudes (Misis et al., 2013). Farkas (1999) reports that gender does not influence attitudes toward inmates in general, while Misis et al. (2013) indicates that female staff’s self-efficacy influenced attitudes toward offenders. Lavoie et al. (2006) found that female correctional officers in the study’s sample were more supportive of rehabilitation. Likewise, Vermass, Green, Haley, and Haddock (2017) found that being female was a predictive characteristic for mental health literacy among clergy in the United States. No prior research has investigated female correctional officers’ attitudes toward offenders with
mental illness. The prior research on female correctional officers studied punitive attitudes toward offenders in general, not offenders with mental illness (Misis et al., 2013). The findings from the current study indicate that female correctional officers score significantly less on the MHLS than male correctional officers. The descriptive data collected for this study did not provide enough information to speculate as to why females scored lower than the males in this sample.

**Limitations of the Current Study**

Although the current study has merits and contributes to the knowledge base of jail correctional officers’ mental health literacy and attitudes toward offenders with mental illness, it is not without limitations. The study used a cross-sectional design that prohibits the consideration of any causal relationships (Rubin & Babbie, 2010). The exploratory nature of the cross-sectional design identifies the demographics and status of Louisiana’s jail correctional officers, but no evidence was gathered that meets the temporal precedence requirement to conclude that one attribute caused another. The study included only jail correctional officers and no comparison or reference group. The results did not reveal whether correctional officers’ mental health knowledge or attitudes differed from those of the general public. Lastly, the sample was drawn from Louisiana jail correctional officers whose Sheriffs agreed to participate in the survey. The results may not generalize because the survey was requested during an election year, and the perceived political risks may have diminished the willingness of some Sheriffs to participate. Because of self-selection bias and the unique culture in Louisiana’s criminal justice system, the ability to generalize findings from this study to other states and jurisdictions is questionable.
Because the researcher was present for the survey collection, social desirability bias is a possibility (Rubin & Babbie, 2010). No mechanism was included in the survey to account for socially desirable answers. The surveys were disseminated and collected by the researcher, possibly contributing to the officers’ feeling pressure to respond in a way that they believe was desirable to the researcher (Alexander & Link, 2003). Castle (2008) conducted survey research with jail correctional staff and suggested in-person collection is preferable to web-based survey for optimal response rate.

To gain a deeper understanding of the findings, Alexander and Link (2003) suggested including quality of contact and quality of relationship variables in research conducted to investigate the connection between contact and attitude. The current study included two measures of contact between correctional officers and people diagnosed with mental illness. One measured the level of intimacy of the relationship (i.e., level of contact report), and the other measured the frequency of professional contact with offenders diagnosed with mental illness. Although the measures captured relevant information, they only note the existence of the relationship, not the quality of the relationship (Lee & Seo, 2018). Further information regarding the mental health diagnosis and quality of the relationship would allow for a more thorough exploration of the connection between contact and attitude (Barr & Bracchitta, 2015). The study did not include behavioral indexes for correctional officers, which would have assisted in detecting whether discriminatory behaviors occurred in the presence of negative stereotypical views. Lastly, the survey inquired about CIT training but did not ask when participants attended the training or whether the training addressed correctional or patrol-based information/scenarios for training.
Implications for Social Work Practice

The National Association of Social Workers’ (NASW) Code of Ethics asserts that social workers challenge social injustice and respect the dignity and worth of every person (NASW, 2017). Social workers in practice within the criminal justice system have a unique opportunity to advocate for vulnerable and oppressed people and work to reduce human suffering (Dvoskin & Spiers, 2004). Findings from the current study have practical implications for training, advocacy, and practice to meet these objectives. The literature review identified a gap in the research on jail correctional staff and their attitudes toward and relationships with offenders with mental illness. Much of the commentary on correctional officers’ attitudes and the role of social workers in a correctional environment stressed the importance of consultation and collaboration on multidisciplinary and treatment teams (Dvoskin & Spiers, 2004; Weaver et al., 2019). Consultation is discussing offenders with other staff and requires developing a culture of mutual support (Dvoskin & Spiers, 2004). Weaver et al. (2019) stressed the importance of interdisciplinary teams because competing ideologies between correctional officers (e.g., crime and punishment) and social work values (e.g., human dignity and rehabilitation) may cause program failure and struggles. Social workers can provide support for correctional officers who find themselves serving dual roles of strict disciplinarian charged with safety and security and protector and facilitator of rehabilitative functions (Dvoskin & Spiers, 2004).

Schools of social work and social work educators prepare students for social work practice and advocacy in the forensic setting. Preparation for work in the field of criminal justice includes cross-training social worker and criminal justice students at the university level to work on interdisciplinary teams, emphasize collaboration, and identifying mutual goals (Weaver 2019). Social work and criminal justice programs should produce practitioners prepared for
advocacy and collaborative roles once they enter the workforce (Church et al., 2009). Social 
workers' training should include preparation to accept information, and work with other 
professionals in an open and honest dialogue, develop relationships with other staff for positive 
exchange (Dvoskin & Spiers, 2004).

Social work is a unique discipline with social justice objectives preparing social work 
professionals to be leaders and educators. During multidisciplinary trainings and collaborations, 
social workers bring social justice approaches to address oppressed and subordinate groups like 
offenders with mental illness (Weaver et al., 2019). Social work can provide unique perspectives 
to engage the public and criminal justice community for reform in achieving social justice 
objectives. Correctional staff is an ideal target for improved training and growth for criminal 
justice outcomes for offenders with mental illness (Lowder et al., 2019). Training that includes 
positive, contact-based interactions with people with mental illness, such as the CIT model, 
challenge the negative stereotypes that correctional officers may have about people with mental 
ilness (Lowder et al., 2019). The contact-based interactions provide accurate and empathetic 
information about the struggles of people who have a mental illness (Alexander & Link, 2003). 

Daily tasks of line staff (i.e., talking to offenders, listening to them, and keeping them safe) are 
examples of informal verbal exchanges that can be seen as intervention strategies. Correctional 
officers have ample opportunity to defuse potential crises on a daily basis. Mental health 
treatment in the correctional environment is seen as contributing to the safety of the facility. 
Social workers are part of the safety mechanism by assisting offenders to cope with a stressful 
environment as well as assisting the security staff in understanding offender behavior. These 
tasks are achieved by using both formal and informal intervention strategies (Dvoskin & Spiers, 
2004).
Further research

Despite evidence that knowledge and attitude are connected, little research is conducted on jail correctional officers and attitudes toward offenders with mental illness (Lowder et al., 2019). The current study identified inconsistencies in the relationship between personal and professional contact, attitudes, and mental health literacy. More research is needed on how quality, frequency, and type of contact, attitudes, and behavior of correctional staff impacts outcomes for offenders diagnosed with mental illness. Research has supported the claim that knowledge has an impact on attitude, and attitude can alter behavior. The question is whether this alteration in knowledge translates into improved outcomes for offenders. Intervention research is needed to identify effective interventions that effectively improve mental health literacy within the context of a correctional environment (Kutcher, 2016). Further research is needed to determine if jail correctional officers’ contact with people with mental illness is related to professional discretion. The connection between stigma and behavior within the correctional environment and whether the correctional officer behavior is associated with outcomes for offenders with mental illness is warranted.

Summary and Conclusions

Correctional officers play an integral role in the delivery of crisis intervention services in the correctional environment, and provide important collaborative information that mental health staff uses to develop appropriate treatment plans (Dvoskin & Spiers, 2004). When working relationships are not ideal and correctional staff hold stigmatizing beliefs about offenders with mental illness, the quality and effectiveness of services suffer (Church et al., 2009). It is incumbent on the social worker to work toward creating a just environment within the correctional facility. The results of this study indicate that the level and frequency of contact with
people diagnosed with a mental illness is not a significant predictor of mental health literacy or attitudes, but education and knowledge are the keys to improving attitudes. Mental health training for correctional officers can be an important tool to reduce the trauma associated with incarceration for offenders with mental illness.
APPENDIX A: IRB EXEMPTION APPROVAL

ACTION ON EXEMPTION APPROVAL REQUEST

TO:        Amber Hebert
           Social Work

FROM:      Dennis Landin
           Chair, Institutional Review Board

DATE:      June 5, 2019

RE:        IRB# E11737

TITLE:     Correctional Officers' Mental Health Literacy and Attitudes toward Offenders with Mental Illness


Review Date:  6/5/2019

Approved____ X ______ Disapproved________

Approval Date:  6/5/2019  Approval Expiration Date:  8/4/2022

Exemption Category/Paragraph:  2b

Signed Consent Waived?:  No

Re-review frequency:  (three years unless otherwise stated)

LSU Proposal Number (if applicable):

By: Dennis Landin, Chairman

PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING – Continuing approval is CONDITIONAL on:
1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects*
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins), notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants, including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
8. SPECIAL NOTE: When emailing more than one recipient, make sure you use bcc. Approvals will automatically be closed by the IRB on the expiration date unless the PI requests a continuation.

* All investigators and support staff have access to copies of the Belmont Report, LSU's Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at http://www.lsu.edu/irb
APPENDIX B. PARTICIPATION REQUEST TO SHERIFFS

Amber Hebert, LCSW
Awood46@lsu.edu ☎️ (337) 230-7908

Parish Sheriff’s Office

I am a doctoral student at Louisiana State University in Baton Rouge and I am interested in providing a complimentary one-hour mental health training to your correctional staff in exchange for permission to conduct a survey of correctional officers within your agency. The purpose of the survey is to gain information on correctional officers’ knowledge of mental health and how they interact with offenders diagnosed with mental illness. The surveys are anonymous, no personal information about the officers will be collected, and no agency will be identified by name. The final report will include a description of the survey sample (total number of officers surveyed, their age, race, and gender), along with the size and region of each jail represented. I have included a copy of the demographic page of my survey for your review. My goal is to complete the surveys July 1, 2019. Please consider participating in this survey. The total size of your facility or staff is not important, I would like all sizes and locations represented in the study. Every jail in Louisiana is eligible to participate in the survey.

Once the surveys are complete, each participating agency will receive a written summary of the findings. Please contact me with any questions or concerns that you have regarding my offer. Law enforcement references are available upon request.

Sincerely,

Amber Hebert, LCSW-BACS
Dear Sheriff,

I am sending a second request for Parish Sheriff’s Office’s participation in my dissertation research and hope that you are able to help me. I am interested in learning more about what jail correctional officers know about mental health. As you know, far too many offenders with mental illness are in jail throughout the state. This places an unnecessary stress on the correctional staff and offenders.

During my 10 years as a correctional mental health supervisor I learned that correctional officers are caring and concerned professionals who want to do their jobs well. Now as a researcher, I want to help correctional administrators determine how to make their jails safer and their staff remain on the job longer.

The survey is anonymous. I do not record the names of the officers. No jails will be named in my research. My research is not about any one jail or officer, it is focused on helping the Sheriffs in Louisiana provide the best services possible to the people of Louisiana.

In return for your help, I am offering to provide free training to your staff at your convenience. I am willing to conduct the survey in person during a time that is most convenient for your facility. I can distribute the surveys at a regularly scheduled training, or wait in the lobby or breakroom while deputies complete the survey at their convenience. I am agreeable to conducting the survey in a manner that least disturbs your staff.
I need your help! Nine parishes have agreed to participate in my study, but this only represents a small percentage of the jails in the state. Please consider helping me with this research. Feel free to call or email with questions or for clarification.

Sincerely,

Amber R. Hebert, LCSW-BACS
Doctoral Candidate
Louisiana State University- Baton Rouge
APPENDIX C. SURVEY INSTRUMENT

Correctional Officers’ Mental Health Literacy and Attitudes toward Offenders with Mental Illness

This survey consists of 3 sections. It should take less than 30 minutes to complete the entire survey. Please read the instructions before each section carefully.

This survey is voluntary and anonymous. Your identifying information is not recorded or used in any way.

Section I. Mental Health Literacy Scale

The purpose of these questions is to gain an understanding of your knowledge of various aspects of mental health. When responding, we are interested in your degree of knowledge.

1. If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have social phobia

   Very Unlikely    Unlikely    Likely    Very Likely

2. If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued, then to what extent do you think it is likely they have generalized anxiety disorder

   Very Unlikely    Unlikely    Likely    Very Likely

3. If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep, then to what extent do you think it is likely they have Major Depressive Disorder

   Very Unlikely    Unlikely    Likely    Very Likely

4. To what extent do you think it is likely that Personality Disorders are a category of mental illness

   Very Unlikely    Unlikely    Likely    Very Likely

5. To what extent do you think it is likely that Dysthymia is a disorder

   Very Unlikely    Unlikely    Likely    Very Likely
6. To what extent do you think it is likely that the diagnosis of Agoraphobia includes anxiety about situations where escape may be difficult or embarrassing
   Very Unlikely  Unlikely  Likely  Very Likely

7. To what extent do you think it is likely that the diagnosis of Bipolar Disorder includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood
   Very Unlikely  Unlikely  Likely  Very Likely

8. To what extent do you think it is likely that the diagnosis of Drug Dependence includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)
   Very Unlikely  Unlikely  Likely  Very Likely

9. To what extent do you think it is likely that in general in the United States, women are MORE likely to experience a mental illness of any kind compared to men
   Very Unlikely  Unlikely  Likely  Very Likely

10. To what extent do you think it is likely that in general, in the United States, men are MORE likely to experience an anxiety disorder compared to women
   Very Unlikely  Unlikely  Likely  Very Likely

11. To what extent do you think it would be helpful for someone to improve their quality of sleep if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)
    Very Unhelpful  Unhelpful  Helpful  Very Helpful

12. To what extent do you think it would be helpful for someone to avoid all activities or situations that made them feel anxious if they were having difficulties managing their emotions
    Very Unhelpful  Unhelpful  Helpful  Very Helpful

13. To what extent do you think it is likely that Cognitive Behavior Therapy (CBT) is a therapy based on challenging negative thoughts and increasing helpful behaviors
    Very Unlikely  Unlikely  Likely  Very Likely
14. Mental health professionals are bound by confidentiality; however, there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to break confidentiality:

*If you are at immediate risk of harm to yourself or others*

<table>
<thead>
<tr>
<th>Very Unlikely</th>
<th>Unlikely</th>
<th>Likely</th>
<th>Very Likely</th>
</tr>
</thead>
</table>

15. Mental health professionals are bound by confidentiality; however, there are certain conditions under which this does not apply.

To what extent do you think it is likely that the following is a condition that would allow a mental health professional to break confidentiality:

*If your problem is not life-threatening and they want to assist others to better support you*

<table>
<thead>
<tr>
<th>Very Unlikely</th>
<th>Unlikely</th>
<th>Likely</th>
<th>Very Likely</th>
</tr>
</thead>
</table>

Please indicate to what extent you agree with the following statements:

<p>| 16. I am confident that I know where to seek information about mental illness | Strongly Disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |
| 17. I am confident using the computer or telephone to seek information about mental illness | Strongly Disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |
| 18. I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the GP) | Strongly Disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |
| 19. I am confident I have access to resources (e.g., GP, internet, friends) that I can use to seek information about mental illness | Strongly Disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |
| 20. People with a mental illness could snap out if it if they wanted | Strongly Disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |
| 21. A mental illness is a sign of personal weakness | Strongly Disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |
| 22. A mental illness is not a real medical illness | Strongly Disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |</p>
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. People with a mental illness are dangerous</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>24. It is best to avoid people with a mental illness so that you don't develop this problem</td>
<td></td>
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<tr>
<td>25. If I had a mental illness I would not tell anyone</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>26. Seeing a mental health professional means you are not strong enough to manage your own difficulties</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>27. If I had a mental illness, I would not seek help from a mental health professional</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Please indicate to what extent you agree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Definitely unwilling</th>
<th>Probably unwilling</th>
<th>Neither unwilling or willing</th>
<th>Probably willing</th>
<th>Definitely willing</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. How willing would you be to move next door to someone with a mental illness?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. How willing would you be to spend an evening socializing with someone with a mental illness?</td>
<td></td>
<td></td>
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<tr>
<td>31. How willing would you be to make friends with someone with a mental illness?</td>
<td></td>
<td></td>
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<tr>
<td>32. How willing would you be to have someone with a mental illness start working closely with you on a job?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>33. How willing would you be to have someone with a mental illness marry into your family?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?

<table>
<thead>
<tr>
<th>Definitely unwilling</th>
<th>Probably unwilling</th>
<th>Neither unwilling or willing</th>
<th>Probably willing</th>
<th>Definitely willing</th>
</tr>
</thead>
</table>

35. How willing would you be to employ someone if you knew they had a mental illness?

| Definitely unwilling | Probably unwilling | Neither unwilling or willing | Probably willing | Definitely willing |

---

Section II. Attitudes Toward Mentally Ill Offenders

**Attitudes Towards Mentally Ill Offenders Scale (ATMIO; Brennan et al., 2002)**

A mentally ill offender can be defined as an individual who has a serious mental illness that may require inpatient hospitalization, treatment, and medication, and who has committed a crime.

There are no right or wrong answers.

<table>
<thead>
<tr>
<th>1. Mentally ill offenders don’t fully understand their crime.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2. Mentally ill offenders need affection and praise just like anybody else.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. Trying to rehabilitate mentally ill offenders is a waste of time and money.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. I should be informed if a mentally ill offender is living in my community.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. You should be constantly on your guard with mentally ill offenders.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6. Mentally ill offenders are always trying to get something out of somebody.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>7. My taxes should not be used to support mentally ill offenders.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>8. Most mentally ill offenders can be rehabilitated.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>9. Mentally ill offenders respect only brute force.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>10. If a mentally ill offender does well in prison, he or she should be let out on parole.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>11. Only a few mentally ill offenders are dangerous.</th>
<th>Disagree Strongly</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
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</tr>
<tr>
<td>12. It doesn’t pay to give privileges to mentally ill offenders because they only take advantage of them.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>13. If you give mentally ill offenders an inch, he or she will want to take a mile.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>14. Mentally ill offenders deserve a second chance.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>15. Mentally ill offenders are not completely responsible for their crimes.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>16. For mentally ill offenders, preventing escape is more important than the treatment for their mental illness.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>17. If mentally ill offenders had simply used will power, they wouldn’t be in trouble in the first place.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>18. Physical punishment of mentally ill offenders is occasionally necessary.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>19. Despite their crime, mentally ill offenders deserve sympathy.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>20. Given a chance, most mentally ill offenders would try to escape from prison or a hospital.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>21. Most mentally ill offenders should be in prison rather than a hospital.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>22. Mentally ill offenders should have the same rights as any other mentally ill person.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>23. Mentally ill offenders deserve to be helped.</td>
<td>Disagree</td>
<td>Strongly</td>
<td>Disagree</td>
<td>Somewhat</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
</tbody>
</table>
Section III. Demographics

1. How old are you today? ______________ (years)

2. Please place an X next to the term that best describes your sex:
   □ Male   □ Female

3. Please record your race/ethnicity (mark all that apply):
   □ Black or African American, non-Hispanic
   □ American Indian or Alaskan Native
   □ Asian
   □ Hispanic origin (includes Mexican, Mexican American, Cuban, Puerto Rican/Caribbean, Central South American Spanish, and other Spanish
   □ White, non-Hispanic
   □ Native Hawaiian or other Pacific Islander
   □ All other races (Please identify) ______________________________

4. What is the highest level of education you have received?
   □ Did not complete high school   □ Graduated high school or GED/HiSET Diploma
   □ Some college   □ Associate Degree
   □ Bachelor’s Degree   □ Master’s Degree
   □ Other (If other, what education did you attain?) ______________________________

5. If you attended college, but did not graduate, how many semesters did you complete?
   ___________Semesters

6. Was criminal justice your major in college? □ Yes □ No □ N/A

7. Have you ever attended a Crisis Intervention Team (CIT) training? □ Yes □ No

8. How long have you served as a correctional officer (at this or any other location)?
   ___________Years ___________Months

9. How often do you have contact with offenders with mental illness? (circle one)

<table>
<thead>
<tr>
<th>Daily</th>
<th>2-3 times per week</th>
<th>Once a week</th>
<th>2-3 times per month</th>
<th>Once per month</th>
<th>Less than once per month</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Do you personally know someone with a mental illness? □ Yes □ NO
Please read each of the following statements carefully. After you have read all the statements below, place a check by the statements that best depict your experience with persons diagnosed with a mental illness.

<table>
<thead>
<tr>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have watched a movie or television show in which a character depicted a person with mental illness.</td>
</tr>
<tr>
<td>My job involves providing services/treatment for persons with a severe mental illness.</td>
</tr>
<tr>
<td>I have observed, in passing, a person I believe may have had a severe mental illness.</td>
</tr>
<tr>
<td>I have observed persons with a severe mental illness on a frequent basis.</td>
</tr>
<tr>
<td>I have a severe mental illness.</td>
</tr>
<tr>
<td>I have worked with a person who had a severe mental illness at my place of employment.</td>
</tr>
<tr>
<td>I have never observed a person that I was aware had a severe mental illness.</td>
</tr>
<tr>
<td>My job includes providing services to persons with a severe mental illness.</td>
</tr>
<tr>
<td>I have a friend of the family has a severe mental illness.</td>
</tr>
<tr>
<td>I have a relative who has a severe mental illness.</td>
</tr>
<tr>
<td>I have watched a documentary on the television about severe mental illness.</td>
</tr>
<tr>
<td>I live with a person who has a severe mental illness.</td>
</tr>
</tbody>
</table>
APPENDIX D. MENTAL HEALTH LITERACY SCALE $M$ and $SD$

Mental Health Literacy Scale Scores ($N=207-212$)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have social phobia</td>
<td>0.75</td>
<td>0.18</td>
</tr>
<tr>
<td>2</td>
<td>If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigues then to what extent do you think it is likely they have generalized anxiety disorder</td>
<td>0.74</td>
<td>0.22</td>
</tr>
<tr>
<td>3</td>
<td>If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have Major Depressive Disorder</td>
<td>0.72</td>
<td>0.24</td>
</tr>
<tr>
<td>4</td>
<td>To what extent do you think it is likely that Personality Disorders are a category of mental illness</td>
<td>0.76</td>
<td>0.22</td>
</tr>
<tr>
<td>5</td>
<td>To what extent do you think it is likely that Dysthymia is a disorder</td>
<td>0.64</td>
<td>0.23</td>
</tr>
<tr>
<td>6</td>
<td>To what extent do you think it is likely that the diagnosis of Agoraphobia includes anxiety about situations where escape may be difficult or embarrassing</td>
<td>0.61</td>
<td>0.25</td>
</tr>
<tr>
<td>7</td>
<td>To what extent do you think it is likely that the diagnosis of Bipolar Disorder includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood</td>
<td>0.84</td>
<td>0.20</td>
</tr>
<tr>
<td>8</td>
<td>To what extent do you think it is likely that the diagnosis of Drug Dependence includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)</td>
<td>0.81</td>
<td>0.24</td>
</tr>
<tr>
<td>9</td>
<td>To what extent do you think it is likely that in general in the United States, women are MORE likely to experience a mental illness of any kind compared to men</td>
<td>0.58</td>
<td>0.28</td>
</tr>
<tr>
<td>10</td>
<td>To what extent do you think it is likely that in general, in the United States, men are MORE likely to experience an anxiety disorder compared to women*</td>
<td>0.53</td>
<td>0.23</td>
</tr>
<tr>
<td>11</td>
<td>To what extent do you think it would be helpful for someone to improve their quality of sleep if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)</td>
<td>0.76</td>
<td>0.23</td>
</tr>
</tbody>
</table>
12 To what extent do you think it would be helpful for someone to avoid all activities or situations that made them feel anxious if they were having difficulties managing their emotions * 0.43 0.27

13 To what extent do you think it is likely that Cognitive Behavior Therapy (CBT) is a therapy based on challenging negative thoughts and increasing helpful behaviors 0.69 0.19

14 Mental health professionals are bound by confidentiality; however, there are certain conditions under which this does not apply. To what extent do you think it is likely that the following is a condition that would allow a mental health professional to break confidentiality: If you are at immediate risk of harm to yourself or others 0.84 0.23

15 Mental health professionals are bound by confidentiality; however, there are certain conditions under which this does not apply. To what extent do you think it is likely that the following is a condition that would allow a mental health professional to break confidentiality: If your problem is not life-threatening and they want to assist others to better support you * 0.72 0.28

16 I am confident that I know where to seek information about mental illness 0.72 0.24

17 I am confident using the computer or telephone to seek information about mental illness 0.76 0.23

18 I am confident attending face to face appointments to seek information about mental illness (e.g., seeing the GP) 0.73 0.22

19 I am confident I have access to resources (e.g., GP, internet, friends) that I can use to seek information about mental illness 0.78 0.21

20 People with a mental illness could snap out if it if they wanted * 0.72 0.28

21 A mental illness is a sign of personal weakness * 0.79 0.23

22 A mental illness is not a real medical illness * 0.85 0.20

23 People with a mental illness are dangerous * 0.48 0.23

24 It is best to avoid people with a mental illness so that you don’t develop this problem* 0.81 0.21

25 If I had a mental illness I would not tell anyone * 0.67 0.24

26 Seeing a mental health professional means you are not strong enough to manage your own difficulties * 0.78 0.24

27 If I had a mental illness, I would not seek help from a mental health professional * 0.76 0.22

28 I believe treatment for a mental illness, provided by a mental health professional, would not be effective* 0.77 0.22

29 How willing would you be to move next door to someone with a mental illness? 0.55 0.24

30 How willing would you be to spend an evening socializing with someone with a mental illness? 0.67 0.24

85
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>How willing would you be to make friends with someone with a mental illness?</td>
<td>0.71</td>
<td>0.22</td>
</tr>
<tr>
<td>32</td>
<td>How willing would you be to have someone with a mental illness start working closely with you on a job?</td>
<td>0.60</td>
<td>0.25</td>
</tr>
<tr>
<td>33</td>
<td>How willing would you be to have someone with a mental illness marry into your family?</td>
<td>0.64</td>
<td>0.24</td>
</tr>
<tr>
<td>34</td>
<td>How willing would you be to vote for a politician if you knew they had suffered a mental illness?</td>
<td>0.46</td>
<td>0.26</td>
</tr>
<tr>
<td>35</td>
<td>How willing would you be to employ someone if you knew they had a mental illness?</td>
<td>0.58</td>
<td>0.22</td>
</tr>
</tbody>
</table>
## APPENDIX E. ATTITUDE TOWARD MENTALLY ILL OFFENDERS M and SD

Attitude Toward Mentally Ill Offenders Scale and Negative Stereotypes Subscale scores ($N=203-209$).

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mentally ill offenders don’t fully understand their crime.</td>
<td>2.14</td>
</tr>
<tr>
<td>2</td>
<td>Mentally ill offenders need affection and praise just like anybody else.</td>
<td>3.36</td>
</tr>
<tr>
<td>3</td>
<td>Trying to rehabilitate mentally ill offenders is a waste of time and money. *</td>
<td>3.91</td>
</tr>
<tr>
<td>4</td>
<td>I should be informed if a mentally ill offender is living in my community. *</td>
<td>2.49</td>
</tr>
<tr>
<td>5</td>
<td>You should be constantly on your guard with mentally ill offenders. *</td>
<td>1.67</td>
</tr>
<tr>
<td>6</td>
<td>Mentally ill offenders are always trying to get something out of somebody. *†</td>
<td>3.38</td>
</tr>
<tr>
<td>7</td>
<td>My taxes should not be used to support mentally ill offenders. *†</td>
<td>3.52</td>
</tr>
<tr>
<td>8</td>
<td>Most mentally ill offenders can be rehabilitated.</td>
<td>3.04</td>
</tr>
<tr>
<td>9</td>
<td>Mentally ill offenders respect only brute force.*†</td>
<td>3.85</td>
</tr>
<tr>
<td>10</td>
<td>If a mentally ill offender does well in prison, he or she should be let out on parole.</td>
<td>2.58</td>
</tr>
<tr>
<td>11</td>
<td>Only a few mentally ill offenders are dangerous.</td>
<td>2.36</td>
</tr>
<tr>
<td>12</td>
<td>It doesn’t pay to give privileges to mentally ill offenders because they only take advantage of them.*†</td>
<td>3.55</td>
</tr>
<tr>
<td>13</td>
<td>If you give mentally ill offenders an inch, he or she will want to take a mile. *†</td>
<td>3.11</td>
</tr>
<tr>
<td>14</td>
<td>Mentally ill offenders deserve a second chance.</td>
<td>3.41</td>
</tr>
<tr>
<td>15</td>
<td>Mentally ill offenders are not completely responsible for their crimes.</td>
<td>1.95</td>
</tr>
<tr>
<td>16</td>
<td>For mentally ill offenders, preventing escape is more important than the treatment for their mental illness. *†</td>
<td>3.04</td>
</tr>
<tr>
<td></td>
<td>Statement</td>
<td>Mean</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>17</td>
<td>If mentally ill offenders had simply used will power, they wouldn’t be in trouble in the first place. *†</td>
<td>3.6</td>
</tr>
<tr>
<td>18</td>
<td>Physical punishment of mentally ill offenders is occasionally necessary. *†</td>
<td>3.29</td>
</tr>
<tr>
<td>19</td>
<td>Despite their crime, mentally ill offenders deserve sympathy.</td>
<td>2.24</td>
</tr>
<tr>
<td>20</td>
<td>Given a chance, most mentally ill offenders would try to escape from prison or a hospital. *†</td>
<td>2.72</td>
</tr>
<tr>
<td>21</td>
<td>Most mentally ill offenders should be in prison rather than a hospital. *†</td>
<td>3.81</td>
</tr>
<tr>
<td>22</td>
<td>Mentally ill offenders should have the same rights as any other mentally ill person.</td>
<td>3.38</td>
</tr>
<tr>
<td>23</td>
<td>Mentally ill offenders deserve to be helped.</td>
<td>4.12</td>
</tr>
</tbody>
</table>

* Reverse scored item
† Negative Stereotype Subscale
REFERENCES


National Institute of Corrections. (2010). *Crisis intervention teams: A frontline response to mental illness in corrections.* Received as part of training materials


VITA

Amber Rebecca Hebert worked as an educator before earning her Master’s Degree in Social Work from Louisiana State University in 2003. She worked as a social worker in the areas of child protection, child and family advocacy in private practice, correctional social work, mental health, and adult protective services. After nine years of professional practice she return to Louisiana State University to earn a Ph.D. in social work. Although she continued to work full-time through several years of the Ph.D. program, Ms. Hebert eventually returned to school full-time. Ms. Hebert worked as a graduate assistant and taught Introduction to Social Work while working on her Ph.D. Ms. Hebert plans to return to clinical practice upon completion of her Ph.D.