Correctional Officers' Knowledge of Mental Illness and its Relationship with Self-Efficacy

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Dedication

To Victor Pantesco, who has taught me that laughter is imperative, especially when you are
face to face with a snake, but not a spider...

Your stories will continue to guide me as I travel the paths life has prepared for me.

From the bottom of my heart, thank you.

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Abstract

Correctional institutions are currently housing a large number of mentally ill inmates. It is estimated that more than half meet the criteria for a mental disorder. While the inmate population continues to exhibit greater incidence of mental illness, there has been little effort to provide correctional officers with mental health training. This is problematic because officers are required to interact with and manage the inmate population effectively, including the mentally ill, and are faced with the stressors of inmate behaviors that are directly related to mental illness (e.g., psychosis or mania). The present study was on correctional officers' self-reported mental health knowledge and work-related self-efficacy. Study sample consisted of correctional officers employed by a local county jail. Correctional officers ($N=40$) completed the *Multiple-Choice Knowledge of Mental Illness Test* (MC-KOMIT) and then read five short scenarios of inmate problematic behavior and rated their self-efficacy in each situation. Correctional officers were found to have low levels of mental illness knowledge, but a generally high degree of self-efficacy when working with mentally ill inmates. Officers who had higher education reported greater mental illness literacy than those with less education. No relationship between the degree of knowledge about mental illness and self-efficacy was detected. Self-efficacy was influenced by age, with older correctional officers reporting less self-efficacy than younger ones. These results are discussed.

Keywords: Correctional officers, mental health literacy, MC-KOMIT, mental illness, correctional settings, self-efficacy

Correctional Officers' Knowledge of Mental Illness and its Relationship with Self-Efficacy

Chapter 1

In the United States, individuals convicted of crimes may be incarcerated as punishment. Historically, a sentence decision has been guided to varying degrees by goals of retribution, rehabilitation, and deterrence. Although various criminal justice systems ascribe to different philosophies of punishment, it has been reported that imprisonment is used more often and that sentences are longer in the US than in any other Western country (Melton, Petrila, Poythress, & Slobogin, 2007). In 2008, it was reported that one out of every 100 adults in the US was incarcerated (Pew Centers on the State, 2008). In addition, correctional institutions are currently housing a large population of mentally ill inmates.

Mental Illness in Correctional Settings

Estimates of prevalence of mental illness in correctional settings, while high, vary. Prins (2011) reported that 14.5% of male and 31% of female inmates meet the criteria for severe and persistent mental illness. Hatton and Fisher (2008) reported that over half of all incarcerated individuals meet criteria for a mental illness, including mood disorders, psychotic disorders, substance abuse, and personality disorders. Gostin (2008) reported that prevalence of mental illness in correctional settings is 10 times higher than in the general population. Although correctional institutions serve many mentally ill inmates, they receive little to no treatment for mental illness and they are often housed with the general prisoner population.

The growing presence of mental illness in jails and prisons has an impact on correctional staff, because they interact with mentally ill inmates on a daily basis. Correctional officers, who have traditionally served a custodial role, are expected to effectively manage a difficult population. The notion of correctional officers serving as agents of change has been described in

the literature as early as the 1970s (Smith, Milan, Wood, & McKee, 1976). However, there has been little effort to provide correctional officers with additional training to prepare them for this increased responsibility. Because it is not known whether didactic training would prepare officers for this change in roles, the present study aimed to explore the relationship between officers' knowledge of mental illness and their self-efficacy to manage the mentally ill.

Correctional officers work in a stressful environment. Pan, Deng, Chang, and Jiang (2011) reported that correctional staff generally experience needs for training, pay increase, career enrichment opportunities, and a more positive public image. Among the many stressors of correctional work, Pan et al. identified "role problems, work overload, demands for social contact (with prisoners, colleagues, and supervisors), and poor social status" (p. 865) as most notable. Mental illness in correctional settings, as reported by Walsh and Freshwater (2009), may be viewed as an added stressor to the already demanding employment.

Mentally ill inmates tend to be perceived as more problematic in correctional settings than the general inmate population. Because mental illness can, and frequently does, manifest through disruptive symptoms (e.g., mania or psychosis), inmates with such disorders are likely to be disciplined and placed in more restrictive environments. Correctional officers reported that despite feeling competent in working with the general inmate population, they often feel less confident in their ability to be effective with inmates diagnosed with mental disorders (Parker, 2009; Walsh & Freshwater, 2009). However, a distinction should be made between competence, which is an observed behavior, and confidence, which is a feeling. Competence and confidence are not necessarily interdependent. Although many officers have been described as already having skills needed to interact with special inmate populations, most of the officers in the Walsh and Freshwater (2009) study did not have any knowledge about mental illness. Some officers

reported that as a result of this lack of understanding of mental illness, they had maintained judgmental attitudes and perceived mentally ill inmates as “nutter[s]” (p.307) or crazy. An officer’s lack of understanding of mental illness is likely to increase his or her frustration, stress, helplessness, and inefficacy when working with mentally ill inmates.

Statement of the Problem

With the increase of mentally ill inmates in jails and prisons, it can be argued that correctional officers are no longer serving purely custodial roles in a punitive justice system; in fact, they also take part in the rehabilitative process. Legally, correctional institutions are obligated to provide all inmates with adequate medical and psychiatric care by promoting healing and rehabilitation (Dvoskin & Spiers, 2004). It has been theorized that officers can contribute to inmate rehabilitation through talking with the mentally ill, consulting about them, observing and reporting their behavior, and implementing special activities (Dvoskin & Spiers, 2004).

Currently, there are very few studies (e.g., Parker, 2009; Walsh & Freshwater, 2009) that have examined the importance and effectiveness of mental health training for correctional officers, and no studies have investigated mental health literacy and correctional officers’ self-efficacy while working with mentally ill inmates. Instead, researchers have focused on experiences of correctional officers, their attitudes, and the stress related to correctional employment (Farkas, 1999; Griffin, 2002; Kjelsberg, Hilding Skoglund, & Rustad, 2007). The next step in research, therefore, should include an effort to understand what factors influence correctional officers’ self-efficacy. Such research would help agencies to take the appropriate steps to increase correctional officers’ self-efficacy.

Therefore, assessing the relationship between correctional officers’ knowledge of mental

illness and self-efficacy is important. Parker (2009) and Walsh and Freshwater (2009) found that correctional officers with no knowledge of mental illness frequently expressed feeling less confident in their abilities to work with the mentally ill inmates. The study participants shared this information during debriefing with the researchers. While this information was included as qualitative data in these studies, the present study assessed self-efficacy of correctional officers with an objective measure. In addition, officers in Parker and Walsh and Freshwater studies frequently reported feeling more confident in their abilities to work effectively with mentally ill individuals in the correctional settings after receiving training about mental illness.

Knowledge of mental illness. Correctional officers are not typically required to complete training in mental health. Therefore, their mental health knowledge is likely comparable to that of the general public. Compton, Hankerson-Dyson, and Broussard (2011) reported that the public's knowledge of mental health is scant. Generally, people are unable to identify common psychological disorders, and they lack knowledge of risk factors, causes, interventions, and availability of professional help. Because much of this is professional knowledge, the general population's lack of knowledge of the psychology discipline is to be expected. Thus, without knowledge of mental illness, correctional officers are likely to have difficulties in distinguishing inmates who are suffering from a mental illness from those who are not.

Moreover, correctional officers are likely to hold negative attitudes toward the mentally ill jail and prison subpopulation because mentally ill inmates are more likely to exhibit behavioral problems. Gostin (2008) reported that there is a myth in the general society about individuals with mental illness posing a danger to the public (e.g., through unprovoked attacks or as gun users), despite the fact that the majority of violent crimes are committed by individuals who do not have a mental illness. Gilliagn (2001) pointed out that the public generally does not

care about the well-being of mentally ill individuals. The public also dislikes criminals. It is not surprising then that people have little sympathy for people who are both mentally ill and criminals.

Stresses of correctional officers. The work environment of correctional officers is typically stressful. They face dangerous situations, experience threat to personal safety, work long hours, receive low salaries, receive little social support, have limited trainings (including in mental illness), and have scarce opportunities for career enrichment (Pan et al., 2011; Parker, 2009). As a result, officers often feel insecure and unsupported as well as have little confidence in their ability to perform their work effectively, which may lead to low self-efficacy and resignation. Pan et al. reported that these stressors frequently lead to high turnover rates, burnout, illness, dissatisfaction with work, and high rates of absenteeism.

These stressors, compounded by low self-efficacy, are likely to affect the choices correctional officers make daily in their interactions with inmates. Because officers are trained to focus on maintaining order and security, effective punishment, and discipline, rather than rehabilitating offenders, they are more likely to use a punitive approach toward inmates, including those suffering from mental disorders. Griffin (2002) also found that poor quality of supervision, role conflict, and fear of being victimized are highly correlated with the likelihood of officers' use of force. It appears, therefore, that a punitive orientation and high levels of stress are likely to result in punitive actions, including the use of force.

To date, there are no studies exploring the relationship between correctional officers' knowledge of mental illness and their self-efficacy in managing mentally ill inmates. Because the literature identified mental illness as one of the stressors in correctional work (Walsh & Freshwater, 2009), the present author proposed to examine the degree of knowledge of mental

illness among correctional officers, the degree of perceived self-efficacy when working with mentally ill inmates, and whether a relationship exists between the two.

Significance to Potential Stakeholders

It has been established that a significant number of inmates meet the criteria for at least one mental illness (Gostin, 2008; Hatton & Fisher, 2008; Prins, 2011). Correctional officers tend to view mental illness as an added stressor to their already stressful work environment. Also, officers who experience their work environment as dangerous and unpredictable tend to have a low sense of control, high feelings of insecurity, and little to no clinical knowledge about mental illness to guide them (Parker, 2009). Correctional employment, by its very nature, will always have elements of danger, unpredictability, and lack of control. As a result, certain limitations must be accepted as part of employment in correctional settings, while acknowledging that there are aspects of correctional work that are amendable. Therefore, identifying problems that can be resolved is important.

Training in mental illness and management of mentally ill inmates is one needed area for improvement. Such training may increase feelings of control, self-efficacy, and security among officers. Parker (2009) reported that when provided with psychoeducation about psychological disorders, correctional officers have not only reported a better understanding of mental illness and increased confidence, but have also reported that the behavior of mentally ill inmates and the functioning of the institution have improved as well. Consequently, the present author identified correctional officers, mentally ill inmates, and jails and prisons as potential stakeholders in the proposed study.

Correctional officers. Because the lack of knowledge regarding mental illness has been linked to feelings of low confidence when dealing with mentally ill inmates, it is important to

assess the correctional officers' degree of familiarity with mental illness. Such an assessment will serve to illuminate areas of need, which may be amended through basic training in mental illness. Officers will be able to use their knowledge in situations where disruptive behavior is directly influenced by illness (e.g., manic episode of bipolar disorder or psychotic episode of schizophrenia). Research supports a relationship between an increase in knowledge of mental illness and a decrease in the number of assaults on correctional officers by inmates (Parker, 2009). Therefore, mental health training may contribute to maintaining the safety of correctional officers who work with mentally ill inmates.

Inmates. Mentally ill inmates must rely on scarce mental health providers employed by the correctional facility for treatment. However, some researchers have argued that correctional officers can provide basic mental health services to inmates (Dvoskin & Spiers, 2004; Parker, 2009). There may be more appropriate interpersonal communication between correctional staff and mentally ill inmates. For instance, threatening a paranoid inmate with physical force or other punitive action is likely to increase the inmate's paranoia rather than stop the inmate's behavior. Conversely, inmates who are treated in a respectful and compassionate manner that fosters healing and rehabilitation are less likely to act out, receive disciplinary action, and be placed in isolation (Parker, 2009).

In addition, misunderstanding of mental health problems (e.g., assuming that suicidal gestures or disclosing hallucinations are means to elicit attention) can be perceived as disrespectful by the inmates. Humiliation and disrespect have been identified as the most frequent cause of assaultive behavior in prisons (Dvoskin & Spiers, 2004; Gilligan, 2001). Inmates frequently enter correctional institutions experiencing feelings of anger and resentment; encounters with staff that are perceived as disrespectful exacerbate these feelings. Gilligan

reported that hearing a correctional officer yell “Hey shithead, the nut-doctor’s here to see you!” (p. 56), immediately prompted his intervention of educating about the dangers to both inmates and staff that such disrespectful communication invited.

Institutions. The safety and security of each correctional facility and its employees (e.g., administrative staff, medical staff, education staff, or correctional staff) depend on the relationship between staff and inmates. Society depends on the correctional staff to keep inmates safe, maintain order, and ensure effective and secure functioning of the jail or prison institution. In turn, all staff members rely on the inmates, who outnumber the staff greatly, to follow the rules of the facility. This relationship between the staff and inmates is what promotes the safety and security of the institution. When jail and prison environmental stressors increase (e.g., inmates acting out or correctional officers using physical force) so do the levels of stress and tension between inmates and officers. This process creates a volatile atmosphere for inmates and staff alike, making the prison a more dangerous place than it has to be (Dvoskin & Spiers, 2004).

Theoretical Framework

The theory of self-efficacy is used to conceptualize correctional officers’ interactions with mentally ill inmates. As described by Bandura (1983), the theory of self-efficacy postulates that perceived lack of control over potentially difficult situations leads to fear, whereas belief in personal agency over a situation leads to more effective performance. For example, while investigating the processes by which modeling alleviated phobia in snake-phobic patients, Bandura found that self-efficacy beliefs (which the phobic individuals had in their own capabilities to alleviate their phobia) mediated changes in behavior and fear-arousal. On the other hand, individuals with low self-efficacy beliefs tend to approach perceived adversities anxiously and experience heightened levels of arousal, which, in turn, lowers their self-efficacy beliefs.

One caveat is that it is important to remember that self-efficacy belief is not actual skills, abilities, or work competencies an individual possesses, but the judgment of what he or she can achieve with the skills and abilities. Researchers reported that individuals with strong self-efficacy are healthier, more successful, persistent, and experience less depression and anxiety than people who do not perceive themselves as self-efficacious (Mayers, 2009).

Self-efficacy usually develops through an interactive or reciprocal relationship with the environment. Bandura (2012) postulated that individuals develop high self-efficacy beliefs in four ways: mastery experiences, social modeling, social persuasion, and the choice process. Mastery experiences involve overcoming obstacles in achieving goals and learning to manage failures. Social modeling involves observing the success of individuals with strong beliefs in their own abilities. Social persuasion relies on the encouragement from others to increase resolve. Finally, the choice process involves exercising personal agency through making choices and decisions concerning own behaviors.

Parker (2009) reported that correctional officers face difficult situations in their work environments that are frequently perceived as negative and uncontrollable. Although many officers reported supporting rehabilitative efforts of correctional settings, they also expressed disillusionment with a system that requires them to function as agents of punishment and rehabilitation simultaneously (Farkas, 1999). This dichotomy of roles is what leads to role confusion and inconsistent and ineffective efforts by staff. Low self-efficacy is often the result of having little control over environmental factors, high levels of stress, and confusion about employment roles. Officers are then likely to exhibit indifference and the cynical attitude of the public in general toward the mentally ill, criminals, and mentally ill inmates. The author proposed that the lack of knowledge about mental illness would relate significantly to feelings of

low self-efficacy concerning work with mentally ill inmates. This relationship, however, has not been investigated quantitatively by the few studies on correctional officers' morale experiences.

Research Questions

The present study answered the following questions:

- What is the degree of mental illness knowledge of correctional officers employed at a local jail?
- What is the degree of self-efficacy of correctional officers when working with mentally ill inmates?
- Is there a relationship between correctional officers' mental illness knowledge and self-efficacy when working with mentally ill inmates?

Definition of Terms

Correctional officers. In correctional settings, correctional officers are staff members who are responsible for the security, safety, and supervision of inmates, the facility, and the correctional staff. Their responsibilities include enforcing facility rules and regulations, maintaining order, disciplining inmates, searching inmates and cells for contraband, engaging in crisis management and first-response in cases of emergency, as well as transporting inmates to outside appointments (e.g., court or medical appointments).

Inmates and county jail inmates. Individuals who are serving a term of incarceration in any correctional institution make up the inmate population. The present study focused on jail inmates, who are a diverse population. Individuals incarcerated in jails comprise a constantly changing population, because inmates generally serve shorter sentences (typically a term of less than one year) than those housed in prisons. To elucidate, in comparison to state and federal prisons, jails receive 30 times as many new admissions annually (Griffin, 2002). In addition, jails

frequently house inmates awaiting trials, parole and probation violators, inmates awaiting transfers to other facilities, and convicted offenders who are serving a short sentence (Farkas, 1999). Therefore, jails have a high turnover rate; high levels of substance abuse and dependence, mental illness, and suicide attempts. They similarly have a problem with overcrowding (Griffin, 2002).

Mental illness. The author used the criteria provided by the *Diagnostic and Statistical Manual of Mental Disorders-4th Edition-Text Revision (DSM-IV-TR* [American Psychiatric Association, 2000]). The DSM-IV-TR defines mental illness as a constellation of symptoms associated with significant distress, disability, or increased risk of pain, death, disability, or loss of freedom. Furthermore, such a constellation of symptoms cannot be an expression of culturally accepted reaction to a specific event. It must also manifest as an expression of psychological, behavioral, or biological dysfunction. In addition, the author utilized specific diagnostic criteria for identifying particular disorders (e.g., schizophrenia, major depressive disorder, or antisocial personality disorder) to develop vignettes that were presented in the author-developed self-efficacy measure.

Self-efficacy. Self-efficacy is defined as an individual's perceived belief in one's ability to effectively utilize one's skills in a potentially threatening situation (e.g., managing mentally ill inmates). Bandura (1977) postulated that an individual's perception of personal efficacy influences his or her motivation and behavior (e.g., believing in one's abilities leads to greater expansion of effort and persistence). Never a static attribute, self-efficacy increases with experiences that promote personal agency and decreases with failures.

Summary

Over the past decades there has been a significant increase in the number of mentally ill

inmates in correctional institutions. Correctional officers, who spend the most face-to-face time with inmates, receive training that is devoid of psychoeducation about mental illness. This absence of formal knowledge likely contributes to stress, helplessness, low self-efficacy, negative attitudes toward mentally ill inmates, and an indifferent approach to managing inmates. Because correctional officers can potentially serve important roles in the rehabilitation of mentally ill inmates, it is important to assess their knowledge of mental illness and assess their self-efficacy in interacting with mentally ill inmates. The following chapter, Chapter 2, provides a select literature review on mental illness in correctional settings.

Chapter 2

This chapter presents a review of the literature relevant to the study. First, the author briefly discusses how mental illness in correctional settings has changed over the course of history. Different theories about the increasing presence of mental illness in corrections are presented, followed by a brief discussion of challenges to effective treatment of mental disorders in correctional settings. Second, the correctional work environment, typical attitudes toward inmates and mental illness, and roles of correctional officers are presented. Third, the author discusses the various training models utilized for corrections officers. Last, a brief overview of self-efficacy is provided and its significance to work in correctional work is discussed.

Mental Illness in Correctional Settings

Prisons as the new asylums. Gilligan (2001) postulated that centuries ago the mentally ill were most often housed in prisons and did not receive mental health services. In the mid 1800s, largely due to the work of Dorothea Dix, treatment of mentally ill changed profoundly. Dix visited numerous prisons across the country and found that individuals with mental illness were housed in appalling conditions that exacerbated their illness. She firmly believed that criminalizing mental illness was harmful and that society would benefit from providing humane treatment conditions for the mentally ill. Dix set out to change the system and move individuals with mental disorders from “places of punishment to houses of healing” (Gilligan, 2001, p. 45). Her campaigning significantly contributed to the creation of the public mental hospital system, where the mentally ill were to be treated with a focus on healing. The asylums, however, deteriorated over time. As the patient population changed to include millions of immigrants, public support declined. Due to lack of funding these houses of healing became commonly known as “snake pits” (Gilligan, 2001, p. 46).

As the asylums became neglected warehouses, the movement of deinstitutionalization began with the Community Mental Health Act in the 1960s. According to Gilligan (2001), the purpose of this reform was to remove the mentally ill from destitute and isolated mental hospitals and provide them with community-based treatment. This, it was believed, would provide effective and affordable care without removing the patients from their community. Although thousands of patients were released from mental hospitals, the integration of the mentally ill into the community proved to be difficult and expensive. And, as the number of mentally ill people in mental hospitals decreased, the number of mentally ill people in jails and prisons increased. Patients who were released from the hospitals lacked the means of reintegration and social support. Some became homeless and some turned to crime as a means of survival. Thus, over a century and a half after Dix initiated prison reform, the mentally ill have largely returned to where they started—prisons and jails. Therefore, deinstitutionalization may be more accurately termed *trans-institutionalization* (Gilligan, 2001, p.46) as it moved mentally ill patients from mental hospitals that were derelict, secluded, and big to equally large and more violent prisons.

Although the theory of trans-institutionalization is often used to explain the increasing numbers of mentally ill inmates, not everyone ascribes to it. Many researchers view this theory as unproven (Fraser, Gatherer, & Hayton, 2009; Prins, 2011) and have proposed that other factors, such as changing laws, poor economy, and lack of appropriate services in the community better account for the presence of the mentally ill in correctional settings. Prins postulated that the majority of individuals released from psychiatric hospitals do not end up incarcerated, that the two populations differ significantly and that majority of discharged patients received satisfying services in the community. Regardless of the reasons for increase of mental illness in correctional settings, the one thing researchers agree on is that the numbers continue to increase.

Correctional settings today. Correctional facilities have expanded significantly and continue to grow. The United States has the greatest number of inmates per 100,000 residents in the world, exceeding Russia and Belarus, which are in the second and third place, respectively (Pew Center on the States, 2008). The American prison system is currently the largest in the world (Pizarro & Stenius, 2004). In 2002 it was reported that the incarcerated population exceeded 2 million individuals, making 1 in 142 Americans a prisoner (Dvoskin & Spiers, 2004). In 2008, it was reported that 1 out of every 100 Americans was incarcerated, with an additional 5 million people on parole and probation (Pew Center on the States, 2008). Among the millions of men and women currently incarcerated throughout the country, many have been found to suffer from various mental disorders and substance abuse (Magaletta, Patry, Dietz, & Ax, 2007).

Although there is general agreement that many incarcerated individuals are mentally ill, there is no clear agreement on the exact number. Dvoskin and Spiers (2004) reported that in 1998, 19% of male inmates and 30% of female inmates met diagnostic criteria for a mental disorder. According to Prins (2011), 14.5% of incarcerated males and 31% of females currently meet the criteria for severe and persistent mental illness. Hatton and Fisher (2008) postulated that these numbers have increased significantly since 1998 and that, currently, over half of all prisoners meet criteria for some form of a mental illness. Gostin (2008) reported that prevalence of mental illness in correctional settings is ten times as high as it is in the general population. Mania, major depression, and psychotic disorders were identified as common diagnoses, affecting 20% to 50% of all inmates. In comparison to the general population, the prevalence of mood disorders and psychosis in correctional settings is reportedly three times greater (Parker, 2009). Additionally, inmates often struggle with behaviors of self-harm, suicidal ideation, personality disorders, and the detrimental effects of the correctional environment (Walsh &

Freshwater, 2009).

Mental illness and incarceration. For inmates who enter the correctional system with a preexisting mental illness, the stressors of incarceration are often devastating. Dvoskin and Spiers (2004) described five major stressors encountered by most new prisoners: the majority of inmates enter the correctional setting with a significant amount of anger, fear regarding their safety, anxiety about losing their autonomy, and difficulty adjusting to environmental and physical discomfort. The last stressor, the most destructive one that Dvoskin and Spiers identified, is the humiliation prisoners potentially face in their interactions with other inmates and staff. Similarly, Pizarro and Stenius (2004) discussed stressors that had been originally identified by Gresham Sykes in 1958. These stressors included loss of liberty and autonomy, inability to have heterosexual relationships, lack of access to various goods and services, and fears for personal safety. These stressors, when compounded by a major mental illness, contribute greatly to an atmosphere of tension and volatility in jails and prisons.

Parker (2009) reported that mentally ill inmates are more likely to be disciplined for institutional infractions, charged with assaults, and housed in special housing units (isolation cells where the inmate spends 24 hours per day, with an option of one hour of exercise outside of the cells). Consequently, mentally ill inmates face more punitive restrictions, which are detrimental to their already vulnerable psychological states. The symptoms of mental illness, especially psychosis or mania, can contribute to disorderly behaviors. These disruptive behaviors, in turn, are the primary reason for inmate allocation to special housing units. The rationale for this placement is to focus on a secure environment and the safety of others (inmates and staff), but the fact remains that isolated housing exacerbates the very symptoms that led to the more restrictive custody. The negative effects of isolation, especially long-term placement,

have been well documented in the literature (Fraser et al., 2009; Miller, 1994; Parker, 2009; Pizarro & Stenius, 2004).

The presence of mental illness in correctional institutions adds to the already existing problems of overcrowding and insufficient health care. However, all correctional facilities, intended on delivering punishment, providing protection, and offering rehabilitation simultaneously, are bound by law and ethical standards to provide adequate care to all inmates (Dvoskin & Spiers, 2004). In addition, to providing protection and preserving the mental health of inmates, correctional facilities need to utilize more than health care providers (Fraser et al., 2009). Therefore, decreasing the suffering of inmates, in addition to maintaining safety, preventing escapes, increasing morality, and assisting in daily systems operations, should be shared by both the mental health professionals as well as the correctional staff (Dvoskin & Spiers, 2004; Fraser et al., 2009).

Correctional Officers

Parker (2009) reported that correctional officers often perceive “high psychological demands on the job, accompanied by low social support, a low sense of control, and feelings of insecurity” (p. 644), a combination of factors that can lead to undesirable treatment of inmates. In addition, correctional officers work long hours for average wages and they face daily risks of violence and possible death. Even those officers who have expressed feeling secure and confident in working with the general prison population admitted that they feel less confident in their capacity to manage mentally ill inmates. This lack confidence may be influenced by the two most common, albeit erroneous, assumptions that officers have about mentally ill individuals. Namely, they frequently see mentally ill persons as violent and incapable of being rational (Ruiz & Miller, 2004).

Attitudes toward inmates. Melvin, Gramling, and Gardner (1985) noted that despite an increasing number of rehabilitative programs for prisoners, many correctional officers maintain negative attitudes toward inmates and become cynical over time. In addition, Melvin et al. postulated that correctional officers are instrumental in the rehabilitation of inmates. Over a decade later, Farkas (1999) reported that the attitude of correctional officers toward rehabilitation were more positive and did not follow the social and political trend of the 1990s for a more punitive orientation in correctional settings. The popular view of previous times was to make incarceration a more frequent and lengthy punishment for breaking laws and to ensure that jails and prisons provided an uncomfortable environment; however, many correctional officers maintained an attitude of openness toward inmate rehabilitation. Unfortunately, systemic factors that give priority to management and custody affect the motivation of correctional officers who become disillusioned with their individual intentions and efforts to facilitate rehabilitation of inmates.

Farkas's (1999) study suggested that officers may be somewhat ambivalent about the punitive function of correctional facilities. Questioning the deterrent aspects of incarceration is not a new phenomenon. Researchers demonstrated the lack of deterrent properties of punishment through incarceration over three decades ago (Erickson & Gibbs, 1976). It is not surprising then that correctional officers, who watch the effects of incarceration on inmates on a daily basis, question the punitive role of incarceration. Farkas (1999) reported that only half of the participants in her study expressed the belief that making prisons more uncomfortable would lower crime rates. Also, slightly more than half of the officers believed that prisons would be most effective if they were run akin to a military regime. Showing similar dissension, 50% favored the punitive function of correctional facilities, while the greater majority (71%) agreed

that rehabilitative programs are worth the time and money. This seemingly contrasting orientation of correctional officers may very well reflect the dialectic of the correctional system—mainly, to punish and rehabilitate at the same time.

Consequently, correctional officers may experience confusion about what is expected of them. The lack of clarity about their roles and tasks contributes to work stress and increased role conflicts. Farkas (1999) found that officers who expressed experiencing conflict of roles rejected both the rehabilitative and punitive roles. Instead, they expressed a desire for increased social distance from the inmates. These officers also reported believing that inmates should never be trusted because they are manipulative, and that being lenient toward prisoners lead to being taken advantage of. At the opposite end, officers who chose to identify with the rehabilitative orientation appeared to derive greater job satisfaction and were more effective in coping with their work-related stress.

Attitudes toward mental illness. Because correctional officers express a variety of attitudes toward inmates, there are also significant differences in how they perceive mentally ill inmates. Ruiz and Miller (2004) posited that there are five general aspects often leading to physical violence in interactions between mentally ill persons and officers of the law. These include fear experienced by the mentally ill individual, reluctance or refusal to comply with orders issued by the officers, fear inspired by the uniforms and authoritative attitudes of officers, officers' lack of empathy and understanding, and the fear officers feel toward individuals with mental illness. It is important to note that the fear mentally ill persons feel toward police or correctional officer may be born out of their illness (e.g., out of paranoid delusions), or may be based on the reality of past negative experiences with authority figures. Similarly, the fear officers harbor when they work with persons with mental illness may be caused by common

misconceptions (e.g., mentally ill individuals are unpredictable and violent) or based on negative personal experiences (e.g., being attacked by a mentally ill inmate).

Officers as part of the rehabilitative process. Some researchers (Dvoskin & Spiers, 2004; Parker, 2009; Walsh & Freshwater, 2009) suggested that correctional officers have the potential to become part of the rehabilitative process, rather than serve solely custodial or punitive roles. Because they have more contact with inmates than any other correctional employee, and it has been found that officers' attitudes are crucial in the change process (Melvin et al., 1985), it seems logical to expand the role of correctional officers. It has been postulated that correctional officers could become involved in the rehabilitative process in the following ways: talking with inmates, providing consultations about inmates, observing and reporting the effects of medication, and developing and implementing special activities and behavioral programs (Dvoskin & Spiers, 2004; Parker, 2009). Correctional officers may also assist inmates to adjust to the incarceration, become involved in the referral process for inmates (e.g., mental health services, medical attention, spiritual counseling), and help inmates with problems that are institutional in nature (Farkas, 1999). Furthermore, many correctional officers have learned skills to effectively participate in the treatment of mentally ill inmates (e.g., active listening, using a simple reward system, or showing empathy). However, they may lack the theoretical knowledge about mental illness and, consequently, confidence in their abilities to respond to mentally ill inmates (Walsh & Freshwater, 2009).

Talking with inmates. Correctional officers have the most direct contact with inmates. As such, they assist in problem-solving among inmates, disciplining inmates, and acting as liaisons between the inmates and various correctional staff; they are often the first responders to crisis situations and are the first ones expected to diffuse potential crises (Farkas, 1999). It is important

that officers use common sense, empathy, and patience when communicating with mentally ill inmates, whether in crisis or not (Dvoskin & Spiers, 2004). For example, it would likely be beneficial to use a calm and reassuring tone when speaking with a psychotic inmate. On the other hand, using a loud and commanding voice or threatening the inmate with physical force may exacerbate the symptoms of psychosis and increase disruptive behaviors. Therefore, utilizing skills in listening and talking to inmates can serve a therapeutic purpose. However, the nature of the interaction between correctional officers and inmates is affected by the beliefs that the officer holds about inmates and the role of the correctional system. For example, Farkas (1999) reported that younger officers tend to have a custodial orientation, whereas older and more experienced officers favor the rehabilitative function of correctional institutions.

Providing consultation about inmates. Consultation in correctional settings can be a valuable asset to integrative treatment, allowing staff from various departments to communicate and maximize the effectiveness of treatment. Dvoskin and Spiers (2004) stressed the importance of systemic flow of information, which would be both given and received by correctional officers. Clinical staff can benefit greatly from seeking information about the correctional environment, where the inmate resides. Furthermore, correctional officers can provide important observations to clinical staff, noting increases or decreases in symptomatology or symptomatic behaviors. Similarly, clinical staff can assist correctional officers by providing them with information about the state of an inmate's psychological functioning. For example, if an inmate discloses worsening depressive symptoms the correctional officers could use this information to increase monitoring for suicidal or self-harm gestures.

Observing effects of medication. Correctional officers can be invaluable in noting and reporting the effects and side effects of psychotropic medication, because they have the most

direct and consistent contact with the inmates on daily basis. Due to the possibility that patient self-reports may be inaccurate, clinicians can gain important information from correctional officers and use it in treatment planning. Dvoskin and Spiers (2004) provided an example of a correctional officer who escorted an inmate to an appointment with a psychiatrist. After the inmate was prescribed medication for depression, the officer asked the doctor what the pills looked like; he then proceeded to inform the doctor that the inmate took similar pills in the past and reacted with a psychotic-like state. After further investigation the psychiatrist learned that the inmate suffered not from depression, but from bipolar disorder, and had previously reacted to antidepressants with a severe manic state. This illustrates the usefulness of historical information privy to the officer but not the psychiatrist.

Special activities and programs. Dvoskin and Spiers (2004) described various programs that can be developed and implemented by correctional officers with high success rates. Even in rigid work settings, the authors postulated that correctional officers can implement simple reward systems and behavioral programs that promote the reinforcement of desirable behaviors and the extinction of problematic ones. Farkas (1999), in a study involving 125 officers at two local jails in a Midwestern state, found that the officers generally expressed interest in participating in the rehabilitative process of inmates. The majority of the study participants did not believe that rehabilitation should be left solely to mental health professionals, but they also believed that counseling should be performed by counselors. This view may be due to the fact that officers do not perceive they have the skills to counsel inmates, leaving this to trained professionals. However, a lack of specialty professional training in counseling does not preclude correctional officers from using traditional and innovative behavioral programs aimed at inmate rehabilitation. Thus, simple behavioral and cognitive techniques, such as offering

reinforcements, modeling, and non-physical punishment could be effectively executed by the correctional staff.

Dvoskin and Spiers (2004) described a simple behavioral program in which inmates gained or lost certain privileges based on their behaviors. The implementation of the program required cooperation of the warden, staff psychologists, and correctional officers. It was the officers, however, who designed the schedules of reinforcement and assessed the effectiveness of the program. They also ensured that all inmates were treated with respect and consistency. This simple intervention program, managed mainly by correctional officers, led to a significant decrease of incident rates.

Training Programs for Correctional Officers

Correctional officers could benefit greatly from training programs providing them with education about mental illness. Parker (2009) described the successful implementation of such a training program for officers working in a special housing unit in an Indiana correctional facility. The National Alliance on Mental Illness (NAMI) of Indiana developed a short training program for correctional officers. The ten-hour training, delivered in two-hour sessions over a period of five weeks, provided basic information through an interactive process. The training included information about major mental disorders, biological aspects of psychiatric disorders, treatment options for mental illness, and effective interaction with mentally ill individuals. All sessions were designed to be informative, to be supplemented by case examples, and to be discussion-based. The final session summarized the previous weeks' information.

The first training session described by Parker (2009) educated officers about major mental disorders. It provided information about symptoms and diagnostic criteria of mood disorders, substance abuse disorders, anxiety disorders, psychotic disorders, and personality

disorders. The trainers used examples from their own clinical experiences as well as the media to illustrate the disorders. The second session educated about biological aspects of mental illness. Neuropsychological diagrams were used to explain basic structures and functions of the brain and the effects of mental illness on the structure and chemistry of the brain. In the third session officers were provided information about the available treatment for mental illness. They were given an overview of psychiatric medications, their effects on neurotransmitters, and about available psychological treatments. In the fourth session, officers were educated about effective interaction with individuals suffering from mental illness. In this training session, NAMI invited two outside consumer-speakers, who spoke to the officers about their own experiences with mental illness. In the final session, information from previous sessions was reviewed, summarized, and reflected on.

Parker (2009) reported that the officers were receptive to the educational sessions and expressed interest in further expansion of their knowledge in the area of mental health. This was noted in correctional officers who were initially reluctant to participate. In addition, the number of incidents at the facility nine months after the training was almost 50% lower than the number of incidents nine months prior to the training. This decrease was noted in the occurrence of events involving the use of physical force by the officers and in the number of assaults on the officers by inmates.

Walsh and Freshwater (2009) described a training program for correctional officers that was developed and implemented in Wales and England. This 18-hour training was delivered over three days in a setting away from correctional facilities, and was offered to officers from all prisons in the United Kingdom. The program was designed to be interactive and combined didactic lectures with experiential exercises. Core areas targeted by the training included

information about mental illness and health, mental health awareness, women prisoners, adolescents and mental health, communication and documentation skills, and understanding self-harm behaviors and suicide. The authors reported that this training was well received by the correctional officers who indicated they would change their approach to mentally ill inmates upon return to work. Officers also reported developing a deeper understanding of mental illness and feelings of greater confidence in working with this population.

These training studies suggest that correctional officers are interested in expanding their knowledge of mental illness, which can then be applied effectively in their daily interactions with mentally ill inmates. Furthermore, implementing short training programs does not appear to have excessive financial cost and can be accomplished in a fairly short period of time. The benefits, such as lower rates of institutional incidents, increased understanding of mental illness, and increased confidence in correctional officers' abilities to work with the mentally ill population, greatly outweigh the costs of providing such training.

Self-Efficacy

The concept of self-efficacy was born from a broader theory of social and cognitive psychology (Bandura, 2012). From this perspective, individuals are seen as capable of intentionally influencing their environments, which, in turn, influences individuals. Human functioning, then, is conceptualized as triadic reciprocal relationships between intrapersonal characteristics (e.g., cognitive, affective, and biological events), human behavior, and environmental factors (Bandura 2012; Bandura 1978a). Furthermore, there are three types of environments and each has a potential different influence on the individual's functioning. The imposed environment acts on the individual whether they want it to or not and the only choice they have is how they react to it. The selected environment is, by its very definition, one that

individuals chose on purpose. The constructed environment is one that individuals create and, therefore, have greater control over (Bandura, 2012).

Self-efficacy beliefs have a significant effect on how people cope with difficult situations. Bandura (1983) reported that individuals who anticipate that they will not be able to handle a situation effectively are more likely to act anxiously and imagine worst outcomes. It is the perceived efficacy, rather than actual skill, that influences how a person will act. For example, if a young man believes that he cannot drive in snowy conditions and will likely crash, he will experience the situation as much more stressful than a man who believes he can drive well. If, however, the young man develops more confidence that he can drive in snowy conditions, he will approach the situation much more calmly and rationally. People who believe that they have some control over a situation are less likely to experience arousal and impairment in their functioning (Bandura, 2012). Bandura conceptualized individuals as self-organizing, proactive, self-reflecting, and self-regulating. Lack of self-efficacy may lead to a state of learned helplessness, where a person will perceive the environment as completely independent of his or her influence (Bandura, 1978b).

Relevance of self-efficacy to correctional officers. Perceived self-efficacy affects what decisions a person will make about his or her behaviors regarding the environment. In settings where these decision-making processes affect large populations, such as the correctional setting, it is important that the decisions are not driven by anxiety. Because there are many misconceptions about individuals with mental illness, which may lead to physical confrontation, it is important that correctional officers experience a high degree of self-efficacy. If, on the other hand, they approach situations with perceived lack of control, they may actually increase the amount of conflict and stress in correctional settings.

Summary

This chapter presented a review of literature relevant to the study. The author discussed mental illness in correctional settings, the correctional work environment, past studies of training programs for officers, and the theory of self-efficacy and its relevance to the correctional setting. The next chapter, Chapter 3, explains the study's methodology and provides descriptions of the population recruited for the study and measures used.

Chapter 3

Method

The author assessed mental illness literacy levels and perceived work-related self-efficacy in correctional officers employed at a local county jail. The participants of the study filled out three measures: a demographic questionnaire, the MC-KOMIT, a measure that assesses mental health knowledge, and a self-efficacy measure designed by the author in consultation with a mental health counselor employed long-term at the jail where the study was conducted.

Setting. The study was conducted at a local New Hampshire county jail, where correctional officers have daily contact with the inmate population, which includes mentally ill individuals. The prevalence of mental illness at the county jail is comparable to national rates (20%–50%) reported in current research literature (Hatton & Fisher, 2008; Parker, 2009). The mental health coordinator of the New Hampshire county jail reported that in 2010 65% of the inmate population received mental health services and two inmates required a transfer to a hospital where they could receive psychiatric services. Seventy percent of the inmates required active mental health services, which were delivered via weekly or biweekly sessions by mental health service providers employed by the jail. Of these, 30% of inmates required maintenance mental health services with sessions provided on an as needed basis. Overall, 68% of the inmates received psychotropic medications and 54% met criteria for co-occurring disorders (Axis I diagnosis co-occurring with alcohol and/or drug abuse or dependence). Among those receiving mental health services, 61% met criteria for a personality disorder. In addition, 6% were assessed to be at high risk for suicide attempt and 6% were assessed to be at high risk for violent behavior.

Participants. The sample consisted of correctional officers currently employed at the above-mentioned county jail and working with mentally ill inmates described in the previous

paragraph. Participation was open to male and female correctional officers who were recruited through the employment site. Although only 28 participants are required to achieve preferred power to show a large effect size (.50) at $\alpha=.05$ (Cohen, 1992), additional participants were recruited to account for response rate and attrition. In total, 40 officers participated in the study. All participants were 18 years of age or older.

Of the 40 correctional officers, 80% were male, 20% were female. Their mean age was 34.97 years ($SD = 11.1$ years) and they averaged 4.38 years of experience as a correctional officer ($SD = 4.03$ years). Both age and experience distributions were positively skewed. The range of age was 40 years, and the range of years of experience was 16.8. See Figures 1 and 2 for age and years of experience distributions, respectively. There was a bimodal distribution for income ($M = \$32,888.89$, Median = \$34,000, $SD = \$5645.11$). See Figure 3 for distribution of income.

Nearly half (45%) were married, nearly one-third (32.5%) were single, and one-tenth were either divorced (7.5%) or separated (2.5%). The breakdown of race was 92.5% identifying as White, 2.5% identifying as Black, and 5% did not report their race or ethnicity.

In terms of educational attainment, 37.5% completed some college, 25% completed high school or equivalent (i.e., GED), 22.5% received a Bachelor's degree, 12.5% received an Associate's Degree, and 2.5% received a Master's Degree. Less than a majority of participants (42.5%), had ever taken a psychology course, but nearly the same number (45%) reported having personal experiences with some sort of duress in their lives. See Table 1 for demographic information.

Figure 1. Distribution of Age

Figure 2. Years as Correctional Officer

Figure 3. Distribution of Income

Table 1

Participant Demographics

	<i>n</i>	Mean	Median	<i>SD</i>
Age	38	34.97	33	11
Sex				
Male	32			
Female	8			
Marital Status				
Single	13			
In relationship	5			
Married	18			
Separated	1			
Divorced	3			
Income	27	32,888	34,000	5, 645
Ethnicity				
European American	26			
Other	2			
Omitted	12			
Race				
White	37			
Black	1			
Other	1			
Omitted	1			
Education				
High School/GED	10			
Some college	15			
Associate's	5			
Baccalaureate	9			
Master's	1			
Years as CO	40	4.38	3	4.03
Psychology Class				
Yes	17			
No	23			
Personal Experience with Mental Illness				
Yes	18			
No	21			

Measures. Correctional officers were asked to fill out three questionnaires. These were a demographic questionnaire, a validated instrument of knowledge of mental illness, and a self-efficacy instrument developed by the author.

Demographic questionnaire. The author studied the relationship between select demographics (such as sex, years of employment, age, and educational attainment) and the study's two other measures. See Appendix C for the Demographic Questionnaire.

Knowledge of mental illness. The participants completed the *Multiple-Choice Knowledge of Mental Illness Test* (MC-KOMIT). This 33-item instrument (see Appendix D for the MC-KOMIT) has been developed to measure an individual's knowledge of mental illness (Compton et al., 2011). All questions are followed with multiple-choice responses, as in the following examples:

People who have posttraumatic stress disorder are at highest risk for also having which of the following?:

- (a) Alcohol abuse
- (b) Bipolar disorder
- (c) Early-onset dementia
- (d) Mental retardation
- (e) Schizophrenia

Delirium and seizures may occur during withdrawal from heavy, long-term use of which of the following substances:

- (a) Alcohol
- (b) Inhalants
- (c) Marijuana

(d) Mushrooms

(e) Narcotics

Which of the following is a common sign of mania?:

(a) Becoming forgetful

(b) Being more talkative than usual

(c) Experiencing repeated flashbacks

(d) Feeling helpless or hopeless

(e) Having anxiety attacks

Compton et al. (2011) tested the MC-KOMIT's criterion-related validity by assessing its sensitivity to change over time. They conducted a paired sample t-test to determine differences before and after training weeks and found a statistically significant difference ($t=4.24$, $p<0.001$, $N=199$). This means that the MC-KOMIT is sensitive to increase in knowledge of mental illness. The authors also assessed construct validity (convergent validity) by conducting a Pearson correlation with education attainment. They found a significant correlation between the MC-KOMIT scores and education attainment ($r=.35$, $p<.001$, $N=199$). To assess the measure's internal consistency, the authors used the KR-20 statistics, which found reliabilities of .72 and .73 for the two groups (the Monday and Friday groups respectively) of the study. Of note, the authors reported KR-20 values showed greater test-retest variability between the two groups. On the first day of testing, the KR-20 statistic was .74 for the first group and .73 for the second group, while on the second day it was .68 and .75 for the first and second group, respectively. This is similar to the sample used in Compton et al. (2011), who administered the MC-KOMIT to two groups of police officers on two different days. The authors reported test-retest stability as $\alpha = .79$ ($p<.001$). In the current study, the Cronbach's alpha for the MC-KOMIT was $\alpha = .72$.

Self-efficacy. To assess correctional officers' self-efficacy when working with mentally ill inmates, the author constructed short descriptions of five vignettes portraying specific mental illnesses (see Appendix E for Self-Efficacy measure). The author had consulted with the mental health clinician at the local jail, where the data were collected, to obtain descriptions of potential problematic behaviors exhibited by the mentally ill inmates. Officers were asked to rate their self-efficacy with regard to responding to the provided situations. They were asked to assess their perceived capacity to cope effectively (with physical force being the last resort) with the situation described in the vignettes. For example, they were asked to rate their self-efficacy using a 1–5 scale (5= Very High, 4= High, 3= Neutral, 2= Low, and 1= Very Low) when faced with the following situations (higher scores are keyed in the direction of the construct: for example, very high self-efficacy=5):

- (a) Mr. Jenkins is a 30-year-old inmate who has been feeling unusually sad and miserable for the past few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. Mr. Jenkins does not feel like eating and has lost weight. He has not cleaned his cell in weeks and says he simply “has no energy” when you ask him to clean it;
- (b) Mr. Hanley is a 24-year-old inmate who began to act differently about 6 weeks ago. He stopped talking to other inmates and staff, eating meals with the inmates he once sat with, and he has to be coaxed into taking showers. You observe him pacing in his cell while talking, shouting, and sometimes arguing with someone who is clearly not there. When you ask him about his behavior, he whispers, “they are watching me and they want to hurt me.”

The Cronbach's alpha of the correctional officers' self-efficacy scale was $\alpha = .67$.

Procedures. The superintendent of the local jail granted the present author verbal and

written permission to conduct the present study. (See attached letter of institutional permission in Appendix A). The author attended three consecutive weekly meetings for correctional officers held at the facility. Before the meetings concluded, the author introduced herself to the staff and provided them with a description of the research and an informed consent form (see Appendix B). The author invited officers to participate in the study and explained that there were no negative consequences of declining to participate. Correctional officers who expressed an interest in participating in the study were then asked to sign and return the informed consent. They were then asked to fill out a demographic questionnaire, a measure of mental health knowledge and another measure assessing their self-efficacy to effectively manage mentally ill inmates. See the previous section on Measures.

On the first day of data collection all officers present at the training expressed interest in participation ($n = 12$). On the second day of data collection all officers agreed to participate ($n = 15$), but one person asked to join the last week's group, citing time constrictions. On the final day, all officers present participated in the study ($n = 13$).

Data security. The author collected all materials and placed them in a locked filing cabinet located in her apartment. Subsequently, the records of all surveys were transferred and stored electronically by her on an encrypted and password protected hard drive. Although the surveys were anonymous, to further protect anonymity, all potentially identifying information was protected by assigning pseudonyms and location codes.

Research Hypotheses

The research hypotheses for the study were as follows:

- Correctional officers' levels of knowledge of mental illness are low and comparable to that of the general public.

- Correctional officers' self-efficacy is low (a score of 50% and below) when they are required to manage mentally ill inmates.
- There is a positive, significant relationship between correctional officers' levels of knowledge of mental illness and self-efficacy when working with mentally ill inmates.

The first hypothesis that correctional officers' level of mental health literacy is low was tested with the MC-KOMIT. Means and standard deviations were compared with the means and standard deviations of the original instrument-development study. The second hypothesis that correctional officers who work with mentally ill inmates have low self-efficacy was examined using five scenarios of disruptive behavior of mentally ill inmates. The third hypothesis that there is a positive, significant relationship between knowledge of mental illness and sense of self-efficacy was the finding of primary interest.

Data Analyses

The relationship between level of knowledge about mental illness and levels of self-efficacy was analyzed using a Pearson correlation matrix. Because this study focused on the degree of strength and directionality of a relationship between variables, the use of a correlation coefficient was appropriate. It should be noted that this procedure does not infer causality, but rather, the direction and magnitude of a given relationship. Although not utilized to test the aforementioned hypotheses, descriptive statistics were calculated for each of the measures and the demographic items. Significant differences in scores relative to a measure's (MC-KOMIT, Self-efficacy) mean were calculated for each respondent to identify how many scores were significantly above the sample mean, how many scores were significantly below the sample mean, and how many scores were around the sample mean.

Summary

This chapter described the methodology used in the present study, which has aimed to assess the existence and directionality of a relationship between levels of mental health knowledge and self-efficacy in correctional officers working with mentally ill inmates at a local county jail. The following chapter, Chapter 4, presents the results of data analyses.

Chapter 4

Results

This chapter presents the results of the study on correctional officers' knowledge of mental illness and its relationship to their self-efficacy. First, the internal consistency reliabilities of the measures used this study are reported. Second, descriptive statistics for the measures are presented. Third, the three research hypotheses are tested. Fourth, additional research questions and findings are reported. Finally, qualitative data are presented.

Internal Consistency Reliabilities

Multiple-Choice Knowledge of Mental Illness Test (MC-KOMIT). The scores on the MC-KOMIT are dichotomously scored. Cronbach's alpha for the 33-item MC-KOMIT was $\alpha = .72$, demonstrating acceptable internal consistency. This is similar to the sample used in Compton et al. (2011), who administered the MC-KOMIT to two groups of police officers on two different days. They reported KR-20 statistics of .72 and .73 for all groups taking the test on Monday and Friday, respectively.

Self-efficacy measure. Cronbach's alpha for the 5-item self-efficacy measure was $\alpha = .67$. Three subjects were removed from the sample due to incomplete data (i.e., they omitted one question). The scale uses a 5-point Likert scale to rate self-perceptions of efficacy (5 = *Very High*, 4 = *High*, 3 = *Neutral*, 2 = *Low*, and 1 = *Very Low*) for five vignettes describing interactions with mentally ill inmates. The vignettes were designed specifically for correctional officers at a local county jail.

Descriptive Statistics

Multiple-Choice Knowledge of Mental Illness Test (MC-KOMIT). The mean total MC-KOMIT score ($N = 40$) was 19.48 ($SD = 4.75$) out of a maximum score of 29 and a

minimum score of 7, which resulted in a range of 22. The median score for the sample was 19.5. These scores are shown in Table 2.

Self-efficacy measure. The mean total self-efficacy score ($N = 40$) was 18.18 ($SD = 2.64$) out of a maximum score of 25 and a minimum score of 12, resulting in a range of 13. The median score for the sample was 18.5. These scores are shown in Table 2.

Table 2

Means and Standard Deviations on the MC-KOMIT and self-efficacy measure

	N	Mean	SD	Minimum	Maximum
MC-KOMIT	40	19.48	4.75	7	29
Self-efficacy	40	18.18	2.64	12	25

Research Hypotheses

Hypothesis 1. The first hypothesis predicted that correctional officers' levels of knowledge of mental illness are low and comparable to that of the general public. This hypothesis was confirmed. The average score on the MC-KOMIT was 19.48. The majority of individuals obtained a failing score below 70% ($n = 31$), while a number scored above 70% ($n = 9$).

Hypothesis 2. The second hypothesis predicted that correctional officers' self-efficacy is low (a score of 50% and below) regarding the management of mentally ill inmates. This hypothesis was rejected. The mean score on the self-efficacy measure was 18.18 ($SD = 2.64$), with item mean of 3.62. The scores on the self-efficacy measures were on a Likert scale, with a maximum score of 5.

Hypothesis 3. The third hypothesis stated that there is a positive, significant relationship between correctional officers' levels of knowledge of mental illness and self-efficacy when working with mentally ill inmates. This hypothesis was rejected. A Pearson's correlation between the MC-KOMIT total scores and the self-efficacy measure total scores produced no significant correlation ($r = .042$, $p = .80$) between the two variables. Correlations are shown in Table 3 below.

Table 3

Correlations Between MC-KOMIT and Self-efficacy Scores

	MC-KOMIT	Self-efficacy
MC-KOMIT	1.00	.042
Self-efficacy		1.00

Additional Research Questions and Analyses

To understand what factors may contribute to knowledge of mental illness and to self-efficacy, the author posited additional research questions and performed additional data analyses. Two additional research questions were postulated. The first question asked whether demographic variables influenced the correctional officers' degree of knowledge of mental illness. The second question asked whether any demographic factors influenced participants' degree of reported self-efficacy.

Knowledge of mental illness. The study sample was divided into two groups based on their level of education. The first group ($n = 25$) was inclusive of individuals with high school graduation and those with some college education. The second group ($n = 15$) included college graduates and those with higher than college education. Individuals in the college educated group ($M = 17.87$, $SD = 4.00$) scored, on average, three points higher on the MC-KOMIT than those from the less educated group ($M = 14.92$, $SD = 4.64$), which was statistically significant ($t = -2.042$, $df = 38$, $p = .048$, effect size $d = .66$).

The MC-KOMIT scores of the participants who had taken a psychology course ($n = 17$) were compared to those who had not ($n = 23$). Despite the correlation between higher education and knowledge of mental illness, there was no relationship between the scores on the

MC-KOMIT and having taken a psychology class. In addition, individuals who reported they had experienced in their personal lives some interactions with an individual under duress ($n = 18$) did not score higher on the MC-KOMIT.

Self-efficacy. There was a significant, negative correlation between age and self-efficacy ($r = -0.39, p = .02$). Older correctional officers expressed lower self-efficacy than younger officers. However, no relationship was found between years spent as a correctional officer and self-efficacy ($r = -.14, p = .40$).

Qualitative Analyses

In addition to the quantitative data collected through this study, the author collected qualitative information from the participants. Specifically, in the demographic questionnaire, officers were asked an open ended question: “Have you ever experienced, in your personal life, an interaction with a person under duress?” If the participant answered affirmatively, a follow up question asked for a description of that experience. Thirty-nine officers answered the question, with 18 reporting previous experience with a person under duress.

Personal experiences with mental illness. Officers who reported having a personal experience with a person under duress were asked to describe the experience and explain how, if at all, it has influenced their reactions to mentally ill individuals. Generally, officers described interactions that occurred at work, such as “I’ve dealt with many people during the performance of my duties that were actually suicidal and making legitimate attempts on their lives;” “Inmates come into the facility with PTSD, Bipolar and are not on any medication. Also have dealt with a lot of dementia in several inmates. They were confused, angry, moody, sad”; “Attempted suicide, medical issues, hysteria, delusions”; and “I was attacked by an inmate who was mentally unstable.” Two described experiences from their personal lives, one describing a friend who

“began to develop, various mental issues about the time we were 18 years old. As time went on his entire personality changed. The change created a truly different person.” The other individual described his or her child, “My son has been sent to the mental health unit several times for suicide attempts and drug overdose, as well as physically attacking myself and [spouse].”

Generally, participants reported that past experiences with mentally ill individuals at work and in their personal lives made them more “cautious” but understanding. One officer reported that “Based on my experience with him [a mentally ill inmate] and a number of others I have met since starting work at [name deleted] I’ve learned to tolerate and work with, perhaps out of sympathy, those individuals that I might otherwise dismiss as “crazy.” I’ve also developed a strong resentment of those individuals that attempt to fabricate an illness or disorder as a means to justify or excuse their behavior.” Another one stated: “I know that they can be dangerous to themselves and others and that they require more help than the state seems willing to provide.” Others reported that their perceptions of mentally ill have not been influenced by their experiences.

Summary

This chapter presented the results of data analyses. The internal consistency and reliability of measures used in this study were presented. Descriptive statistics and tests of difference were provided for the study participants and for the two measures used in the study. Three hypotheses were tested and two additional research questions and findings were reported.

Correctional officers participating in the study were found to have low levels of mental illness knowledge. However, officers who had higher education (college graduates and above) displayed greater mental illness literacy than those with less education (high school to some

college). Officers generally reported a high degree of self-efficacy when working with mentally ill inmates. There was no relationship between the degree of knowledge about mental illness and expressed self-efficacy. Rather, self-efficacy was influenced by age, with older correctional officers reporting less self-efficacy than younger ones.

The next chapter, Chapter 5, provides an interpretation and a discussion of the results. The significance of the findings is explored and directions for future research are suggested. Finally, limitations of the study are discussed.

Chapter 5

Discussion

The author conducted a study of correctional officers' knowledge of mental illness and its relationship to work-related self-efficacy. Quantitative measures were used to assess knowledge of mental illness and self-efficacy. A demographic questionnaire was used to gather participant information and qualitative data were obtained about participants' personal experiences with mental illness. This chapter provides an interpretation of the results and a discussion of the findings. The limitations of the study are then presented, followed by a discussion of directions for future research.

Knowledge of Mental Illness. The study confirmed the author's hypothesis that correctional officers generally have limited knowledge of mental illness. This finding is consistent with the results reported by Compton et al. (2011), which concluded that a lay person's knowledge of mental illness is scant. The average score obtained by police officers who had no prior training on mental illness ($n = 199$) was 18.7 ($SD = 5.0$) on tests administered on Monday and 19.1 ($SD = 5.2$) on Friday. Correctional officers in the present study were not better than the general public in identifying common psychological disorders, common risk factors, causes, or effective interventions. Their scores on the MC-KOMIT were comparable to those of police officers in the original study by Compton et al. (2011). However, there were two notable differences between the present study and the original study. Specifically, Compton et al. (2011) used a sample of $n=199$ and reported a standard deviation of 5.0 and 5.2 for the two sets of data collected. The present study's sample consisted of $N=40$ and showed a smaller standard deviation of 4.75.

Psychology is a scientific discipline, especially in the areas of assessment and diagnosis

of psychopathology. Therefore, it is not surprising that correctional officers do not possess higher levels of mental illness literacy than the general population even if they may have taken a course in psychology and know people who have mental illness. It is important to remember that correctional officers are hired to work in a given correctional setting and attend to all inmates. As such, they generally receive training that will be applicable to all inmates, with no focus on mental illness. Perhaps when one considers the responsibilities of a correctional officer, mainly those of a custody officer, there does not appear to be a need for training about mental illness. After all, officers are not hired to counsel inmates about their mental illness, but to ensure the safety and security of an institution.

There are currently no national standards for training in psychology disciplinary contents or specifications for required amounts of training for correctional officers. The local jail where the study was conducted observes the recommendations of the New Hampshire Association of Counties (NHAC). Specifically, in addition to a standard 40-hour new employee training, each newly hired officer attends 120 hours of field training. According to the facility director of training (personal communication, April 24, 2012), this training is mostly experiential and it includes intake and booking procedures, control and patrol, and unit management. Booking procedures include new intakes, search procedures, inmate property work release, bail process, filing systems, and shackle and handcuff procedures. Control and patrol training focuses on learning responses to different emergency codes, key control, control room operations, and escorting and changing inmates. The last part of the training, unit management, focuses on skills and information essential to the daily running of a unit or a cell block. Topics include conducting a headcount, cell inspection and searches, distribution of meals, and issuing razors. This training curriculum does not distinguish between mentally ill inmates and inmates from the general

population. The topic of mental illness is not included in this basic training.

In addition, correctional officers that were part of the present study experienced a mentoring style of training. Each officer is required to complete a probation period, which lasts six months but can be extended up to 12 months. After completion of the training required by the jail, officers are provided with additional training, which totals about 100 hours for each year. Among the topics recommended by the NHAC are suicide prevention, special needs inmates, interpersonal communications, and stress and trauma. Each of these topics is covered in about 4-8 hours of training. Although this education provided to the officers is likely beneficial and increases their knowledge in certain areas, it does not appear to have much effect on knowledge of specific mental illness symptoms, causes, treatment, or risk factors.

It is also important to note that the special needs inmates training covers a rather wide range of topics, making it difficult to provide detailed information on specific psychiatric disorders. The curriculum that was shared by the training coordinator included the following topics: homosexuality, problems with sexual preference, homosexual rape trauma, medical problems, contagious diseases, addictions, supervising the mentally handicapped, mentally ill inmates, personality disorders, managing schizophrenic inmates, and other disorders. Therefore, even when provided with specialized training, mental illness is covered in limited detail.

A finding that was not previously reported in the literature was that correctional officers with some college education and above obtained higher scores on the MC-KOMIT. However, scores were not affected by previous completion of a psychology class. This, perhaps, is due to the difference between taking a single psychology course and pursuing college education in general. The latter tends to make individuals more knowledgeable in general, but also promotes critical thinking skills and an orientation toward learning. Individuals who pursue college and

graduate education may also have a thirst for knowledge, leading them to seek and absorb new information. As such, they may go above and beyond what is expected of them. For example, rather than being satisfied with the basic training they receive through employment orientation, these officers may be more likely to spend personal time expanding their knowledge related to their employment, such as mental illness. It is also likely that an introductory level psychology class does not provide in-depth information, and may easily be forgotten by students who do not pursue further education in the field of psychology. Rather, general psychology courses tend to provide an overview of the discipline, focusing on the historical and theoretical aspects of the subject. These classes do not teach about the causes, common presentations, risk factors, or effective treatments of major mental illnesses. The positive relationship between higher education and knowledge of mental illness is one that may warrant further exploration.

In addition, having had personal experience with mental illness did not contribute to higher levels of mental illness literacy. This finding is contrary to that reported by Compton et al. (2009), who found that police officers with a history of personal mental health treatment scored higher on the MC-KOMIT ($M = 22.5, SD = 3.4$), as compared to officers without a treatment history ($M = 18.3, SD = 5.0$), ($t = 3.19, df = 185, p = 0.002$). This difference is perhaps due to the different nature of experiences described by the participants of the Compton et al. study (i.e., having a personal treatment history rather than having contact with someone under duress). Also, in regard to personal experiences with an individual under duress, officers appeared to experience a change in attitude rather than a change in knowledge. It likely depends on the nature of the experience, but officers frequently reported feeling more cautious and approaching inmates with more understanding after a personal experience with an individual affected by psychological difficulties.

Self-efficacy. This study found that correctional officers reported having medium to high levels of work-related self-efficacy when working with mentally ill inmates. This finding is contrary to the reports by Parker (2009) and Walsh and Freshwater (2009) that correctional officers who worked with mentally ill inmates often expressed feeling less confident in their abilities to effectively perform their duties. Self-efficacy of the officers in this study appears to fall in a range of scores between high to very high. These officers rarely reported feeling low or very low sense of self-efficacy when working with mentally ill inmates.

Several factors may have influenced the rating of perceived self-efficacy by correctional officers in the study. It is possible that although these officers have low levels of training in topics specific to mental illness, they receive frequent training that hones their knowledge of and skills in crisis management. The director of training (personal communication, April 24, 2012) for the jail where the present study was conducted informed the author that this particular jail facility provides newly hired officers with more training than is typical at other county jails in the state. Therefore, officers may feel fairly confident in their abilities to deal with mentally ill inmates who are in a crisis situation by translating the skills of general crisis intervention learned during one of the trainings they attended. In addition, the facility philosophy is to provide humane treatment and a rehabilitative setting, providing support for any offender who seeks positive change in his or her life. Safety and security are the facility's primary concerns and all staff at the jail are encouraged to adhere to this philosophy.

Another factor that may have contributed to perceived high self-efficacy when working with mentally ill inmates is fear of negative consequences. Although the self-reports of the study were anonymous and the author assured officers that there would be no negative consequences or evaluations from their employer, it is possible that officers exaggerated their self-efficacy to

appear as more confident. Officers may have perceived admitting low self-efficacy when working with mentally ill inmates as risky because this admission may involve situations that can potentially affect other individuals and the safety of the facility. Absence of self-efficacy would be particularly troubling in correctional settings, given Bandura's (1983) postulation that individuals with low self-efficacy will behave anxiously or fearfully and, as a result, not perform productively. To elucidate, an officer with a low self-efficacy would approach a mentally ill inmate in an anxious manner, expecting to be ineffective in his or her interaction. The said nervousness would impact actual fearful, aggressive, or avoidant behaviors in an officer, increasing the likelihood that the interaction would be ineffective. Officers in the present study, therefore, may have wanted to appear competent at their job and exaggerated their perceived self-efficacy.

Because self-efficacy is achieved via interaction with the environment, it is possible that factual knowledge about mental illness plays a smaller role in developing self-efficacy. Although the training programs described by Parker (2009) and Walsh and Freshwater (2009) were reportedly effective in increasing knowledge about mental illness and self-efficacy of correctional officers, other factors, such as experiential training, followed with reflections and insight, may have contributed to this outcome. Because Parker's (2009) study involved officers working in a special housing unit, which typically has a higher number of mentally ill inmates, the officers' motivation for additional hands-on training should be taken into account. These officers likely had more contact with mentally ill inmates; therefore, they may have experienced a higher motivation to increase their self-efficacy through training and, subsequently, perceived an effective outcome.

An interesting correlation was found between age and self-efficacy in the present study

that has not been reported in previous studies. Specifically, younger officers reported higher levels of self-efficacy than older officers. It is possible that younger officers have more positive attitudes and believe in their capabilities in general and perceive fewer negative experiences with disruptive or mentally ill inmates. The younger officers might have been of the same age as the jail inmates and more about how to interact with similar aged individuals. Older officers may perceive themselves as less efficacious in general, have more awareness of their limitations, and evaluate more negatively their experiences with disruptive inmates. However, no relationship between years spent as a correctional officer and self-efficacy was found. Being older, they might have felt less familiarity with the behaviors of the younger generation. Because there is no research exploring this relationship between work-related self-efficacy and age, it is difficult to tell whether this is specific to correctional officers or a more general trend in different fields of employment. In a study of self-efficacy in chronic pain patients, Chong, Cogan, Randolph, and Racz (2001) looked at the relationship between self-efficacy and age. Unlike the present study, they found that younger individuals expressed lower self-efficacy than middle aged adults. Interestingly, they found no difference in self-efficacy between younger and older adults and no difference between middle aged and older adults.

Knowledge of Mental Illness and Self-efficacy. Contrary to this author's hypothesis that there is a significant positive relationship between correctional officers' knowledge of mental illness and work-related self-efficacy, no such relationship was found by the study. Although some researchers (Parker, 2009; Walsh & Freshwater, 2009) reported positive effects of educational training about mental illness (e.g., better understanding of inmates and increased confidence), such effects do not appear to relate directly to self-efficacy. It appears that specific knowledge of mental illness, which can be attained through didactic training, is not essential to

self-efficacy, but supervised step-by-step practice experience, accompanied by the reinforcements of mentors, may be related to self-efficacy. This does not mean, however, that knowledge does not play any role in increasing self-efficacy; the power of knowledge may have a mediational role, which the present study did not statistically investigate. The sample size would need to be much larger for the study of moderating effects.

Because self-efficacy is achieved through a complex system of interpersonal interactions within the environment, such as with role models and the professional reinforcements of role models, a contextual examination of the social cognitive learning process (Bandura, 2012) may be necessary in a study of correctional officers. Mastery experiences, social modeling, social persuasion, and the process of making choices or problem-solving are aspects of building self-efficacy that have been identified by Bandura and built into Bandura's controlled experimental studies, but which were not a part of the present study's survey design. Correctional officers would ideally acquire self-efficacy through managing difficult situations when working with mentally ill inmates, learning from successes and failures, observing the success of others, experiencing encouragement by supervisors and peers, and finally exercising own agency in decisions and actions. Having knowledge about mental illness can influence two of these factors. Namely, it can increase the potential for effective resolution of conflict or learning from failure, and it can inform the decision-making or problem-solving process. However, knowledge in absence of the other social cognitive learning aspects will likely not make a significant difference in self-efficacy.

Although there is limited research that postulates there is a relationship between training in mental illness and self-efficacy (Parker, 2009; Walsh & Freshwater, 2009), the relationship does not appear to be a linear one. It is possible that knowledge influenced the officers' approach

to inmates, indirectly increasing mastery of difficult situations and decision-making processes. Had the study investigated the work stresses of correctional officers, such as dangerous situations, threats to personal safety, long hours of work, low salaries, little social support, scarce opportunities for career enrichment, high turnover rates, burnout, dissatisfaction with work, high rates of absenteeism, or illness (Pan et al., 2011; Parker, 2009), the study may have found a strong relationship between these variables and correctional officers' self-efficacy beliefs.

Study Limitations. The author has identified five limitations of the present study. The first one is the lack of consistency among correctional agencies and in the existing literature in operationalizing the concept of mental illness. Specifically, some studies include diagnoses of personality disorders while others only look at severe and persistent mental illness. Similarly, some institutions use psychiatrists to diagnose disorders, others use psychologists, while some may use licensed master's level clinicians, primary care physicians, or nurses. Such professional diversity in identifying or diagnosing mental illness makes it difficult to establish rates and degrees of severity of mental illness. Professional differences among assessors may be related to current estimates of mental illness in correctional settings ranging from about 14.5% to 50% (Dvoskin & Spiers, 2004; Gostin, 2008; Prins, 2011).

The second limitation is the small study sample, and the third limitation is the homogeneity of the sample. Because the study was conducted at a small local county jail, which employs about 45-50 correctional officers, the author was only able to obtain 40 participants for the study. Although only 28 participants are needed to detect a large effect size of (.50) at $\alpha=.05$, the author would need 85 participants to detect a medium effect size of (.30) and 783 participants to detect a small effect size of (.10) at $\alpha=.05$ (Cohen, 1992). The study's small sample could not achieve a medium effect size, except for the significant positive effect of higher

education on mental health knowledge. The sample was fairly homogenous. The majority of participants were Caucasian males, young adult to middle-aged (mean age of 34.97). Therefore, the finding of this study may not be representative of a more diverse population of correctional officers in urban areas.

The fourth limitation of the study is that it did not study self-efficacy as a complex social and contextual concept that requires measurement of variables different from knowledge. The author also focused on one aspect of a complex relationship among different factors of self-efficacy. It is likely that a more comprehensive measurement approach, one that would look at mastery experiences, social modeling, social persuasion, and the process of making choices (Bandura, 2012) would allow for a conceptually more accurate approach to assessing self-efficacy.

The fifth limitation of the study was the setting. Specifically, the county jail where the study was conducted was possibly not representative of other county jails, and very likely not representative of other correctional facilities, such as state or federal prisons. The director of training of the jail reported that although the facility ensures that officers receive some training that is related to mental illness, many correctional facilities do not provide such training (personal communication, April 24, 2012). In addition, this facility provides a supportive environment to the employees, which likely increases their self-efficacy. There are opportunities to process crisis situations, thus increasing the potential for increasing mastery experiences and learning from failures. In addition, because the facility uses a mentoring training model where newly employed correctional officers work under close supervision, they have ample opportunities to observe more experienced officers at work. This provides officers with positive social modeling, which increases self-efficacy.

Directions for Further Research. It is important to understand the factors influencing correctional officers' work-related self-efficacy when they serve mentally ill inmates because mental illness in correctional settings continues to increase. Because no relationship was found between self-efficacy and knowledge of mental illness, it is important to explore other aspects that will allow for more effective training for correctional officers. Therefore, future research should focus on achieving two objectives: a larger and more diverse sample and a broader investigation of self-efficacy aspects. Having a heterogeneous sample from different correctional facilities will limit the interference of facility-specific factors. A larger population will also allow for an acceptable small effect size.

In addition, future research should explore what factors influence each aspect of self-efficacy. Specifically, it should look at the four ways of achieving self-efficacy identified by Bandura (2012), which are mastery experiences, social modeling, social persuasion, and the process of making choices. Therefore, future research should assess the nature of these factors. For example, a facility that provides positive social modeling for newly hired officers will likely create a different environment for self-efficacy than a facility that does not provide mentoring and social modeling.

Summary

Correctional facilities house a large number of mentally ill inmates. It is estimated that more than half meet the criteria for a mental disorder. However, although the inmate population continues to exhibit a high incidence of mental illness and correctional officers are expected to effectively interact with this population, there has been little effort to understand what would make officers more effective at their work. In addition, there has been minimal movement to prepare officers for work with mentally ill inmates and to provide them with proper training. The

author, therefore, conducted a study to gather information about officers' knowledge of mental illness, self-efficacy, and the relationship between the two.

The author found that correctional officers in the study have low levels of mental illness knowledge, which is comparable to the general public's knowledge. However, officers who had higher education (college graduates and above) showed greater mental illness literacy than those with less education (high school to some college). Officers reported an overall medium to high self-efficacy when working with mentally ill inmates. No significant relationship between the degree of knowledge about mental illness and expressed self-efficacy was detected. Rather, self-efficacy was related to age, with older correctional officers reporting less self-efficacy than younger ones.

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Appendix A: Letter of Institutional Permission

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Richard Van Wickler, Superintendent
Gemma Lantry, Executive Assistant
Phone: (603) 903-1600
Fax: (603) 352-4044

Captain Kevin Clark, Director of Classification
Captain Hank Colby, Director of Programs
Major John Mousseau, Director of Safety & Security

May 7, 2012

To Whom It May Concern:

Margaret Podkova, a doctoral student in the Clinical Psychology Department at Antioch University New England, has our permission to complete research at the Cheshire County House of Corrections that will be included in her dissertation. We are committed to supporting Ms. Podkova in any way that we can to successfully complete her research project.

Richard N. Van Wickler
Superintendent

Barnes K. Peterson, LCMHC, CCFC
Mental Health Clinician

Appendix B: Informed Consent

Correctional Officers' Knowledge of Mental Illness: Relationship with Self-Efficacy
In Interactions with Mentally Ill Inmates

My name is Margaret Podkova and I am a third-year clinical psychology doctoral student at Antioch University New England in Keene, New Hampshire. I am conducting a research project as part of my training at my university, and I am inviting you to participate in this project. The purpose of this study is to explore how correctional officers feel about working with mentally ill inmates.

You will be asked to fill out three measures, which should take about 45-60 minutes of your time. The study will be conducted at the jail during your work hours. We do not foresee any emotional or other risks. The information collected may not benefit you directly, but what I learn from this study should provide general benefits to correctional institutions and may be used to assess the effectiveness of training provided to correctional officers.

Your survey responses will be confidential, available only to me for the purpose of analyses. Survey responses will be coded by number and will not use any identifying information. I do this to ensure your responses remain anonymous and that you feel comfortable to respond as freely as possible.

Please know that your participation in this study is voluntary and that you may withdraw at any time. If at any time doing the study you decide you no longer wish to be part of this research project, please let me know and I will withdraw your survey from the data collection. There is no penalty, either from Antioch University New England or from your employers, for declining participation or withdrawing. You may decline to answer any particular question, although I encourage you to respond to all items.

If you have questions about this project, please feel free to contact me, Margaret Podkova (MPodkova@antioch.edu; 201-988-2452), or my faculty supervisor (Gargi Roysircar, groysircar@antioch.edu; 603-283-2186). If you have questions or concerns about your rights as a research participant, please contact Kevin Lyness, Chair of the Human Research Committee at 603-283-2149, or Stephen Neun, Vice President of Academic Affairs, 603-283-2150; Antioch University New England, 40 Avon Street, Keene, NH 03431.

***** Consent Statement *****

I have read and understood all the above information. Any questions that I had previously have been adequately addressed by the researcher. I am aware of the risks and benefits of this study and I have received a copy of this form in its entirety.

☐ I consent to participation in this study.

Signature _____ Date _____

Appendix C: Demographic Questionnaire

Age: _____

Sex:

_____ Male
_____ Female

What race would you assign yourself? _____

What ethnicity would you assign yourself? _____

Marital Status (Check one):

_____ Single
_____ In a relationship(not married)
_____ Married
_____ Separated
_____ Divorced
_____ Widowed

Highest Level of Education Attained (check one):

_____ Did not complete high school
_____ Graduated high school or GED Diploma
_____ Some college
_____ Associate Degree
_____ Bachelor's Degree
_____ Master's Degree
_____ Doctorate Degree
_____ Other (If other, what education did you attain?) _____

How many years have you worked as a correctional officer? _____

Have you ever taken a psychology course in school? Yes _____ No _____

If yes what course? _____

What is your income?

_____ Per year

Have you ever experienced, in your personal life, an interaction with a person under duress?

_____ Yes _____ No

If YES, please describe:

If so, how has that experience influenced your reaction to mentally ill individuals?

Appendix D: MC-KOMIT

For each of the following questions, circle the best answer. Please answer every item.

1. Some people with obsessive-compulsive disorder may benefit from which of the following?
 - A. Developing new hobbies
 - B. Dietary counseling
 - C. Legal restraining orders
 - D. Limiting social contacts
 - E. Support groups
2. A 76-year-old man has mild memory problems, difficulty maintaining his house, and some confusion about which month it is. Which of the following resources may be most beneficial to him?
 - A. Assisted living facility
 - B. Nursing home
 - C. Outpatient psychotherapy
 - D. Physical exercise counseling
 - E. Rehabilitation hospital
3. A 19-year-old begins to hear voices and act paranoid several months after graduating from high school. Which of the following is the most likely cause of these problems?
 - A. Excessive worries about other peoples' intentions
 - B. Genetic tendency toward developing an illness
 - C. Increasing use of alcohol during adolescence
 - D. Not enough support from parents
 - E. Stress of graduating from high school
4. Which of the following community services is especially important for people with dementia and their families?
 - A. Detoxification programs for those with alcohol abuse
 - B. Hygiene programs for those with grooming problems
 - C. Memory retrieval programs for those with memory loss
 - D. Re-orientation programs for those who are disoriented
 - E. Safe return programs for those who become lost
5. A man is evaluated by a psychiatrist, who tells him that psychotherapy is much more important for his problems than any medications. Which of the following disorders is he most likely being seen for?
 - A. Bipolar disorder
 - B. Dependent personality disorder
 - C. Dyslexia
 - D. Heroin withdrawal
 - E. Paranoid schizophrenia
6. People who have had an episode of major depression are at most risk for which of the

following?

- A. Becoming addicted to anti-depressant medicines
 - B. Being diagnosed with migraines
 - C. Developing schizophrenia
 - D. Experiencing flashbacks about their depression
 - E. Having another episode of depression
7. Psychotherapy may be the most beneficial resource for which of the following conditions?
- A. Alcohol withdrawal
 - B. Cognitive disorders
 - C. Developmental disorders
 - D. Learning disorders
 - E. Personality disorders
8. Which of the following is a feature of all developmental disabilities?
- A. Difficulties walking
 - B. Impairment in daily functioning
 - C. Inability to communicate verbally
 - D. Mental retardation
 - E. Unusual body appearance
9. Which of the following is most true of psychiatric medicines for children?
- A. They are helpful for all psychiatric disorders
 - B. They are often crushed and mixed in food
 - C. They improve some types of symptoms
 - D. They require a signature from both parents
 - E. They should only be used after puberty
10. A woman sees a therapist weekly to work on her maladaptive patterns of behavior which have repeatedly interfered with relationships and work. When stressed out, she becomes very impulsive, feels empty, thinks of suicide, and makes multiple cuts on her forearms. Which of the following most likely contributed to her problems?
- A. A brain infection in childhood
 - B. Abusive or neglecting parents
 - C. Influence of bad friends in adulthood
 - D. Lack of everyday rest and relaxation
 - E. Not enough vitamins and minerals in her diet
11. Which of the following is a common symptom of obsessive-compulsive disorder?
- A. Fear of social situations
 - B. Intrusive thoughts or impulses
 - C. Ongoing concern about having a panic attack
 - D. Overeating and weight gain
 - E. Thinking that others are watching or following
12. A woman brings her 16-year-old son to a psychologist for an evaluation of failing grades.

In order for the psychologist to ensure that this young man does not have mental retardation, which of the following questions is he likely to ask?

- A. Did any of his family members have learning problems?
 - B. Do his classmates make fun of him?
 - C. Does he also have unusual beliefs?
 - D. When did his learning difficulties first begin?
 - E. Which class does he currently like the least?
13. A 35-year-old woman has been court-ordered to see a psychologist for problems stemming from her alcohol and cocaine use. Which of the following is the psychologist likely to be working to change?
- A. Avoidance
 - B. Denial
 - C. Pessimism
 - D. Violence
 - E. Withdrawal
14. A woman who has borderline personality disorder frequently becomes suicidal due to an ongoing fear. Which of the following is she most likely subconsciously afraid of?
- A. Abandonment
 - B. Being followed
 - C. Contamination
 - D. Gaining weight
 - E. Growing old
15. People who have posttraumatic stress disorder are at highest risk for also having which of the following?
- A. Alcohol abuse
 - B. Bipolar disorder
 - C. Early-onset dementia
 - D. Mental retardation
 - E. Schizophrenia
16. A 13-year-old girl with severe mental retardation has been followed by a child psychiatrist for ten years. She has never taken medications, but the psychiatrist has now decided that a medication may be beneficial. Which of the following is the most likely reason the medication is being prescribed now?
- A. It is now clear that the mental retardation is not getting better without medicine
 - B. Medicine may help with problems that are worsening, such as behavior outbursts
 - C. School demands are now greater and she will need medicine to help with learning
 - D. She is now an adolescent and can take psychiatric medications
 - E. The mental retardation has advanced from a moderate to severe level
17. Delirium and seizures may occur during withdrawal from heavy, long-term use of which of the following substances?
- A. Alcohol

- B. Inhalants
 - C. Marijuana
 - D. Mushrooms
 - E. Narcotics
18. Which of the following is a common reason why a woman with schizophrenia might not regularly take her medicine?
- A. Her anxiety disorder makes her too nervous
 - B. She does not recognize that she has an illness
 - C. She needs psychotherapy instead of medicine
 - D. The medicine is addictive and she is afraid to take it
 - E. The pills are very large and hard to swallow
19. Most people in treatment for depression are treated by which of the following?
- A. Case managers
 - B. Family therapists
 - C. Primary care physicians
 - D. Psychiatrists in hospitals
 - E. The clergy
20. Which of the following best describes the treatment approach for developmental disabilities?
- A. Combination of medications to control behavior
 - B. Combination of special supports and services
 - C. Long-term institutional care
 - D. Long-term psychotherapy
 - E. Supervision by a life coach
21. A mother and father meet with a mental health professional for three sessions over the course of a month after their 25-year-old son committed suicide. Which of the following is the most likely reason for their meetings?
- A. To assess for any mental illnesses
 - B. To attempt to determine what the warning signs had been
 - C. To begin processing their grief and loss
 - D. To determine what could have been done to prevent the suicide
 - E. To make a diagnosis of their son's likely mental illness
22. Which of the following is likely a cause of attention-deficit/hyperactivity disorder in children?
- A. An inherited risk
 - B. Certain medications
 - C. Eating too much sugar
 - D. Not getting enough sleep
 - E. Poor control over classrooms
23. Which of the following is the most common long-term course of dementia?

- A. Improvement
 - B. Paralysis
 - C. Progression
 - D. Remission
 - E. Stabilization
24. A woman is diagnosed with depression by her doctor during a hospital stay for asthma. Her doctor was most likely prompted to screen for depression because the woman has which of the following?
- A. A long history of smoking cigarettes
 - B. Family members with depression
 - C. Little improvement from asthma treatment
 - D. Poor understanding of her condition
 - E. Three children under the age of 18
25. Which of the following is a common sign of mania?
- A. Becoming forgetful
 - B. Being more talkative than usual
 - C. Experiencing repeated flashbacks
 - D. Feeling helpless or hopeless
 - E. Having anxiety attacks
26. A 25-year-old woman receives a number of services through the local mental health system and social agencies, including someone to visit her at home to help with hygiene and cooking, a job coach, a psychiatrist, and a neurologist. Which of the following conditions does she most likely have?
- A. Adjustment disorder
 - B. Dementia
 - C. Developmental disability
 - D. Drug addiction
 - E. Personality disorder
27. An 8-year-old boy is diagnosed as having depression by a psychiatrist. The psychiatrist tells the boy's parents that sometimes depression in children appears different from depression in adults. Which of the following is an example of what the psychiatrist is describing?
- A. Having high energy rather than low energy
 - B. Hearing voices rather than feeling hopeless
 - C. High self-esteem rather than low self-esteem
 - D. Homicidal thoughts rather than suicidal thoughts
 - E. Irritability rather than feeling depressed
28. Which of the following best describes an addiction?
- A. Family members are often unaware that any problem exists
 - B. It is a chronic disorder requiring many treatment approaches

- C. It is a short-term behavioral problem usually tied to a major life event
 - D. Recovery is rare when a psychiatric disorder is also present
 - E. Treatment usually includes a medicine that is taken long-term
29. Which of the following is most likely to increase one's risk for depression?
- A. Being abused as a child
 - B. Eating a high-fat diet
 - C. Moving to a new residence
 - D. Not relaxing enough
 - E. Working past the age of 65
30. A man at an airport is talking and laughing very loudly, passing out twenty-dollar bills, and telling people he plans to fly around the world to attend sixteen diplomatic meetings. He likely has which of the following?
- A. Alcohol abuse
 - B. Delirium
 - C. Mania
 - D. Obsessions
 - E. Pathological lying
31. People who have personality disorders usually have these problems during which of the following life stages?
- A. Adolescence and adulthood
 - B. After major life events
 - C. Childhood and adolescence
 - D. Older adulthood
 - E. When going through puberty
32. A man has been having episodes of chest pain, hyperventilation, and extreme anxiety during the past few months. He is afraid that he will die of a heart attack during one of these episodes. He has seen several doctors, who assure him that his heart is healthy. He now avoids driving because it seems to trigger these attacks. Which of the following treatments would be most helpful?
- A. Counseling
 - B. Herbal supplements
 - C. Mood stabilizer
 - D. Physical therapy
 - E. Regular exercise
33. Which of the following is a common sign of oppositional defiant disorder in childhood?
- A. Arguing with teachers
 - B. Being teased at school
 - C. Crying at doctors' offices
 - D. Feeling depressed
 - E. Not wanting to get on the school bus

Please rate how you perceive your self-efficacy (a sense of ability and capacity to manage effectively, without the use of threats or physical force) in the following situations.

1. Mr. Jenkins is a 30-year-old inmate who has been feeling unusually sad and miserable for the past few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. Mr. Jenkins does not feel like eating and has lost weight. He has not cleaned his cell in weeks and says he simply “has no energy” when you ask him to clean it.

I rate my self-efficacy in this situation as:

5	4	3	2	1
I-----I				
Very High	High	Neutral	Low	Very Low

2. Mr. Hanley is a 24-year-old inmate who began to act differently about 6 weeks ago. He stopped talking to other inmates and staff, eating meals with the inmates he once sat with, and he has to be coaxed into taking showers. You observe him pacing in his cell while talking, shouting, and sometimes arguing with someone who is clearly not there. When you ask him about his behavior, he whispers, “they are watching me and they want to hurt me.”

I rate my self-efficacy in this situation as:

5	4	3	2	1
I-----I				
Very High	High	Neutral	Low	Very Low

3. Mr. Nelson is a 48-year-old inmate who was exhibiting unusual behavior in D-Block for one week. He had been sleeping no more than 3 hours a night, talking incessantly about past accomplishments that seemed unrealistic, and he was telling everyone that he knew many important people who would help him get out of jail. He received a disciplinary write-up for Disorderly Conduct due to tipping over a chair after an officer asked him to lower his voice when he was disturbing inmates who were attempting to watch TV. He was placed in S-Block. After an appointment with the PA in the Medical Services Office, you escort Mr. Nelson back to S-Block. As you begin to unlock his second cuff, he pulls away from you and runs into his cell. He begins to talk loudly and quickly, accusing you of disrespecting him, and he does not respond to your repeated requests to complete the uncuffing process.

I rate my self-efficacy in this situation as:

5	4	3	2	1
I-----I				
Very High	High	Neutral	Low	Very Low

4. Mr. Perkins is a 32-year-old male inmate housed in R-Block. You observe him in his cell

shaking, sweating, and appearing distressed. He reports that he feels nauseous, dizziness, and that he is having difficulty breathing. This is the third time you have observed this happening and you are certain that this is not a heart attack because the first time these symptoms occurred the PA ensured Mr. Perkins that there was nothing medically wrong with him.

I rate my self-efficacy in this situation as:

5	4	3	2	1
I-----I				
Very High	High	Neutral	Low	Very Low

5. Ms. Austin is a 26-year-old inmate housed in F-Block. She is frequently involved in conflicts with staff, has difficulty controlling her anger, has frequent mood swings, is impulsive, and switches between loving and hating staff members. You know that she was just issued a write-up due to a rule infraction and was upset. You observe her in her cell using a sharpened instrument to inflict shallow cuts into her leg.

I rate my self-efficacy in this situation as:

5	4	3	2	1
I-----I				
Very High	High	Neutral	Low	Very Low