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# Correctional Officers' Perceptions of Working with Inmates with Mental Illnesses and the Effectiveness of Mental Health Training

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Correctional Officers' Perceptions of Working with Inmates with Mental Illnesses and  
the Effectiveness of Mental Health Training

Submitted by Cerenity Petracek  
May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work  
St. Catherine University & University of St. Thomas  
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### Abstract

Many correctional officers have voiced not receiving adequate training in mental health and how to best work with inmates who may be experiencing mental health symptoms. Crisis Intervention Team (CIT) training has improved officers' responses to working with individuals during a mental health crisis. The purpose of this project was to examine correctional officers' perceptions of working with inmates with mental illnesses and how prepared they feel working with inmates who are in crisis. Seventy correctional officers were surveyed in two county jails in Minnesota. The sample of participants included officers who have been certified in CIT. Results were analyzed using descriptive and inferential statistics. While findings indicated there were no differences in perceptions of inmates with mental illnesses between correctional officers certified in CIT and correctional officers who were not, correctional officers who were certified in CIT self-reported they felt more prepared to work with inmates experiencing mental health symptoms and inmates who were in crisis. A third finding demonstrated correctional officers who indicated they were prepared to work with these inmates also had more positive perceptions of them. The participants surveyed were unrepresentative across gender and race. Conducting further research will help gain a better understanding on the views correctional officers have towards mental illnesses and responding to inmates who have mental illnesses, or who are in crisis.

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## Table of Contents

INTRODUCTION.....	p. 1
LITERATURE REVIEW.....	p. 5
CONCEPTUAL FRAMEWORK.....	p. 29
METHODS.....	p. 30
DISCUSSION.....	p. 55
REFERENCES.....	p. 62
APPENDICES.....	p. 68
Appendix A. Survey Questions.....	p. 68
Appendix B. Agency Consent Form .....	p. 70
Appendix C. Agency Approval Letters.....	p. 73
Appendix D. Participant Consent.....	p. 74

## List of Tables

Table 1: Sample Demographics and Characteristics.....	p. 35
Table 2: Perception Scale Scores and Sample Characteristics.....	p. 38
Table 3: Ability Scale Scores and Sample Characteristics.....	p. 42
Table 4: Relationship Between Ability and Perception Scale Scores of Participants...	p. 44
Table 5: Pearson Correlation Between Self-Reported Ability and Perceptions of Inmates with Mental Illnesses.....	p. 46
Table 6: Perceptions of Mental Health Training in Current Place of Employment.....	p. 49
Table 7: Participants' Responses to Certification in CIT and the Location Where Participants Received Their Training.....	p.50
Table 8: Crosstabulation Between Gender and Rehabilitation.....	p.54
Table 9. Crosstabulation Between Race and Rehabilitation.....	p.55

List of Figures

Figure 1: Department’s Policy/Protocol Clearly States How to Respond to Mental Health Crises.....p.47

Figure 2: Participants Mental Health Training in Past Five Years.....p.48

Figure 3: Outcomes of Certification in CIT.....p.51

Figure 4: Participants’ Responses for Not Being Certified in CIT.....p.52



Correctional Officers' Perceptions of Working with Inmates with Mental Illnesses and  
the Effectiveness of Mental Health Training

America's criminal justice system is complex and has endured many transformations throughout its history. The effectiveness of our country's criminal justice system has been at the forefront of political and personal debates. Despite the differing viewpoints regarding "punishment" versus "rehabilitation," our nation's inmate populations in prisons and jails have increased from 330,000 in 1972 to 2.1 million in 2004 (King, Mauer, & Young, 2005). An even more staggering statistic is the growing population of inmates with mental illnesses appearing in correctional institutions. According to United States Department of Justice, more than half of the inmates in 2005 reported they had a mental health problem (James & Glaze, 2006).

Individuals whose mental illnesses go untreated are often faced with poverty, homelessness, substance abuse, and incarceration (Fellner 2006a, 2006b). These individuals often face social isolation. Families of those individuals also are often disrupted. Individuals with mental illnesses may cycle through the criminal justice system instead of receiving treatment. Many correctional facilities are not equipped to provide adequate mental health treatment when individuals with mental illness are booked into their facilities (Almquist & Dodd, 2009). With statistics showing the prevalence of mental health issues among offenders, and the high recidivism rates among this population, policymakers and practitioners have advocated for new developments to help these individuals (Almquist & Dodd, 2009).

More than 90% of prisoners will be released back into communities (Hill, Siegfried & Ickowitz, 2004). Beginning or maintaining mental health treatment in

correctional settings for these inmates is important in helping these individuals to make a successful transition back into the community. Increasing system changes inside correctional settings and in the community are necessary in aiding a successful transition. Providing inmates and correctional staff with education about mental health symptoms, medications, and skills to manage and cope with symptoms, helps promote safety within correctional settings. This also increases the possibility of improving safety in the community when offenders are released (Dvoskin & Spiers, 2004; Fellner, 2006a).

The New Freedom Commission on Mental Health, established in 2002 by President Bush, examined the delivery of mental health systems services in the United States. The Commission suggested diversion programs and appropriate mental health care in correctional settings could help these individuals to become successful, contributing members in their communities. Persons with mental illness returning to their communities from jail and prison face stigma due not only to their mental illnesses, but also due to their criminal records. They face the two burdens of managing their mental illness and re-entry into society. Specialized re-entry strategies are needed to help individuals manage their mental health, assist in reentry to aid in relapse prevention or recidivism (President's New Freedom Commission on Mental Health, 2003)

Carrying out rehabilitative services in correctional facilities is not an easy task, and requires collaboration between all staff, especially between mental health staff and correctional officers. Correctional officers have been identified as being an integral part of ensuring not only the safety and security of the facilities, but as part of a multidisciplinary team in carrying out mental health services (Appelbaum, Hickey &

Parker, 2001). This has called for a need of more mental health training for correctional officers.

Mental health trainings for staff have been started in many correctional facilities across the nation. The state of Minnesota has taken steps aimed to decrease mental health disparities in the state's criminal justice system (National Alliance on Mental Illnesses-Minnesota [NAMI-MN], September 2010). The addition of mental health courts; pre-booking jail diversion methods; and discharge planning programs for inmates with mental illnesses have all been implemented in Minnesota. Organizations such as the National Alliance on Mental Illness-Minnesota (NAMI-MN) and local stakeholders have been key influences in advocating for such programs.

The Minneapolis Police Department can be credited for the implementation of the pre-booking diversion method of Crisis Intervention Team (CIT) training in Minnesota (NAMI-MN, September 2010). The CIT model is based on a 40-hour training used to give individuals tools and strategies for working with individuals experiencing mental health symptoms (Center for Health, Planning, Policy, and Research [CHPPR], 2007; NAMI-MN, September 2010). For law enforcement officers, CIT training has been shown to improve officers' ability to recognize symptoms related to mental health disorders; respond appropriately to persons experiencing mental health problems; and to make referrals to community-based services instead of taking them to jail (CHPPR, 2007). While CIT training is not required for all law enforcement in the state, Minnesota does require all police officers to be CIT trained before they can carry a Taser (NAMI-MN, September, 2010).

Currently, Minnesota Correctional Facilities vary in the types of mental health training and requirements their correctional officers receive. CIT is currently available to correctional officers voluntarily for a fee of (\$450-700 per officer) through local CIT coordinators in Ramsey and Olmsted Counties, and through organizations such as the Barbra Schneider Foundation and Minnesota CIT Officer's Association (NAMI-MN, September, 2010). The National Institute of Corrections (NIC) is assisting Minnesota in implementing CIT directly into Minnesota prisons (NAMI-MN, September 2010). The Minnesota Department of Corrections Facility (MCF)-Stillwater has recently conducted the first full 40-hour CIT training for their correctional officers. (NAMI-MN, September 2010).

The perceptions correctional officers have towards inmates with mental illnesses, and how effective they view their current training in mental health, is important. Correctional officers have the most contact with inmates, and are responsible for carrying out the policies and procedures their facility has put in place (Appelbaum et al., 2001). Farkas (1999) states, "The underlying beliefs and values held by correctional officers set the tone for interactions between staff and inmates" (p. 496). Correctional officers often have an influence on what policies and procedures correctional management set in place in the facility (Appelbaum et al., 2001).

This study seeks to assess the views correctional officers have towards working with inmates who have mental illnesses, and how effective they view the mental health training they have received at their institution. Correctional officers who are employed in two jails in Minnesota will be surveyed. This study evaluates if correctional officers view working with inmates with mental illnesses in a positive way, and if their correctional

facility has provided them with adequate mental health training. If CIT training is not available through the facility where they are currently employed, correctional officers can take CIT training through other agencies. Correctional officers who have been CIT trained were present in the sample.

## **Literature Review**

### **Background**

An estimated 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates (totaling 1,264,300 inmates) had a mental health problem in 2005 (James & Glaze, 2006). Coinciding with the prevalence of inmates with a mental disorder are high rates of inmates with a co-occurring disorder of substance abuse, with an estimate of 74% state prisoners and 76% of jail inmates (James & Glaze, 2006).

The New Freedom Commission on Mental Health was aimed at examining the delivery of mental health systems our nation offers. After a yearlong study, the Commission sent a letter to the President stating:

Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities (July 22, 2003, p.1).

Individuals with mental illnesses are often poor, homeless, have a drug or alcohol addiction, break the law and end up incarcerated (Fellner, 2006b). This has led to what has been called the “criminalization the mentally ill” (Abramsky & Fellner, 2003; Fellner 2006b). In 1999, the Bureau of Justice Statistics (BJS) found 30% of jail and 20% of prison inmates with mental illnesses reported being homeless or living in a shelter a year

prior to their arrest, and more than 60% of inmates with mental illnesses were under the influence of drugs or alcohol at the time of their arrest.

Inadequate mental health treatment in communities, individuals with high rates of co-occurring disorders, and policy attitudes surrounding the “war on crime,” has pushed for harsher sentences for drug and non-violent crimes (Fellner 2006a); leading to a “revolving door” of persons with mental illnesses repeatedly cycling through the criminal justice system (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006).

While being incarcerated can bring about emotional distress in most individuals, a period of incarceration often intensifies symptoms for those living with a mental illness (Appelbaum et al., 2001; Ditton, 1999; Fellner, 2006a, 2006b; Spearit, 2004). Most facilities are unable to provide adequate mental health treatment based on factors such as: understaffing, lack of programming, conflicting staff views, and correctional facilities’ rules and regulations that restrict a rehabilitative culture (Feller, 2006a, 2006b). Studies indicate correctional facilities differ immensely in regards to the management, treatment, and attitudes towards the treatment of inmates with mental illnesses. (National Institute of Corrections [NIC], February 2001)

### **Screening**

The implementation of screening offenders for mental health concerns has led to the awareness of dramatic increase in rates of inmates with mental illnesses (Abramsky & Fellner, 2003; Fellner 2006a, 2006b). The type of screening assessments, and when inmates are assessed for mental health treatment, varies within correctional facilities (Abramsky & Feller, 2003). In 2006, BJS measured the prevalence of mental health problems occurring in correctional settings from personal interviews conducted of state

prisoners in 2004 and jail inmates in 2002. Rates were measured and defined by a recent history of a clinical diagnosis of mental health symptoms based in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000). The BJS results showed:

More than two-fifths of state prisoners (43%), and more than half of jail inmates (54%) reported symptoms that met the criteria for mania. About 23% of state prisoners and 30% of jail inmates reported symptoms of major depression. An estimated 15% of state prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder (p.1).

Despite the BJS showing 95% of state facilities and 85% of community-based facilities provide mental health screening and treatment for inmates (Beck & Maruschak, 2001), the screening process can often be problematic for a number of reasons. Most facilities do not have appropriate facility tracking databases; some inmates do not report symptoms; records may not follow the inmate if they are transferred; and inmates who may develop symptoms after intake are often not identified (Abramsky & Fellner, 2003). An interview conducted with the chief deputy clinical head of services at an unnamed California State Prison, stated their prison's tracking database is "horrible as a management tool, which affects inmate care. It's harder to monitor whether they're getting what they're supposed to be getting" (Abramsky & Fellner, 2003, p.102).

### **Inmates with Mental Illnesses**

The characteristics and needs of inmates with mental illnesses differ than those inmates who do not suffer from mental health symptoms. The National Institute of Corrections' (NIC) *Effective Prison Mental Health Services Manual* (2004) states,

inmates with mental illnesses, "...may need extra medical attention, treatment, medication, security, suicide precautions, special programming, rehabilitative services, case management, or transition services" (p. 5). Individuals with mental illnesses can present with a wide range of symptoms of varying degrees. The DSM-IV-TR (2000) 4th ed., text rev, published by the American Psychological Association (APA), provides criteria used to identify mental health symptoms and the classification of mental disorders. DSM-IV-TR organizes disorders on an axis system.

Axis I disorders such as schizophrenia include the presence of psychotic symptoms, or other serious dysfunction, inmates may experience delusions, hallucinations, chaotic thinking, or serious disruptions of consciousness, memory, and perception of the environment (APA, 2000). Depressive symptoms seen in major depressive disorder can affect an individual from caring for one's self and increase irritability (APA, 2000). Individuals with Axis II personality disorders such as: borderline and antisocial personality disorders often have a difficult time with interpersonal relationships and impulse control (APA, 2000). These individuals can present as: manipulative, volatile and disruptive, and are likely to engage in aggressive, impulsive behavior, including assaults on others (Abramsky & Fellner, 2003, Fellner, 2006b). If symptoms are not treated individuals may also be at a high risk for self-mutilation and risk of suicide (Abramsky & Fellner, 2003). The number one cause of death in correctional settings results from suicide (Hayes, 2006).

The in 2006, 43% of state and 54% jail inmates reported symptoms that met the DSM-IV-TR criteria for mania; 23% of state prisoners and 30% of jail inmates reported



symptoms of major depression; 15% of state prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder (James & Glaze, 2006).

### **“Ill-Equipped” Facilities**

Traditionally the criminal justice and mental health systems operate on opposing values and missions of “punishment” and “rehabilitation.” Prisons and jails were never intended to become primary mental health care facilities, often over crowded, and understaffed (Fellner, 2006a). Timely access to psychiatric and medical services, or specialized living units for inmates with mental illnesses and disabilities takes numerous days to reach, or simply does not exist in some institutions (Abramsky & Fellner, 2003). Abramsky and Fellner (2003) state, “Such delays are primarily due to lack of staff and lack of space, and sometimes a lethargic bureaucracy plays a part” (p.162).

Correctional facilities operate under strict policies and procedures. Inmates are expected to obey facility protocols. Inmates with mental illnesses often have difficulty understanding, and conforming to the rules of correctional facilities (Abramsky & Fellner, 2003; Fellner, 2006b; Hill et al., 2004). Prison or jail inmates who had a mental health problem are more likely than those without to have been charged with breaking facility rules since admission (James & Glaze, 2006). Frequently the behaviors displayed are the result of distress, and untreated symptoms they are experiencing related to mental illnesses (Abramsky & Fellner, 2003; Fellner, 2006b; Hill et al., 2004). The BJS found inmates with mental illness were more likely to be involved in fights with other inmates, and receive punishment for behavior infractions (Ditton, 1999). In a 2004 summary titled, *Mental Health in the House of Corrections*, prisoner surveys in New York prisons found

disciplinary sentences are thirty-eight months longer than inmates without mental illness with a rate of five months.

Punishments for behavior infractions differ between correctional institutions. Disciplinary violations can result in a “write up,” or often a transfer to segregation (Abramsky & Fellner, 2003; Feller, 2006b). Punishments resulting in segregation often exacerbates symptoms in inmates with mental illnesses. Prolonged periods of isolation when individuals are placed in segregation have detrimental effects for a person with a psychiatric disorder (Abramsky & Fellner, 2003). In an email to the Human Rights Watch included in Abramsky and Fellner’s book, *Ill Equipped: US Prisons and Offenders with Mental Illnesses*, Psychiatrist Dr. Terry Kupers explains:

Prisoners who are prone to depression and have had past depressive episodes will become very depressed in isolated confinement. People who are prone to suicide ideation and attempts will become more suicidal in that setting. People who are prone to disorders of mood, either bipolar...or depressive will become that and will have a breakdown in that direction. And people who are psychotic in any way...those people will tend to start losing touch with reality because of the lack of feedback and the lack of social interaction and will have another breakdown, whichever breakdown they’re prone to (p.152).

Inmates with mental illnesses placed in segregation often experience very tragic outcomes. A 2005-2006 study conducted by the NIC found 38% of inmate suicides occurred in isolation, and 38% of those inmates who had completed suicide had a history of mental illness. Prisoners surveyed in New York prisons discovered 40% of inmates with a mental illness in disciplinary lockdown reported acts of self-harm. Over half

(55%) of those who reported committing an act of self-harm, or attempted suicide also reported receiving a ticket for misbehaving (Correctional Association of New York, 2004).

While most facilities have tried to incorporate mental health treatment for inmates, administration of medication is the most common form of treatment offered (Abramsky & Fellner, 2003; James & Glaze, 2006). In 2006, the BJS concluded about 27% of state prisoners, 19% of federal prisoners, and 15% of jail inmates had taken prescribed medication for a mental problem upon admission. In some states medication had been denied or prescribed by staff without proper licensure and without follow up appointment (Abramsky & Fellner, 2003).

Correctional facilities do not allow privacy while inmates take medications. Abramsky and Feller (2003) list reasons why inmates may decide against taking medications. Most facilities require inmates to stand in a line in the view of other inmates up to twice a day depending on their prescribed times. Inmates who take medications have been labeled as “bugs,” which is slang for inmates who have a mental illness. Inmates who are newly booked from a different facility will often be forced to discontinue their medication, and have to wait days or weeks to be seen again by another psychiatrist if one is available.

### **Correctional Staffs’ Perceptions of Rehabilitation**

Correctional officers have always remained a constant and vital fixture in jails and prisons. Where public and political views have generally held a punitive stance in dealing with inmates regardless if they have a mental illness, the views of correctional officers’ have been mixed (Cullen, Lutze, Link, & Wolfe, 1989).

Research evaluating correctional staffs' professional orientation towards punishment and rehabilitation has been widely documented throughout the decades. Studies have focused on individual and organizational determinates in correctional officers' views of rehabilitation (Cullen et al., 1989; Farkas, 1999; Farkas, 2001; Jurik, 1985; Maahs & Pratt, 2001; Philliber, 1987; Whitehead & Lindquist, 1989), and use of force (Hemmens & Stohr, 2001). Other correctional staff such as prison wardens (Cullen, Latessa, Burton, & Lombardo, 1993) and the inclusion of administration and treatment staffs' perceptions regarding rehabilitation have also been documented (Kiefer, Hemmens, & Stohr, 2003).

Farkas (2001) and Philliber (1987) provide an extensive review of literature based on the individual and organizational factors influencing correctional officers' views of rehabilitation in correctional facilities. Both comprehensive reviews conclude similar findings based on their results. Philliber and Farkas both find correctional officers are supportive of maintaining order, as well as providing rehabilitation for support. Although each of the reviews of literature was concluded decades apart, each paper identifies similar conclusions mentioning their findings were inconsistent and confusing (Philliber, 1987). Farkas states, "Overall, though, the results of many of the studies were confusing, with mixed conclusions. Findings varied with sample size, type of methodology, length of study, and attitudinal definitions and measures" (p. 6). Results concluded in the literature reviews from Cullen et al. (1989), Jurik, (1985) and Whitehead and Lindquist (1989), were based on examining individual and organizational factors of correctional officers influencing their views of rehabilitation.

**Individual Determinants**

Cullen et al. (1989) and Jurik (1985) both concluded that officers who were minorities had more positive views of rehabilitation than officers who were white; Cullen et al., specifically finding African American officers held more rehabilitative views towards inmates. However, Whitehead and Lindquist (1989) did not find similar results in white officers having a more punitive approach. Differences in these findings have been suggested to be due to the differences in the racial disparities of each sample (Whitehead & Lindquist, 1989). Each study also concluded gender and educational background did not have an impact on custodial or rehabilitative views. However, Kiefer, Hemmes, and Stohr's (2003) study did find women held more positive views of rehabilitation.

Jurik (1985) noted older officers held more favorable views towards inmates. Cullen et al. (1989) and Whitehead and Lindquist's (1989) results found officers who became a correctional officer at a later age held more rehabilitative views. Cullen et al. sought to distinguish between chronological age and years worked by computing the "correctional work entry age" with number of years worked. Whitehead and Lindquist attempted to expand on Cullen et al.'s research and found similar results. A more recent finding in Farkas (1999) concluded officers who had worked longer at the facility expressed more rehabilitative views, where Jurik found a negative correlation between number of years as a correctional officer and rehabilitative views. Hemmens and Stohr (2001) specifically examined perceptions of use of force in officers, and concluded officers who have worked one year or less were more in support of utilizing force than those officers who have worked more than ten years. Kiefer et. al (2003) found

correctional officers with less years served as a correctional officer had more positive views of rehabilitation. Pre-service officers in Paboojain and Teske (1997) demonstrated officers who were older, of minority, and who had not yet begun working at a correctional setting, held more supportive views of treatment programs. However, the survey used did not measure if pre-service officers had past employment in a correctional setting. Therefore, results could not account for findings that demonstrated correctional officers who worked longer facilities held more positive views towards rehabilitation (Farkas, 1999).

### **Organizational Determinants**

Organizational factors have also yielded mixed results; favoring more rehabilitative views amongst correctional officers. Higher custodial views were seen in relation to work conditions of role confusion (Cullen et al., 1989). Farkas' (1999) results concluded correctional officers who reported high conflict in their roles listed less support for counseling roles, but did not also report a more punitive view. Results may indicate officers maybe unsure of what role to play in their positions in a "get tough era" (Farkas, 1999). Seventy-three percent of officers in this study disagreed that rehabilitation programs were a waste of time and money, but 63% also responded correctional officers should not be responsible for carrying out counseling roles (Farkas, 1999).

The different types of correctional settings may also have an impact on correctional officers' views. Cullen et al. (1989), Jurik (1985) Whitehead and Lindquist (1989), all surveyed officers in various levels of prison settings. Farkas (1999), however, surveyed all officers from community corrections settings, in local jails. Where prison

settings generally have inmates for longer periods sentences, jails normally face a constantly changing population of inmates serving shorter sentences (Farkas, 1999). Hemmens and Stohr (2001) confirmed the level of security influences the views correctional officers have regarding the use of force. Results indicated the use of force is more favorable in maximum-security prisons than in jails, minimum security and women's prisons. Jurik also found officers in minimum-security prisons held more positive view of inmates. Cullen et al. did not show similar results based on prison level of security, but did find officers who worked the night shift held more custodial views. This result could be because inmates during this time are generally "locked down" (Cullen et al., 1989). In jails, Farkas showed officers who worked the night shift held greater punitive views, but also held more positive views for rehabilitation programming. This result maybe due to jails having more programming in their facilities, but little programming occurs at night (Farkas, 1999).

Other organizational influences that have been documented lie in the staffing of facilities. Kiefer, Hemmes, and Stohr's (2003) results not only included results from two jails, three prisons, and one detention facility; but also included the results from all staff, not just correctional officers. Hemmens and Stohr (2001) originally surveyed all staff in different facilities, but only opted to include results from correctional officers since the area of interest was use of force. Kiefer et al.'s outcomes included 382 security staff, twenty-one treatment staff, and fifty administration staff. All staff in their institutions listed the value of custody and control first. Results were higher for those staff employed in maximum-security prisons.

Cullen, Latessa, Burton, and Lombardo's (1993) national study of prison wardens yielded positive results in favor of rehabilitation, and areas to expand programming. This result goes against Farkas' (1999) reasoning for county corrections officers showing more positive views. Results from this study also indicated wardens who were of minority and had previously served as correctional officers, held more favorable stance towards rehabilitation. Higher education results were shown to influence wardens' belief that treatment helped inmates, but views directly related to education were similar to Cullen et al. (1989) and Jurik (1985), indicating results were insignificant (Cullen, Latessa, Burton, and Lombardo, 1993).

### **Correctional Officers' Views of Inmates with Mental Illnesses**

While individual and organizational factors have been widely researched in correctional officers' professional orientation, correctional officers' views of inmates with mental illnesses has not been as extensively researched. An early study conducted by Kropp, Cox, Roesch, and Evans (1989) surveyed eighty-five correctional officers, and noted inmates with mental disorders were perceived less favorable than inmates without mental disorders. Correctional officers indicated those inmates with mental disorders were seen as less rational, less understandable, and less predictable. A more recent study by Lavoie, Connolly, and Roesch (2006) noted that while correctional officers also perceived inmates with mental disorders as unpredictable and irrational, they also perceived these inmates to be more "good," where inmates without a mental disorder were perceived as more "bad." Eighty-percent of maximum- security correctional officers believed inmates with mental disorders needed praise, affection, and could be more rehabilitated (Lavoie, Connolly, and Roesch, 2006). This supports research



demonstrating correctional officers do not solely hold traditionally punitive stances, and does not support Hemmens and Stohr (2001) findings of correctional officers in maximum prisons favor use of force. Lavoie et al. also found inmates with a mental disorder were viewed as more dangerous, aggressive, and harmful when compared to someone in the general public with a mental disorder. Reasons for influencing this finding were that individuals in prison had committed crime (Lavoie et al., 2006).

### **Mental Health Training**

Examining correctional officers' views regarding their professional orientation towards rehabilitation and of inmates with mental illnesses have been vital in the areas of training and collaboration of correctional staff. Despite many correctional officers in support of rehabilitation and viewing inmates with mental disorders in a positive nature (Lavoie et al., 2006), correctional officers have voiced concern. Finn (2000) and Kropp et al. (1985) identified working with inmates with mental illnesses was a source of stress for correctional officers. While correctional officers in Lavoie et al.'s sample did not indicate a direct correlation between working with inmates with mental illnesses and burnout, 81% indicated working with inmates who had a mental disorder was stressful. One of the major areas Lavoie and colleagues (2006) found was that a majority of officers who worked at a maximum-security prison had mental health training at some point through: education, facility, workshops; and had favorable views of inmates with mental illnesses, but 80% of those officers did not feel their training had prepared them to work with inmates who had mental disorders.

Callahan (2004) surveyed correctional officers from all Department of Corrections in a midwestern state who had the potential to work with inmates with mental

disorders. Correctional officers who attended this special mental health training, as well as officers who attended a mandatory correctional mental health training were included in this sample, for a total of 1,877 participants. Officers were given a survey with questions assessing attitudes, as well as a vignette demonstrating an inmate who was experiencing symptoms of schizophrenia, major depressive disorder, or no disorder. The vignettes also portrayed the presence or absence of violence displayed by the inmate. Results demonstrated a high amount of correctional officers were able to accurately identify symptoms pertaining to schizophrenia and major depressive disorder. Officers also related substance use and brain chemistry as possible causes for schizophrenia and major depressive disorder. Correctional officers also believed the inmate described in the vignettes should voluntarily see a counselor. If the inmate displayed any violent behaviors correctional officers supported forced treatment of talking with a counselor and taking medications, even if there was no presence of a mental disorder.

Callahan's (2004) study did not specify the type of mental health training provided, and the how long the sessions were taught. Parker (2006), on the other hand, examined results of correctional officers who attended a ten-hour mental health training. NAMI helped develop the training that was given to officers who worked in a "supermax" unit in an Indiana Prison. The training consisted of five, two-hour, weekly sessions. Each session was broken down into specific areas pertaining to mental disorders: categories of psychiatric disorders, biology of mental illnesses, treatment of mental illnesses, and effective interactions for working with individuals who have mental illnesses. The trainings included lecture, role-plays, and consumer panels that shared personal experiences of living with a mental illness. However, the training was aimed at

decreasing the use of force correctional officers used and the number of incidents of battery utilizing bodily waste. Where Callahan did not mention the specifics of the mental health training officers were trained in, Parker's study gave an in depth discussion of the mental health training officers were given. Both studies examined only correctional officers who would have contact with inmates with mental illnesses; however, each study differed in what they assessed. Callahan aimed to examine mental health training, and correctional officers' perceptions of inmates with mental illnesses; where Parker examined the effectiveness of mental health training in reducing use of force in a correctional facility.

A survey of 179 respondents varying from sheriffs, jail administrators, medical personnel, and other staff representing the jail systems in all 95 counties in Tennessee, revealed 65 of the jail systems provided in-service mental health training. Trainings varied in regards to the type and how often the information presented. Twenty-three jail systems reported utilizing a one-hour annual training conducted by the Tennessee Corrections Institute (TCI). Eight jails implemented the one-hour TCI training; as well as in-service training from various mental health professionals. Twenty-three systems utilized the TCI training in accordance to quarterly mental health crisis training; eight systems indicated their staff acquired ten hours of mental health training a year; and one facility listed staff attended monthly mental health trainings. Out of the 65 facilities that implement one of the above noted trainings, 55 (88.7%) of the facilities indicated they would like more training (Diehl & Hiland, 2003).

### **Crisis Intervention Team Training**

The history of Crisis Intervention Team (CIT) training dates back to 1988, which has been a model widely accepted and utilized by law enforcement agencies across the nation (CHPPR, 2007). The Memphis CIT model became a pre-booking diversion tool for law enforcement in preventing people with mental illnesses unnecessarily becoming incarcerated (CHPPR, 2007; NAMI-MN, September 2010). This CIT model is an in-depth 40-hour training based on a foundation of effectively interacting with individuals who have mental illnesses. It was developed in collaboration with NAMI and other advocacy organizations; it has become known as the “Memphis Model” (CHPPR, 2007; NAMI-MN, September 2010). The University of Memphis provides an article documenting this particular model’s core elements (Dupont, Cochran, Pillsbury, 2007). The training’s core is rooted in the collaboration of advocates, providers in mental health and criminal justice, and consumers. The training provides officers skills in how to recognize symptoms of mental illnesses, de-escalation techniques, and where to connect individuals to available resources. The format of training includes: lectures, role-plays, activities, site-visits, and consumer panel discussions. Consumer panel discussions allow for officers to hear directly from those who have a mental illness, or hear from those who have a loved one with a mental illness. This CIT model is a nationally recognized program that has been shown to elicit numerous benefits for officers, the community, and individuals with mental illnesses (CHPPR, 2007). CIT has improved officers’ responses in working with individuals during a mental health crisis, and linked law enforcement officers with local mental health community programs (CHPPR, 2007). In 1999, CIT was recognized at a White House Conference on Mental Health as a best practice (CHPPR, 2007). Organizations such as NAMI and NIC have both advocated for the

implementation of CIT in all law enforcement agencies, as well as the expansion into correctional facilities.

Implementing CIT in correctional facilities is a newer intervention that is aimed to help both staff and inmates in correctional facilities. The implementation and evaluation of the expansion of CIT in Maine's county jails was documented in a 2007 report conducted by The Center for Health, Policy, Practice, and Research (CHPPR) located at the University of New England. The results have shown to be highly effective in not only reducing use of force by correctional officers, but also increasing a more accurate, positive view of mental illnesses, and more specifically inmates with mental illnesses. Before the implementation of CIT in the Maine's community correctional facilities, correctional officers reported, "... [they] did not feel adequately trained in crisis intervention" (p.4).

The report titled, *Crisis Intervention Team (CIT) Training for Correctional Officers* (CHPPR, 2007), painted a positive picture how CIT influenced the seven facilities where it was put into action. A focus group of post-trained correctional officers expressed they gained to knowledge in mental illnesses, substance abuse, and skills to effectively work with inmates who were experiencing symptoms. Officers reported being better able to evaluate inmates' mental health symptoms, and utilize interventions in working with inmates showing signs of a mental illness. Results also indicated officers responded highly positive to the way the material was presented. Officers stated the inclusion of a consumer panel, "...felt this helped them empathize with individuals and families" (p.19), and "...the role-playing activities and site visits were helpful components and that the training was an opportunity to learn about local resources" (p.

19). Statistics in the report showed CIT incidents involving verbal de-escalation resulted in 55% versus 25% involving use of force. The most common intervention was a referral to a mental health professional indicated by 44% of officers. If an inmate was perceived as being aggressive, use of force was more likely to be the common intervention.

### **Collaboration**

The behaviors and actions of both inmates and staff have implications for the correctional facility (Dvoskin & Spiers, 2004). The perspectives corrections employees embrace have a profound impact on the implementation of the way facilities operate, often affecting the hiring and training requirements that are put into service (Kifer et al., 2003).

A predominate goal of correctional settings has been the safety and security of staff and inmates that have strict policies and procedures that generally reflect this belief (Fellner, 2006a). Providing both security and rehabilitation has brought tension, and created a divide between professionals whose ethical backgrounds reside in one or the other (Fellner, 2006a). Correctional officers and mental health professionals have often held different views of each other's role. For example, some correctional officers view mental health providers as, "...soft, gullible, and coddling of inmates" and some mental health professionals may view correctional staff as being, "...unnecessarily harsh and punitive" (Appelbaum et al., 2001, p.2).

There are no national guidelines documenting the number or what type of mental health professionals facilities must employ (Hill et al., 2004). Despite the differences in: the numbers of staff employed, facility structure, screen tools for mental illnesses, policy and procedures in how to handle incidents involving inmates with mental illnesses, and

the training available, one common theme emerging from the literature is the importance of collaboration between all correctional staff. Appelbaum, Hickey, and Parker (2001) discuss the importance of correctional officers in a multidisciplinary team. Regardless of the level of security of the institution, correctional officers spend the most time with inmates. Clinicians only have brief contact with clients. Officers are typically the first people to recognize changes in an inmate's behavior, or mental health (Appelbaum et al., 2001; Dvoskin & Spiers, 2004; Schlosser, 2006).

Even if on the surface correctional officers and mental health professionals may have opposing views of one another's roles, there in lies common values and beliefs within all correctional facilities (Appelbaum et al., 2001; Dvoskin & Spiers, 2004). Dvoskin and Spiers (2004) indicate the common shared values and beliefs held in correctional facilities are: "1) keep everyone safe; 2) prevent escapes; 3) minimize human suffering; 4) maximize morale; 5) help maintain systematic operations" (p.46).

The collaboration between correctional staff has been deemed essential in the delivery of adequate services to inmates. In a 2006 article titled, *A Framework for Correctional/Mental Health Partnership*, clinical psychologist Erik Schlosser, states there is often a misunderstanding.

...they [correctional officers] may have no understanding of our work. In the same way that mental health staff may not know or appreciate the types of nonlethal and lethal force, correctional staff may not understand what mental illness is, how therapy works or who gets medications (p.1).

To coincide with this notion Dvoskin and Spiers (2004) state, "Mental health professionals are to be trusted, we must not only to train, but to be trained" (p.17).

To help demonstrate the importance of both correctional and mental health staff as being a part of an interdisciplinary team that carries out common goals, Massachusetts developed a specialized training. Appelbaum and colleagues (2001) cited the DOC-Massachusetts conducts a cross-training program. New clinical staffs are required to attend a weeklong training provided by correctional officers. This training (as cited in Appelbaum, 2001) is implemented to open mental health staffs' perceptions to the duties correctional officers carry out on a day-to-day basis and the importance of maintaining the security of the facility. The correctional officers also attend suicide prevention and mental health trainings. While research has demonstrated correctional officers maintain rehabilitation and punishment are both necessary in correctional settings, Farkas (1999) illustrates 63% of correctional officers believe it is the job of mental health staff to carry out rehabilitative interventions. The evaluation of Maine's CIT training for jail correctional officers supports this view by finding the most common intervention for handling an inmate with mental illnesses is a referral to a mental health professional (CHPPR, 2007). On the other hand, Dvoskin and Spiers (2004), suggest counseling and psychotherapy are key elements to increase collaborative efforts and adequate services to inmates, which correctional officers should participate. A key factor to increase collaboration has been the necessity of effective communication. One of the essential steps to assist this has been the identification of a common language between staff. NAMI-Maine's initiative (2007) and Parker's (2006) results included correctional officers expressed the clinical knowledge used to describe psychiatric disorders was often confusing and too technical.



### **National Guidelines for Mental Health Treatment**

All inmates, especially inmates with mental illnesses, can benefit from more therapeutic services. National organizations such as the American Psychological Association (APA) and the National Commission on Correctional Health (NCCHC), as well as various court rulings, have mandated inmates are entitled access to mental health services (Abramsky & Fellner, 2001); however, correctional facilities across the nation have different policies and procedures for treating inmates with mental illnesses. The APA and NCCHC have established guidelines to assist facilities in providing adequate mental health services (Hill et al., 2004). These guidelines have identified: screening tools, specialized living units, crisis intervention, chemical dependency treatment, release planning, and administering more recent psychiatric medications are all recommendations correctional facilities should implement for treating inmates with mental illnesses (Abramsky & Fellner, 2001; National Commission on Correctional Health Care [NCCHC], 1999).

### **State of Minnesota Corrections**

The Minnesota Department of Corrections estimates 75% of women and 25% of men in prisons are receiving psychiatric or psychological care, and an estimated 60% of jail inmates have a mental illness (NAMI-MN, 2006). In 1999, the NIC surveyed Departments of Corrections (DOC) in the United States to assess the delivery of mental health services offered to inmates. The state of Minnesota was one of the forty-nine states that participated in the survey measuring the delivery of services to currently imprisoned inmates with mental illnesses. While inmates are still given medications to treat mental health disorders, the results indicated Minnesota is one of three states whose prisons

offers specialized mental health services to: juveniles, women, elderly inmates, dual diagnosed substance abusers, sex offenders, ethnic/racial minorities, and inmates housed in super maximum facilities (NIC, February 2001).

A report conducted by NAMI-MN titled, *State of the State: Addressing Mental Health Disparities in the State of Minnesota Criminal Justice System* (September, 2010), illustrates a detailed review of avenues Minnesota has taken to try to improve the gaps between their mental health and criminal justice systems. Along with CIT as a pre-booking diversion strategy, in 2006 Minnesota now requires all county jails to administer the Brief Jail Mental Health Screen (BJMHS) upon intake. To help divert individuals who are in need of treatment services from jail, Minnesota has established two mental health courts and a veteran's court. Reentry services are also provided to individuals being released from Minnesota prisons and jails that have mental illnesses and co-occurring disorders.

While it seems as though Minnesota has begun to take steps to bridge the gap between both the mental health and criminal justice systems, more time and effort are still necessary to increase collaborative attempts (NAMI-MN, September, 2010). NAMI has been a valuable source in continuing this effort, and has been responsible for many of the current policies and programs currently set in place (NAMI-MN, September, 2010).

### **Implications of Previous Literature**

Statistics demonstrated the rates of inmates with mental illnesses are widely prevalent in correctional facilities across the nation. There is a vast amount of research pertaining to the complexity and interconnectedness of the criminal justice and mental health systems. Contributing to the literature is research relating to individual and

organizational factors influencing correctional staffs' views of rehabilitation and inmates with mental illnesses. Studies have also brought to surface correctional staff voicing a need for more mental health training. A wide variation exists in the types and duration of mental health trainings offered to correctional staff. Literature examining and linking variables specific to this study (community corrections officers, perceptions of inmates with mental illnesses, and crisis intervention training) was virtually non-existent. The Center for Health, Policy, Practice, and Research (CHPPR) in Maine's evaluation was the only research specifically related to community correctional officers and the effectiveness of CIT training. Therefore, it was necessary to examine all literature pertaining to variations in these variables. It is imperative to note the disparities in samples, methods, and limitations in the literature reviewed when interpreting the findings.

There were large differences between the research samples assessed. Results from: Diehl and Hiland (2003), Kiefer et al. (2003), and Young and Antonio (2009) included responses from a variety of staff at correctional facilities. Hemmens and Stohr (2001) originally surveyed various correctional staff; however, later limited their sample to correctional officers because the dependent variable pertained to use of force, which correctional officers are responsible for carrying out if needed. Cullen et al. (1993) narrowed their sample to prison wardens throughout the United States. Callahan (2004), CHPPR (2007), Cullen et al., (1989), Jurik (1985), Kropp et al. (1989), Lavoie et al. (2006), Parker (2006), and Whitehead and Lindquist (1989) surveyed only correctional officers. Poboosain and Teske (1997) surveyed pre-service correctional officers; however, the survey questions did not ask if the officers had any past experience as a correctional officer elsewhere.

It is important to note the security level (minimum, medium, and maximum) and the type of state facilities where these officers worked also differed between the samples. Diehl and Hiland (2003) and Farkas (1999) included community correctional staff; however, Farkas narrowed the sample to only community correctional officers. Kiefer et al. (2003) included responses from staff working at prisons, jails, or a detention facility. Cullen et al. (1989), Hemmens and Stohr (2001), and Jurik (1985) specified their procedural methods included survey samples from women prisons.

Limited sample sizes and differences in sampling methods were also a limitation in these studies. The largest number of correctional officers surveyed (n=1877) was in Callahan's (2004) study. Even though the survey was voluntary, the state court ordered the collection and evaluation of the data. Administrators may have urged participants to fill it out. This could have resulted in a higher response rate. In another state evaluation, the sample size of voluntary, Tennessee jail staff only included 179 participants (Diehl & Hiland, 2003). This study was not limited to only staff that may have contact with inmates who have mental illnesses, where Callahan's study was. Sample sizes examining correctional staff included 465 staff in Young and Antonio (2009) and 467 staff in Kiefer et al. (2003).

Instruments used to assess the attitudes of correctional staff and the effectiveness of the training they had received, also varied between studies. The variation between all the samples reviewed in literature limits the generalizability to relate the findings to all correctional officers in the United States. For this research, results cannot be generalized to be the views of all correctional officers working in Minnesota county jails.

### **Conceptual Framework**

The theoretical framework guiding this study was based in systems theory. The systems perspective identifies human behavior as the result of interactions of people operating within connected social systems (Hutchinson, 2008). Psychologists Kurt Lewin, Uri Bronfenbrenner, and biologists Ludwig von Bertalanffy were important figures in social work adopting systems theory. Applying the systems theory model became widely used during the 1960's, as the impact of the environment became a central aspect in examining behavior (Hutchinson, 2008). This shift caused movement away from the more predominant psychiatric model at the time. The central ideas of systems theory are: systems are made up of members who are interrelated creating a linked whole; each system impacts other systems and the whole system; all systems are subsystems of other systems (Hutchinson, 2008). The concepts of roles and boundaries are essential when examining the interactions among systems; they produce both change and stability (Hutchinson, 2008).

The foundation of social work rests in examining client systems on the micro, mezzo, and macro levels. Social workers try to "...understand the functioning of and the resources within each of these systems, including their settings, their clients, their communities, and themselves" (Miley, O'Melia, & Dubois, p. 43). Clinical social workers that work in correctional facilities are exposed first hand to the impact of varying systems. Working with inmates often includes examining family and neighborhood systems the individual is a part of. State and legislative systems are also important to look at, as these systems are responsible for sentencing guidelines for crimes committed. The subject of recidivism shows the influence micro, mezzo, and macro levels systems have

in individuals not being arrested again. Family support and access to resources like housing and employment are essential in reducing recidivism. Offenders being released with mental illnesses have shown to need additional support from mezzo level community systems in remaining out of correctional facilities. Influencing mezzo level community-systems are macro level government systems, which impact funding available to maintain access to community resources.

For this research, correctional facilities are considered an entire system composed of subsystems. Inmates make-up the micro systems; correctional officers frame the mezzo systems, and the larger macro system is composed of facility administration, policies, and procedures. Correctional facilities show how the influence of systemic concepts like that of roles and boundaries impact one another. Inmates and correctional officers are expected to fulfill different roles in the facilities, which comes with certain expectations of them. Review of the literature demonstrated that while the main goal of correctional facilities is to provide safety of staff and inmates, the role of correctional officers has become ambiguous. The policies and procedures carrying out safety and security have been heavily influenced by certain guidelines varying between facilities. National guidelines mandating the screening and treating of inmates with mental illnesses has lead to correctional officers carrying out roles clinicians often do. Correctional officers are often the staff designated to complete mental health assessments upon the inmates arrival to the facility. The high prevalence of mental illnesses in correctional facilities has called for more education and training for correctional officers in the area of mental health, and effective ways to work with inmates who may be experiencing symptoms.

## **Methods**

The purpose of this research was to explore correctional officers' perceptions of working with inmates with mental illnesses, and their perceptions of how effective the mental health training they have received was when working with inmates with mental illnesses. This section will outline the methods used to complete this research.

### **Research Design**

This research design was a quantitative study and used a survey as a means of data collection. Quantitative research involves measuring variables utilizing numbers and counts (Monette, Sullivan, DeJong, 2008). A combination of descriptive and inferential statistics were incorporated into this study. This research examined correctional officers' perceptions of inmates with mental illnesses, and their views about the effectiveness of their mental health training. Assessing correctional officers' perceptions towards working with inmates who have mental illnesses can possibly influence the mental health training correctional facilities are giving to their correctional staff; possibly creating a safer environment for staff and those incarcerated. Therefore, does mental health training impact the views and abilities correctional officers have when working with inmates who have mental illnesses? Do correctional officers certified in CIT hold more positive perceptions of inmates with mental illnesses? Do correctional officers certified in CIT feel more prepared to work with inmates with mental illnesses? And lastly, does a correctional officers self-reported ability to work to with inmates with mental illnesses influence their perceptions of them?

### **Sample**

Correctional officers working at two county adult correctional facilities in the State of Minnesota were the target populations for this study. Correctional officers varied on a number of demographics such as: age, race, gender, and number of years they have worked at the facility. Approximately 240 surveys were sent out to correctional officers between the two correctional facilities targeted for this research. A total of 70 correctional officers completed the survey and their responses were used in this study.

### **Data Collection**

Research was conducted using an online survey consisting of 30 multiple-choice questions. The survey was created using Qualtrics, which is a survey software system. The administration staff at one county correctional facility was responsible for sending out an email to each correctional officer. This researcher sent out an email to the correctional officers at the second site. Participants had three weeks to complete the online survey, and received a reminder email for completion after two weeks. The survey was voluntary. The researcher developed the survey based on information and trends seen by previous literature. The survey questions consisted of a number of questions that were taken from the questionnaire used in NAMI-Maine's CIT Evaluation, as well as questions developed by the researcher. The Center for Health, Policy, Practice, and Research (CHPPR) developed the survey with the collaboration of National Alliance of Mental Illnesses, Maine (NAMI-ME) to assess correctional officers recently trained in CIT (CHPPR, 2007). To view a copy of the survey see *Appendix A*.

### **Protection of Human Subjects**

An agency consent form was signed by the superintendents at each county correctional facility to survey correctional officers at each of their facilities. The



Institutional Review Board of St. Thomas University provided the agency consent form. To view the agency consent form see *Appendix B*. Each correctional facility also provided a letter of consent to the researcher stating their consent to participate in the study, and allow access to survey correctional officers at their facilities (see *Appendix C*). This researcher also obtained consent from each county the correctional facilities were located in.

Individuals for this study were purposefully targeted for the research, but the confidentiality of all participants was ensured. The email addresses of correctional officers included the first and last name in the their county email address. The survey software, Qualtrics, ensured email addresses were hidden from the researcher upon data collection. Survey questions did not include the specific identification of the participant's name. A survey question was included for the identification of which of the two facilities correctional officers were employed. This was necessary because each facility differs in mental health training requirements.

Survey results were kept on the researcher's computer in a separate, password-protected folder. Results were deleted upon the completion of the research study on May 30, 2011. Research participants were notified that their consent to complete the study would mean their responses would be included in the study. For a copy of the consent for participation see *Appendix D*. The consent for participation served as an introduction to the survey, and was included on the same document as the survey. After the description of the study participants were asked to select 'Agree' or 'Disagree' to signify their consent to participate in the study. Participants who agreed were taken to the survey questions.

## Data Analysis

Data received from the surveys was uploaded and analyzed using SPSS. Both descriptive and inferential statistics were used in this research analysis.

## Results

### Participants

This section outlines the demographics of the participants. Descriptive statistics were conducted to breakdown the participants responses to question items: #1, 'What is your gender?;' #2 'What is your age?;' #3 'What is your race?;' #4 'How many years have you served as a correctional officer?;' #27 'I am certified in CIT.' The participants' responses to these questions gave a representation of the sample population surveyed for this study (see *Table 1*).

Of those participants who indicated their gender, 49 were men and 18 were female. The age range of the participants was 22-55+ years. Participants were predominately white ( $n=59$ ). The years each participant served as correctional officer varied on a range scale of 0-15+ years. Twenty-one participants indicated they were certified in CIT and 49 participants indicated they were not certified in CIT.

Table. 1

*Sample Demographics and Characteristics*

Characteristic	Number	Percent
Gender ( <i>n</i> =67)*		
Male	49	70.0
Female	18	25.7
Age ( <i>n</i> =68)**		
22-34	24	35.3
35-44	17	25.0
45-54	19	27.9
55+	8	11.8
Race ( <i>n</i> =68)**		
White/Caucasian	59	86.8
African American	2	2.9
Hispanic	3	4.4
Asian	1	1.5
Native American	1	1.5
Other	2	2.9
Years Served ( <i>n</i> =70)		
0-3 years	12	17.1
3-5 years	12	17.1
5-10 years	15	21.4
10-15 years	10	14.3
15+ years	21	30.0
Certified in CIT ( <i>n</i> =70)		
Yes	21	30.0

No

49

70.0

*Note.* The characteristic variables of gender, age, race, years served as a correctional officer, and if the participant was certified in CIT are represented. The total number of participants who answered the coded variables is by represented by ( $n=$ ). A percent indicates the percent of participants who selected the coded variables.

Participants were allowed to skip survey questions. \*Three participants did not indicate their gender. \*\*Two participants did not indicate their age, race, and years served.

### **Perceptions of Correctional Officers**

A series of t-tests were conducted to determine the relationship between the demographic variables coded as: gender, age, race, years served, and certification in CIT and participants' perceptions of inmates with mental illness. The dependent variables operationalized by questions #2-#4 were recoded to indicate two possible options.

Question #2, 'What is your age?' was recoded to two categories 1) 22-44 years and 2) 45-55+ years. Question #3 'What is your race?' was recoded to signify if participants' race was 1) White 2) Non-White, and question #4 'How many years have you served as a correctional officer?' was recoded to two options 1) 0-10 years 2) 10-15+ years.

Questions #1 'What is your gender?' 1) Male 2) Female, and question #29 'I am certified in CIT?' 1) Yes 2) No, did not need to be recoded because there were only two, nominal options participants could select.

Perceptions correctional officers have of inmates with mental illnesses were measured by creating a Perception scale. The Perception scale was created with the following question items: #17 'Inmates expressing mental health concerns are usually being manipulative;' #18 'Responding to an inmate experiencing mental health concerns makes my job more stressful;' #19 'I believe inmates with mental illnesses pose a higher

threat to my safety of other inmates than those inmates who do not have mental illness;’ #22 ‘Treating inmates with mental health concerns through rehabilitation programs is a waste of time and money.’ These are ordinal level variables using a Likert scale ranging from 1 to 5 with 1=Strongly Disagree, 2=Disagree, 3=Neither Agree nor Disagree, 4=Agree, and 5=Strongly Agree. Questions #20, ‘I believe incarceration can increase mental health symptoms in people who have a mental illness’ and #21 ‘In my role as a correctional officer, I believe I can play a positive role in helping an inmate with a mental illness work towards recovery.’ These are also ordinal level variables using a Likert scale ranging from 1-5 with 1= ‘Most Definitely’, 2= ‘Definitely’, 3= ‘Somewhat’, 4= ‘Definitely Not’, and 5= ‘No’.

The possible response options to each questions was 1-5. To find each of the participants’ scale score the sum of all the scores to questions 17-22 were averaged. Possible response options of the Perception scale were reverse coded to range from 5= Very Positive and 1=Very Negative. A possible scale score range was 6-30. Participants’ scale score ranged from 10-26. A high scale score represented correctional officers had more positive perceptions of inmates with mental illnesses, and a low scale score signified they have more negative perceptions. T-tests were conducted to determine the relationship between the demographic variables coded as: gender, age, race, years served, and certification in CIT and participants’ perceptions of inmates with mental illness. A p-value of less than .05 indicated a statistical significance (see *Table 2*).

Table. 2

*Mean Perception Scale Score and Sample Characteristics*

Characteristics	N	M	t	p-value	df
<b>Gender</b>					
Male	48	19.1875 (3.20675)**	.585	.561	63
Female	17	18.6471 (3.46304)			
<b>Age</b>					
22-44 years	41	19.4634 (3.29467)	.890	.377	64
45-55+ years	25	18.7200 (18.700)			
<b>Race</b>					
White	57	19.1579 (3.25571)	.226	.822	64
Non-White	9	18.8889 (3.68932)			
<b>Years Served</b>					
0-10 years	34	19.4706 (3.01748)	1.001	.320	64
10-15= years	32	18.6563 (3.57960)			
<b>Certified in CIT</b>					
Yes	19	19.2632	.625	.713	66
No	49	18.9184			

*Note.* A p-value less than .05 indicated a statistical significance. There were no statistical differences between each of the sample characteristics and respondents Perception scale score. Standard Deviations appear in parentheses below the means.

*Table 2* shows the results of the t-test comparing the mean Perception scale scores of the respondents based on: gender, age, race, years served as a correctional officers, and certification in CIT. Male participants mean Perception scale score was 19.19, and female participants' mean Perception scale score was 18.65. That is, men on average have more positive perceptions of working with inmates who have mental illnesses. A p-value of .561 is greater than .05; therefore, men and women do not differ significantly in their perceptions of inmates with mental illnesses.

Participants ages 22-44 years had a mean Perception scale score of 19.46 and participants ages 45-55+ years had a mean Perception scale score of 18.72 indicating younger correctional officers on average held more positive perceptions of inmates with mental illnesses. However, a p-value of .377 is greater than .05, which indicated there was not significant difference in the age of the correctional officers and their perceptions on inmates with mental illnesses.

Those participants who indicated their race was white had a mean Perception scale score of 19.16, and participants who indicated their race was non-white had a mean Perception scale score of 18.89, which assumed on average correctional officers who were white held more positive perceptions of inmates with mental illnesses. A p-value of .822 is greater than .05 leading the results to indicate that correctional officers who are white and non-white did not hold significantly different perceptions.

Participants who reported they served 0-10 years as a correctional officer had a mean Perception scale score of 19.47, and participants who reported serving 10-15+ years

as a correctional officer had a mean Perception scale score of 18.67 indicating on average participants who had served fewer years as a correctional officer had more positive perceptions of inmates with mental illnesses. However, a p-value of .320 is greater than .05 resulting in there not being a statistical difference in the perceptions of inmates with mental illnesses based on the number of years participants had served as a correctional officer.

A t-test was used to answer the research question of whether or not correctional officers certified in CIT hold more positive perceptions of inmates with mental illnesses. Correctional officers who were certified CIT had a mean Perception scale score of 19.26, where correctional officers who were not certified in CIT had a Perception scale mean score of 18.92; indicating on average those officers certified in CIT held more positive perceptions of inmates with mental illness. However, a p-value of .713 is not lower than .05. This research ultimately did not find a significant difference in correctional officers who had been certified in CIT and those officers who were not and their perceptions of inmates with mental illnesses.

### **Ability of Correctional Officers**

Another series of t-test were conducted between the demographic variables coded as: gender, age, race, years served, and certified in CIT and participants' reported ability to work with inmates with mental illness.

An Ability scale was created to measure the self-reported knowledge and ability correctional officers had when responding to inmates with mental illnesses. The Ability scale consisted of the question items: #11 'I am confident in my ability to recognize signs and symptoms of mental illnesses in inmates;' #12 'How prepared do you feel when



responding to inmates with mental illnesses who are in crisis;’ #13 ‘To what extent do you feel you are prepared to respond to an inmate threatening to commit suicide;’ #14 ‘To what extent to you feel you are prepared to respond to an inmate experiencing hearing voices’; and #15 ‘I am adequately trained to verbally deescalate a crisis situation.’

Questions #11 and #15 are ordinal level variables using a Likert scale ranging from 1 to 5 with 1= ‘Strongly Disagree’, 2= ‘Disagree’, 3= ‘Neither Agree nor Disagree’, 4= ‘Agree’, and 5= ‘Strongly Agree’. Questions #12-#14: #12 ‘How prepared do you feel when responding to inmates with mental illnesses who are in crisis;’ #13 ‘To what extent do you feel you are prepared to respond to an inmate threatening to commit suicide;’ #14 ‘To what extent to you feel you are prepared to respond to an inmate experiencing hearing voices’ are ordinal variables using a Likert scale with possible response options ranging from 1-4, with 1= ‘Very Prepared’, 2= ‘Moderately Prepared’, 3= ‘Somewhat Prepared’, and 4= ‘Not at all Prepared’. The reverse coding values are represented as 4= Very Prepared, 3=Moderately Prepared, 2=Somewhat Prepared, and 1=Not at all Prepared.

To find participants’ scale score, their responses to questions 11-15 were averaged. Possible response options of the Ability scale were reverse coded to range from 5=Very Prepared to 1=Not at all Prepared. A possible scale score range was from 5-22. Participants’ calculated scale score range was 8-22. A high scale score reflected that participants felt more prepared to work with inmates with mental illnesses. A statistical relationship required the p-value to be less than .05.

Table. 3

*Mean Ability Scale Score and Sample Characteristics*

Characteristics	N	Mean	t	p-value	df
<b>Gender</b>					
Male	49	15.9796 (3.01033)	.649	.519	63
Female	16	15.4375 (2.52900)			
<b>Age</b>					
22-44 years	40	16.2750 (2.94381)	1.041	.302	64
45-55+ years	26	15.5000 (2.96985)			
<b>Race</b>					
White	57	15.9825 (2.87533)	.836	.406	64
Non-White	9	15.1111 (3.10018)			
<b>Years Served</b>					
0-10 years	34	15.9412 (2.91226)	-.037	.971	64
10-15= years	32	15.9688 (3.16721)			
<b>Certified in CIT</b>					
Yes	19	17.8421 (2.33959)	3.312	<b>.002</b>	66
No	49	15.3265 (2.96780)			

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*Note.* A p-value less than .05 indicated a statistical significance. There were a statistical differences between officers certified in CIT and their Ability scale score Standard Deviations appear in parentheses below the means

*Table 3* shows the results of the t-test comparing the mean Ability scale scores of the respondents based on: gender, age, race, years served as a correctional officers, and certification in CIT. Male participants' mean Ability scale score was 15.98, and female participants' mean Ability scale score was 15.44. That is, men on average self-reported they felt more prepared to work with inmates who have mental illnesses. A p-value of .519 is greater than .05; therefore, men and women did not differ significantly in their preparedness to work with inmates who have mental illnesses.

Participants aged 22-44 years had a mean Ability scale score of 16.28 and participants ages 45-55+ years had a mean Ability scale score of 15.50 indicating older correctional officers on average self-reported they felt more prepared to work with inmates with mental illnesses. However, a p-value of .302 is greater than .05, which indicated there was not a significant difference in the age of the correctional officers and their reported ability to work with inmates with mental illnesses.

Those participants who indicated their race was white had a mean Ability scale score of 15.98, and participants who indicated their race was non-white had a mean Ability scale score of 15.11, which assumed on average correctional officers who were white reported they felt more prepared to work with inmates with mental illnesses. The p-value of .406 is greater than .05 leading the results to indicate participants' race does not influence their perceptions of inmates with mental illnesses.

Participants who reported they have served 0-10 years as a correctional officer had a mean Ability scale score of 15.94, and participants who reported serving 10-15+

years as a correctional officers had a mean Ability scale score of 15.97 indicating on average participants who have served more years as a correctional officer self-reported they were more prepared to work with inmates with mental illnesses. However, a p-value of .971 is greater than .05 resulting in there not being a statistical difference in the ability to work with inmates with mental illnesses based on the number of years participants have served as a correctional officer.

A t-test was used to answer the research question of whether or not correctional officers certified in CIT self-reported they felt more prepared to work with inmates with mental illnesses. Correctional officers who were certified CIT had a mean Ability scale score of 17.84, where correctional officers who were not certified in CIT had an Ability scale mean score of 15.33; indicating on average correctional officers certified in CIT did feel more prepared to work with inmates with mental illness compared to those correctional officers who were not certified in CIT. A p-value of .002 is lower than .05 and this research ultimately did find a significant difference in correctional officers who have been certified in CIT, and those officers who have not and their reported ability to work with inmates with mental illnesses.

### **Correctional Officers' Ability and Perceptions**

A correlational test was used to examine the last research question of: Is there was a relationship between correctional officers' self-reported ability to work with inmates with mental illness and their perceptions of these inmates? First, measures of central tendency were used to find the average scores on each scale (see *Table 4*).

Table. 4

*Relationship between Ability and Perception Scale Scores of Participants*

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	Ability Scale	Range	SD
Ability Scale ( <i>n</i> =68)	16.0294	8-20	3.01227
Perception Scale ( <i>n</i> =68)	19.0147	10-26	3.43160

*Note.* The Ability scale includes the average of participants' responses to question items #10-14.

The Perception scale is the average of the participants' responses to question items #16-21.

<sup>a</sup>Two participants did not respond to one question item coded in the Ability and Perception scales. Therefore, two values were not included in the mean results for each scale.

The mean score on the Ability scale was 16.01, and is the average of all the scores to the participants' responses to question items #11-15. The scale score range of 8-20 represented the distance from the lowest score to the highest score in the distribution. A high scale score reflected that participants felt more prepared to work with inmates with mental illnesses. The standard deviation depicted a 3.01 spread between the scores from the mean.

The mean score on the Perception scale was 19.01, which was the average of the all the scores to the participants' responses to question items #17-22. The scale score range of 10-26 represented the distance from the lowest score to the high score in the distribution. A high scale score reflected that participants had more positive perceptions of inmates with mental illnesses. The standard deviation showed a 3.43 spread between the scores from the mean.

A Person Correlation (r-value) indicated the strength and direction of the relationship between the dependent variables of the Ability scale and the Perception scale. A p-value less than .05 indicated if there is a statistically significant relationship between the participants' self-reported ability in working with inmates with mental illnesses and their perceptions of these inmates (see *Table 5*).

Table. 5

*Pearson Correlation Between Self-Reported Ability and Perceptions of Inmates with Mental Illnesses*

	Ability Scale ( $n=68$ )	(p-value)
Perception Scale ( $n=68$ )	$r=.243$	.047

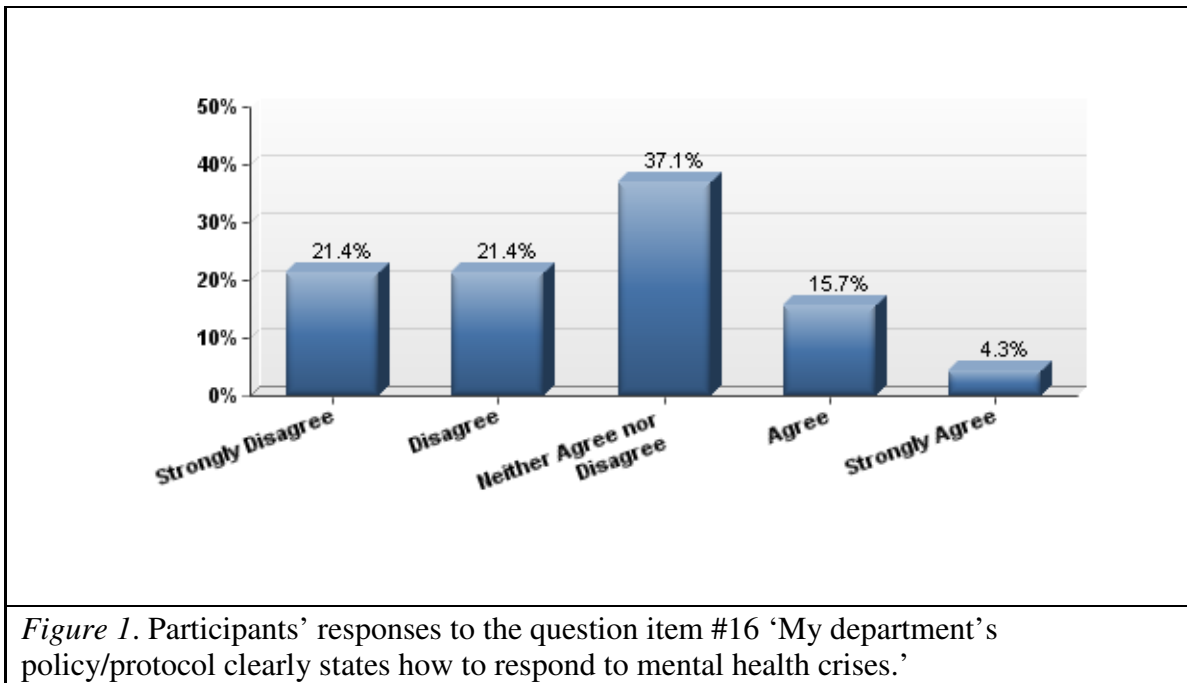
*Note.* The r-value indicates a weak, positive relationship between two variables.

The final research question for this study was: Does a correctional **officers'** self-reported ability to work with inmates who have mental illnesses influence their perceptions of them? *Table 5* shows a correlational relationship between the two variables, Ability scale and Perceptual scale. The calculated correlation ( $r=.243$ ,  $p<.047$ ) indicated a weak, positive correlation. This demonstrated participants who self-reported they felt more prepared to work with inmates with mental illnesses also had more positive perceptions of them as well. Indicating that feeling prepared to work with inmates with mental illnesses increases correctional officers' positive perceptions of them as well.

### **Correctional Officers' Views about Mental Health Training in their Facility**

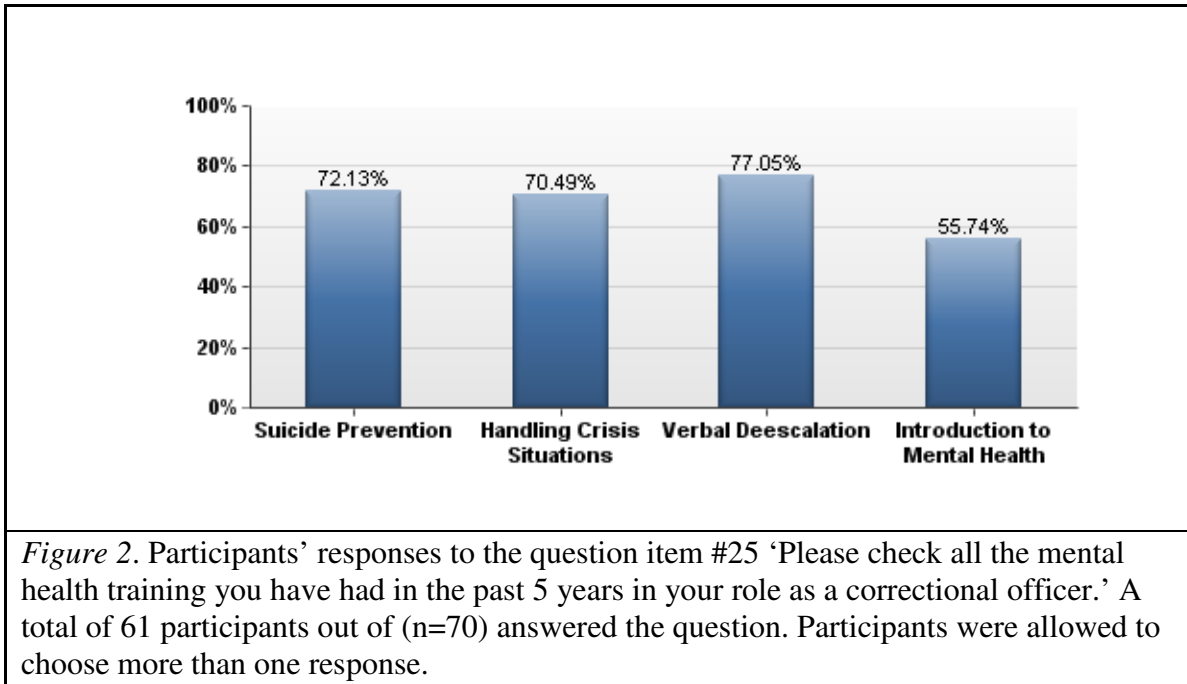
The survey used in this research also asked participants to indicate the mental health training they have received at the correctional facility where they were currently employed. The two correctional settings where the surveys were distributed each differed in the mental health training they offered to correctional officers.

Descriptive statistics were used to analyze participants' responses to question #16, 'My department's policy/protocol clearly states how to respond to mental health crises,' (see *Figure 1*). A majority of the correctional officers (21.4%= 'Strongly Disagreed' & 21.4%= 'Disagreed') indicated they did not agree that the correctional facility where they were employed clearly stated how to respond to an inmate experiencing a mental health crisis. Thirty-seven percent indicated they 'Neither Agreed or Disagreed', 15.7% 'Agreed' their facility did have a clear protocol in place, and only 4.3% 'Strongly Agreed'.



*Figure 2* shows participants' responses to question #25, 'Please check all the

mental health training you have had in the past 5 years.’ A majority of correctional officers had received trainings in areas of: Suicide Prevention (72.3%), Handling Crisis Situations (70.49%), and Verbal De-escalation (77.05%). However, fewer correctional officers (55.74%) indicated they had received training in Introduction to Mental Health.



Descriptive statistics were also used to analyze participants’ responses to question #23, ‘I believe the correctional facility where I work has provided me with an adequate amount of training in mental health?’ #24 ‘I believe more mental health training for correctional officers would increase the safety for staff and inmates?’; #28 ‘If you have not had CIT please select the following responses that apply to you.’; #29 ‘If you are certified in CIT please indicate where you had the training;’ and #30 ‘Please check the following responses that best reflect the results of being certified in CIT.’ Participants’ responses to these questions reflected their perceptions of the effectiveness of the mental health training they have received at the correctional facility where they were currently



employed.

*Table 6* shows participants’ responses to question items #23-25. The table shows 62.9% of the participants felt that the correctional facility where they were currently employed did not provide them with an adequate amount of mental health training. Eight-four percent of participants also reported they believed more mental health training would increase the safety of correctional staff and other inmates, and 82.6% of participants indicated they would like to receive more mental health training.

Table.6

*Perceptions of Mental Health Training in Current Place of Employment*

Question #	Number	Percent
23) Provided an adequate amount of mental health training ( <i>n</i> =70)		
Yes	26	37.1
No	44	62.9
24) More training would increase safety of staff and inmates ( <i>n</i> =69)		
Yes	58	84.1
Not really	7	10.1
No	4	5.8
25) I would like more mental health training ( <i>n</i> =69)		
Yes	57	82.6
No	12	17.4

*Note.* Participants were allowed to skip questions. One participant did not answer # 23 and #24.

**CIT Team Training**

The primary focus of this research was to examine the specific independent variable of CIT training. Of the two correctional facilities the survey was distributed to,

one of correctional facilities had implemented a 32-hour CIT training into their facility. The distributed survey asked four specific question items related to the participants' experience of CIT training. Questions #27-30 asked participants to indicate their experience with CIT training. Question #27 stated, 'I am certified in CIT training in my role as a correctional officer.' If participants selected 'yes' they were brought to question #29 to indicate the location where they received their certification (see *Table 7*), and also asked on question #30 to check the following practices that resulted from being certified in CIT (see *Figure 3*). If participants did not indicate they were certified in CIT they were asked on question #28 to check the following responses that applied to them (see *Figure 4*).

Table. 7

*Participants' Responses to Certification in CIT and the Location Where Participants Received Their Training*

	Number	Percent
<b>Certified in CIT (n=70)</b>		
Yes	21	30.0
No	49	70.0
<b>Location of Certification (n=21)</b>		
Facility where currently employed	19	90.5
Facility where previously employed	0	0.00
Barbra Schneider Foundation	0	0.00
MN CIT Officer Association	2	9.5
I don't know/don't remember	0	0.00

*Note.* The Barbra Schneider Foundation and the MN Crisis Intervention Team Officer Association are two organizations in the state of Minnesota that offer CIT team training to correctional officers for a fee.

*Table 7* shows a total of 70 participants indicated if they were certified in CIT. The 21 participants who indicated they were certified in CIT also reported where they received their certification. Out of the 21 participants who were certified in CIT, 19

participants had received the training at the correctional facility where they were currently employed, and two participants that indicated they had received training from the MN CIT Officer Association.

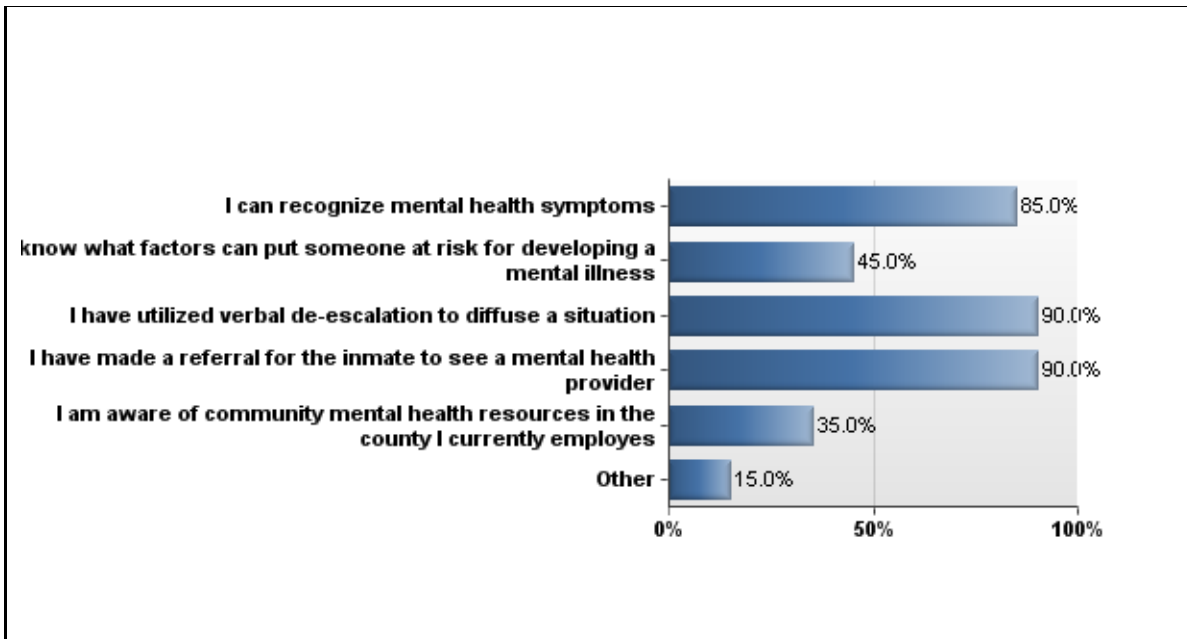
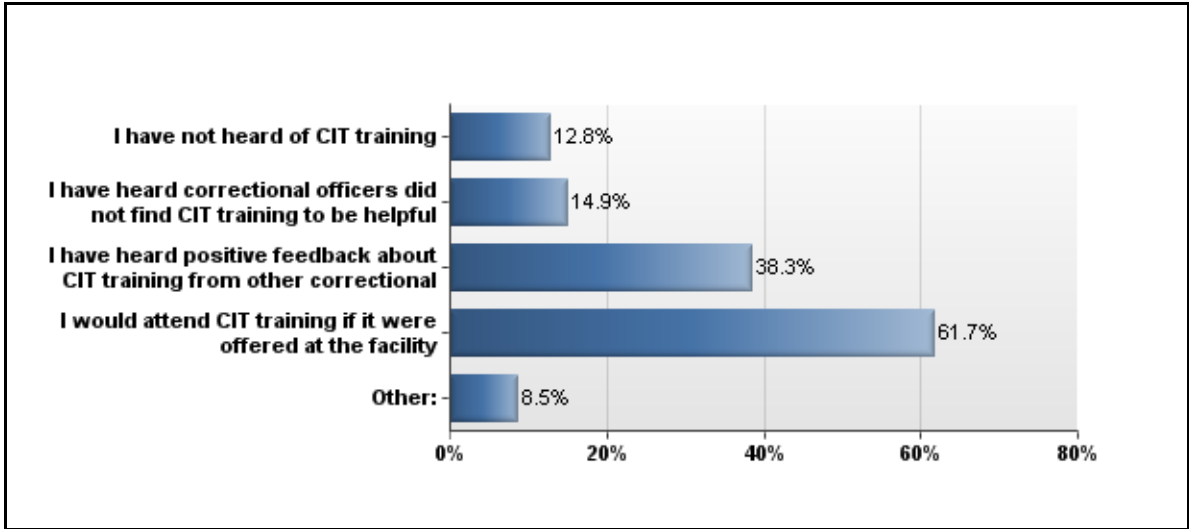


Figure 3. Represents participants’ responses to question item #30 ‘Please check the following responses that best reflect the results of being certified in CIT.’ Of the 21 participants who indicated they were certified in CIT 20 participants answered question #30.

Figure 3 shows participants’ responses to outcomes related to being certified in CIT. A majority of the participants (85%) indicated they were able to recognize mental health symptoms in inmates. Forty-five percent reported they were knowledgeable in the factors that contribute to developing a mental illness. The most reported outcome of officers (90%) certified in CIT was their use of verbal de-escalation to diffuse situations, and making a referral for the inmate to see a mental health provider. The least reported outcome practice (35%) of certification in CIT was awareness of community mental health resources in the county where the correctional facility was located. The

participants who checked ‘Other’ included additional responses to being certified in CIT: “Able to assist other officers not certified in CIT;” “Better able to understand people in crisis and to understand mental illness is not a weakness;” and “Only a qualified psychologist or higher should diagnosis inmates not a less qualified MSW.”



*Figure 4.* Represents participants’ responses to question # 28 ‘If you have not had CIT training please select any of the following that apply to you.’ Forty-seven out of the 49 who indicated they were not certified in CIT gave the following responses.

*Figure 4* shows the responses to the officers who were not certified in CIT. While some (12.8%) of participants had not heard of CIT training, of those who had (14.9%) reported they heard from other correctional officers who were certified in CIT did not find it helpful, and 38.3% reported they heard positive feedback from other officers certified in CIT. A majority of the participants (61.7%) indicated they would attend a CIT training if it was offered at the correctional facility where they were employed. The participants who checked ‘Other’ included additional responses of: “No time;” “I have heard mixed reviews of CIT;” “Only supervisors can get training;” “I have heard about

CIT training and the responses that I hear is, “this is not how we would respond to the situation.””

**Other Findings**

An independent chi-square test was run on question #1, ‘What is your gender’ and question #22, ‘Treating inmates with mental health concerns through rehabilitation is a waste of time and money’ to find if there were statistical differences between gender and race and their views of rehabilitation. *Table 8* shows that, of all the male participants (n=49), 11 (22.4%) ‘Strongly Disagreed’ that treating inmates with mental health concerns through rehabilitation was a waste of time and money, 18 (36.7%) ‘Disagreed’, 16 (32.7%) ‘Neither Disagreed or Agreed,’ 3 (6.1%) ‘Agreed’, and 1 (2.0%) ‘Strongly Agreed’. Of all the female participants (n=17), 1 (5.9%) ‘Strongly Disagreed’, 9 (52.9%) ‘Disagreed’, 4 (23.5%) ‘Neither Disagreed or Agreed’, 3 (17.6%) ‘Agreed’, and 0 (0.%) ‘Strongly Agreed’ that treating inmates with mental health concerns through rehabilitation was a waste of time and money. The table demonstrates both male female participants disagreed that treating rehabilitation programs for inmates with mental health concerns was a waste of time and money. A p-value of 0.3 is greater than .05 indicating there was not statistical association between gender and views of rehabilitation.

Table 8.

*Crosstabulation of Gender and Views of Rehabilitation*

Views of Rehabilitation	<u>Gender</u>		X <sup>2</sup>	p-value
	Males	Females		
Strongly Disagree	11	1	5.3	0.3
Disagree	18	9		
Neither Disagree or	16	4		

Agree

Agree	3	3
Strongly Agree	1	0

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*Note.* A total of 49 out of 49 males and 17 out of 18 females responded to this question

An independent chi-square test was run on question #3, ‘What is your race’ and question #22, ‘Treating inmates with mental health concerns through rehabilitation is a waste of time and money’ to find if there were statistical differences between gender and race and their views of rehabilitation. *Table 9* shows that, out of all white participants (n=58), 11 (19.0%) ‘Strongly Disagreed’ that treating inmates with mental health concerns through rehabilitation was a waste of time and money, 25 (43.1%) ‘Disagreed’, 15 (25.9%) ‘Neither Disagreed or Agreed’, 6 (10.3%) ‘Agreed’, and 1 (1.7%) ‘Strongly Agreed’. Out of all non-white participants (n=9), 1 (11.1%) ‘Strongly Disagreed’, 3 (33.3%) ‘Disagreed’, 5 (55.6%) ‘Neither Disagreed or Agreed’, 0 (0.0%) ‘Agreed’, and 0 (0.0%) ‘Strongly Agreed’ that treating inmates with mental health concerns through rehabilitation was a waste of time and money. A p-value of 1.0 is greater than .05, which demonstrated there was not statistical association between participants’ race and their views of rehabilitation of inmates with mental health concerns.

Table. 9

*Crosstabulation of Race and Views of Rehabilitation*

Views of Rehabilitation	<u>Race</u>		X <sup>2</sup>	p-value
	White	Non-White		
Strongly Disagree	11	1	3.834	1.0
Disagree	25	3		

Neither Disagree or Agree	15	5
Agree	6	0
Strongly Agree	1	0

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*Note.* A total of 58 out of 59 white participants and 9 out of 9 non-white participants responded. A frequency distribution on question #10, ‘Do you know anyone among friends or family who has a mental health problem, or disorder including depression?’ demonstrated 87.1% of correctional officers do know a friend or family member with a mental health problem or disorder.

### **Discussion**

This research did not find a statistical difference of those correctional officers certified in CIT as having more positive perceptions of inmates with mental illnesses than those officers not certified in CIT. The study did find that officers certified in CIT reported they were more prepared to work with inmates with mental illnesses than those officers who were not certified in CIT; this difference was statistically significant. These results coincide with the results found in the 2007 report conducted by The Center for Health, Policy, Practice, and Research (CHPPR) that evaluated the implementation of CIT in Maine’s county jails. Results of the 2007 report demonstrated certified CIT officers indicated they were better able to recognize mental health symptoms in inmates, and the most common interventions utilized were verbal de-escalation techniques and a referrals to mental health providers (CHPPR, 2007). This research found similar results with 85% of certified CIT correctional officers indicating CIT training enabled them to better able to recognize mental health symptoms in inmates. The most common

interventions used as a result of CIT were verbal de-escalation (95%) and a referral to a mental health provider (95%).

The results of implementing CIT in Maine's county jails also resulted in correctional officers having more positive view of inmates with mental illnesses. While this research did not find a statistical significance of CIT resulting in more positive perceptions of inmates with mental illnesses, a positive relationship was found showing the more prepared correctional officers in working with inmates with mental illnesses, the more positive perceptions they have of them.

Correctional officers' responses to the area of mental health training in general also coincided with previous literature (Lavoie et al., 2006). This study found 63% of participants reported the facility where they were employed did not provide adequate training in mental health, and 57% reported they would like more training; with 57% of correctional officers indicating they believed more training would increase the safety of staff and other inmates.

### **Strengths and Limitations**

This study had both strengths and limitations. Because the survey ensured the anonymity of the participants and because it was voluntary, it can be assumed that respondents answered honestly. The time commitment to complete the survey was relatively short. Individuals were able to complete the survey at work during their scheduled hours. Using data analysis software contributed to more accurate results, while limiting the researcher's ability to be bias or misinterpret answers.

The research design faced limitations surrounding the sample surveyed. The participants were directly chosen from two county jails. Therefore, the results are not



generalizable to represent all correctional officers who work in a county jail across the state of Minnesota, or were representative of all community correctional officers across the nation. The sample size included in this research under-represented the views of minorities.

Participants were also only given a few weeks to complete the survey, and were given the choice to not answer questions they did not feel comfortable answering. This decreased the response rate on some question items.

Participants were also asked to indicate other trainings they have had in the area of mental health in the past five years in their role as a correctional officer. It is assumed the other trainings participants indicated they had received in mental health such as: suicide prevention, handling crisis situations, verbal de-escalation, and introduction to mental health could have had an impact on participants' perceptions of working with inmates with mental illnesses and their ability to work with them.

A strength of this research included the creation of the Perception and Ability scales, which allowed for a more in depth examination of correctional officers' perceptions. The two scales were used to analyze the three research questions this study aimed to answer: Do correctional officers certified in CIT hold more positive perceptions of inmates with mental illnesses? Do correctional officers certified in CIT feel more prepared to work with inmates with mental illnesses? And lastly, does a correctional officers' self-reported ability to work to with inmates with mental illnesses influence their perceptions of them? This researcher created the two scales based on the combination of selected survey items asked of the participants.

### **Implications for Further Research**

Further research would want to assess other county jails in the United States. This would aim to ensure results could be more generalizable to community correctional officers. A larger sample size would also have the benefit of including a more representative sample across gender and race. Past research indicated correctional officers who were of non-white held more positive views of rehabilitation (Cullen et al., 1989; Jurik, 1985); however, this research did not demonstrate a statistical difference due to race. Along with Whitehead and Lindquist's (1989) study, this researcher suggests this could be due to the differences in racial disparities of the sample. Cullen et al. (1989) and Jurik (1985), as well as this research, also found gender did not have an impact on rehabilitative views. However, females were under represented in this sample (Males=49, Females=17). While there are typically more male correctional officers than female officers, this researcher is unaware the number of female correctional officers that worked at each facility.

Past research also demonstrated the level of security influenced correctional officers' views of use of force. Hemmens and Stohr (2001) found correctional officers in maximum-security prisons favor the use of force. A primary focus of CIT training is to train officers in verbal de-escalation strategies. Future research may want to examine differing views of correctional officers that have been certified in CIT at jail and prison levels.

Another area future research may want to assess are the differences in the CIT model itself. The findings from the 2007 report that surveyed correctional officers from jails in Maine were based on the 40-hour CIT model developed out of Memphis. This model has become a foundation for the implementation of CIT in correctional settings,

but also allows for flexibility based on the correctional settings needs (CHPPR, 2007). For example, one of the county jails in Minnesota where this research gathered findings was based on a 32-hour model with foundation similar to the “Memphis Model,” but differing in one area. The 32-hour model did not include an opportunity for correctional officers to attend on site visits to local community agencies that provide mental health services where inmates with mental illnesses commonly receive services once they are released. Community site visits are included in the 40-hour model. Exposing officers to local stakeholders in the community is a core element included in the “Memphis Model” (Dupont et al., 2007). It would be interesting to see if correctional officers’ perceptions differ based on the model they are trained in.

CIT training has shown to be effective in working with inmates with mental illnesses. By further implementing CIT, it is hopeful officers will increase their positive perceptions of inmates with mental illnesses, and officers will be supplied with mental health knowledge and skills to verbal de-escalate situations, which ultimately increases their safety and the safety of inmates. Looking at the strengths and limitations of previous studies, and conducting further research will help gain a better understanding on the views correctional officers have towards mental illnesses and responding to inmates who have mental illnesses, or who are in crisis. An overall, greater understanding will help to educate individuals and reduce stigma of not only individuals incarcerated with mental illnesses, but all persons who are living with a with mental illness. This research also demonstrated that 87.1% of correctional officers had a friend or loved on with a mental health disorder.

### **Implications for Social Work**

Although the field of corrections continues to focus on punishment, rehabilitation and concerns about inmate treatment and their well-being is also present. This can be seen with the addition of mental health assessments and areas of programming offered to inmates in many jails and prison across in the nation. With growing populations of inmates with mental illnesses appearing in America's correctional facilities; correctional officers voicing a need for more mental health training to work with these inmates, the implications for social work are seen on the micro, mezzo, and macro levels.

The *Code of Ethics* expresses the values, ethical standards, and principles that each social worker is to work by (NASW, 1999a). Social workers most often work with populations that stigmatized and disenfranchised. Those in jails and prisons often face stigma and discrimination while incarcerated and once they are released. The NASW value of *Social Justice* states, "Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people" (1999a, p.5). To ensure funding is granted to correctional facilities for necessary programming for inmates and the training of staff, social workers must advocate on a macro level. This is also imperative so currently incarcerated individuals are receiving services to reenter into the communities. Around 90% of people incarcerated will be released back into communities (Hill et al., 2004) and face difficulties finding: housing, employment, and supportive services that may impact their chances of remaining out of the criminal justice system. Social workers commonly provide assistance to individuals in these areas through case management services.

Social workers have also taken a variety of roles in providing services to incarcerated individuals inside correctional facilities (Robert & Springer, 2007).

Correctional facilities have become staffed with multidisciplinary teams often consisting of differing perspectives of “punishment” versus “rehabilitation.” The collaboration between all correctional staff is essential in providing adequate services to inmates. The *Code of Ethics* dictates social workers’ roles in maintaining the *Dignity and Worth of a Person* (1999a) and the *Importance of Human Relationships* (NASW, 1999a). Social workers are involved in providing direct, clinical practice with those incarcerated incorporating a variety of evidence-based practices. Social workers also mediate as a broker between strengthening the bonds between the client systems, which often involves families and probation officers.

The National Association of Social Work has deemed the profession of social work in the area of criminal justice as *criminal justice social work* (CJSW), which can be seen at multiple levels of employment such as: probation officers, therapists, counselors in mental health and chemical dependency, advocacy, case management, evidence-based program developers, and evaluators (Wilson, 2012). While social work appears in many levels in the criminal justice system, a majority of social work schools do not offer course work specifically related to areas of practice in correctional settings, and as a result students are unaware or uncomfortable working in these settings (Robert & Springer, 2007). Increasing incarceration rates; increasing rates of mental illnesses in correctional settings; a voiced need for more training and programming amongst staff; and the number of families ultimately effected by incarceration, reveals there is a higher need than ever for social workers in the area of criminal justice.

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## Appendix A

Dear Institutional Review Board of St. Thomas/St. Catherine:

This correctional facility grants permission to Cerenity Petracek, MSW student at the University of St. Thomas/St. Catherine, to survey correctional officers here at this facility. It is my understanding from my conversation with Ms. Petracek, that the survey participation will be completely voluntary and any respondents will remain anonymous. I also understand the facility will not be able to identify which correctional officers completed the survey, or how each individual officers responded to questions.

This facility further agrees to distribute the electronic survey via email to our outlook email to all correctional officers currently employed at the facility. The website link to complete the survey will be forwarded to our department Director and our agency Research and Evaluation Supervisor. The facility will send an introduction letter to our Corrections officers encouraging them to participate in this project. We will also send a follow-up email two weeks after the initial survey is sent out to remind officers about the value of their participation in the survey.

If members of your review board have any questions for us regarding this research project, please feel free to call me at either number listed here.

Sincerely,

December 19, 2011

Dear Institutional Review Board of St. Thomas/St. Catherine:

This facility grants permission to Cerenity Petracek, MSW student at the University of St. Thomas/St. Catherine, to survey correctional officers here at this facility. It is my understanding from my conversation with Ms. Petracek, that the survey participation will be completely voluntary and any respondents will remain anonymous. I also understand the facility will not be able to identify which correctional officers completed the survey, or how each individual officer responded to questions.

This facility further agrees to distribute the electronic survey via email to all correctional officers currently employed at the facility. After receiving the website link I will send an introduction message to our correctional officers encouraging them to participate in this project. A follow-up message will be sent two weeks after the initial survey is sent out to remind officers about the value of their participation in the survey.

If members of your review board have any questions for us regarding this research project, please feel free to call me at the number listed below.

Sincerely,



Appendix B

**Agency CONSENT FORM**

Researcher: Please provide your agency with the information about your project and have your agency contact complete this form.

Agency: Please read this form and ask any questions you may have before agreeing to allow this study to take place at your agency. Please keep a copy of this form for your records.

<b>Project Name</b>		<b>IRB Tracking Number</b>	
General Information Statement about the study:			
Your agency is invited to participate in this research. The agency was selected as a host for this study because:			
Study is being conducted by:			
Research Advisor (if applicable):			
Department Affiliation:			
<b>Background Information</b>			
The purpose of the study is:			
<b>Procedures</b>			
Study participants will be asked to do the following: <i>State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.</i>			
<b>Risks and Benefits of being in the study</b>			
The risks involved for subjects participating in the study are:			
The direct benefits the agency will receive for allowing the study are:			
<b>Compensation</b>			
Details of compensation (if and when disbursement will occur and conditions of compensation)			

include:			
<b>Confidentiality</b>			
The records of this study will be kept confidential. The types of records, who will have access to records and when they will be destroyed as a result of this study include:			
<b>Voluntary Nature</b>			
Allowing the study to be conducted at your agency is entirely voluntary. By agreeing to allow the study, you confirm that you understand the nature of the study and who the participants will be and their roles. You understand the study methods and that the researcher will not proceed with the study until receiving approval from the UST Institutional Review Board. If this study is intended to be published, you agree to that. You understand the risks and benefits to your organization.			
Should you decide to withdraw, data collected about you		will be used in the study	
<b>Contacts and Questions</b>			
You may contact any of the resources listed below with questions or concerns about the study.			
Researcher name			
Researcher email			
Researcher phone			
Research Advisor name			
Research Advisor email			
Research Advisor phone			
UST IRB Office	651.962.5341		
<b>Statement of Consent</b>			
I have read the above information. My questions have been answered to my satisfaction and I consent to allow the study to be conducted at the agency I represent. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent.			
Signature of Agency Representative <input type="checkbox"/> <i>Electronic signature</i>		Date	
Print Name of Agency Representative			
<b>Signature of Researcher</b>			
Signature of Researcher <input type="checkbox"/> <i>Electronic signature*</i>		Date	
Print Name of Researcher			

\*Electronic signatures certify that::

The signatory agrees that he or she is aware of the polities on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.

- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.

### Appendix C

This study is being conducted to evaluate correctional officers' perceptions of working with inmates with mental illnesses, and the effectiveness of the mental health training they have received.

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with your employment agency or the University of St. Thomas. This study will pose no personal risk to you. If you decide to participate, you are free to withdraw at any time up to and until January 1, 2012; however, your data will still be included in the research. The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include: computer records that will be stored on the researcher's computer in a password protected folder. All files will be destroyed May 30, 2012.

The survey will take roughly 10 minutes to complete and participants have 3 weeks to complete the survey. After 2 weeks, participants will receive a reminder email to complete the survey. By completing this survey you are giving your consent to participate in this study. You are free to skip any questions I may ask. The correctional facility and myself will have no way of knowing if you volunteer to take the survey. If you decide to take the survey, all your answers will remain anonymous.

My name is Cerenity Petracek. If you have questions, you may contact me at 612-702-2733. You may also contact the research advisor Philip AuClaire at 612-752-8181 You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns. Thank you for your participation.

If you wish to complete the survey please check "yes". By choosing yes you consent to the above stated information and you will be directed to the survey.

## Appendix D

\*1) What is your gender?

- Male
- Female

\*2) What is your age?

- 18-21
- 22-34
- 35-44
- 45-54
- 55+

\*3) What is your race?

- White/Caucasian
- African American
- Hispanic
- Asian
- Native American
- Pacific Islander
- Other

\*4) How many years have you served as a correctional officer?

- 0-3
- 3-5
- 5-10
- 10-15
- 15+

\*\*5) What correctional facility are you currently employed

- Hennepin County Adult Correctional Facility
- Ramsey County Correctional Facility
- Other:

\*6) How many years have you served as a correctional officer at this facility?

- 0-3
- 3-5
- 5-10
- 10-15
- 15+

\*7) Are you currently working:

- Full-time
- Part-time
- Intermittent

\*8) Rate your knowledge of mental health disorders

- Very Strong
- Strong
- Fair
- Little
- None

\*9) Are mental illnesses biological disorders?

- Yes
- I do not know
- No

\*10) Do you know anyone among friends or family who has a mental health problem, or disorder, including depression

- Yes
- No

\*11) I am confident in my ability to recognize signs and symptoms of mental illnesses in inmates

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

\*12) How prepared do you feel when responding to inmates with a mental illness who are in a crisis

- Very Prepared
- Moderately Prepared
- Somewhat Prepared
- Not at all Prepared

\* 13) To what extent do you feel you are prepared to respond to an inmate threatening to commit suicide

- Very Prepared
- Moderately Prepared
- Somewhat Prepared
- Not at all Prepared

\*\* 14) To what extent do you feel you are prepared to respond to an inmate experiencing hearing voices

- Very Prepared
- Moderately Prepared
- Somewhat Prepared
- Not at all Prepared

\* 15) I am adequately trained to verbally de-escalate a crisis situation

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

\* 16) My department's policy/protocol clearly states how to respond to mental health crises

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

\*\* 17) Inmates expressing mental health concerns are usually being manipulative

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

\*\* 18) Responding to inmate experiencing mental health concerns makes my job more stressful

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

\*\* 19) I believe inmates with mental illnesses pose a higher threat to my safety and the safety of other inmates than those inmates who do not have mental illnesses

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

\* 20) I believe incarceration can increase mental health symptoms in people who have a mental illness

- Most Definitely
- Definitely
- Somewhat
- Definitely Not
- No

\*\* 21) In my role as a corrections officer, I believe I can play a positive role in helping an inmate with a mental illness work toward recovery.

- Most Definitely
- Definitely
- Somewhat
- Definitely Not
- No

\*\* 22) Treating inmates with mental health concerns through rehabilitation programs is a waste of time and money

- Strongly Disagree
- Disagree
- Neither Agree nor Disagree
- Agree
- Strongly Agree

\*\* 23) I believe the correctional facility where I am currently employed provided me with an adequate amount of training in mental health

- Yes
- No

\*\* 24) I believe more mental health training for correctional officers would increase the safety for staff and inmates

- Yes
- Not Really
- No



\*\*25) Please check all the mental health training you have had in the past 5 years in your role as a correctional officer:

- Suicide Prevention
- Handling Crisis Situations
- Verbal De-escalation
- Introduction to Mental Health

\*\*26) I would like more training in the area of mental health

- Yes
- No

\*\*27) I am certified in Crisis Intervention Team (CIT) training in my role as a correctional officer

- Yes
- No

\*\*28) If you have not had CIT training, please select any of the following responses that apply to you:

- I have not heard of CIT training
- I have heard correctional officers did not find CIT training to be helpful
- I have heard positive feedback about CIT training from other correctional
- I would attend CIT training if it were offered at the facility
- Other:

\*\*29) If you are certified in CIT please indicate where you attended the CIT training

- The facility where I am currently employed
- While I was employed in a previous facility
- Through the Barbara Schneider Foundation
- Through the Minnesota Crisis Intervention Team Officer Association
- I don't know/remember

\*\*30) Please check the following responses that best reflect the results of being certified in CIT

- I can recognize mental health symptoms
- I know what factors can put someone at risk for developing a mental illness
- I have utilized verbal de-escalation to diffuse a situation
- I have made a referral for the inmate to see a mental health provider
- I am aware of community mental health resources in the county I currently employees
- Other

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*Note.* Questions marked with \* were taken from a measurement tool created by CHPPR. Questions marked with an \*\* the researcher created