Mental Health Training for Correctional Officers

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Abstract

Purpose & Background: Serious mental illness among incarcerated people continues to rise within the United States. Correctional officers only receive an average of 13.54 hours of training in *special populations,* including the mentally ill (Kois et al., 2020). This lack of training leaves new correctional officers inadequately prepared to manage this population in prison. Education is a cost-effective modality to provide a long-term change of practice. Mental health education was provided to New Correctional Officers (NCOs) at a 2,000-bed facility in Southwestern United States during their initial correctional officer training. Internal permissions were granted by the prison internal review board (IRB) and the Arizona State University IRB.

Methods:NCOs (n = 7) were recruited and consented to participate in psychoeducation specific to mentally ill prisoners. Using an evidence-based curriculum developed by Dr. Dana Dehart at the University of South Carolina, NCOs participated in four (4) 1-hour long mental health trainings that were instructor led. Pre/Post assessment tools were completed using a 10-item trauma quiz and a 12- item Mental Health Knowledge Schedule (MAKS) scale assessing participant attitudes towards mental illness.

Results: Participants were primarily male (57 %), White (42%), with an average age range between 31-40 years old, and with a high school degree. Post intervention quiz and MAKS show improved knowledge for all subjects using both tools.

Discussion/Conclusion: This project highlights cost-effective training with significant preliminary results in reducing stigma towards the mentally ill in prison. Furthermore, this information justifies the support, development, and funding for increasing mental health training for correctional staff nationwide.

Keywords: mental health in prison, correctional officer, mental health stigma, mental health

Mental Health Training for Correctional Officers

The current state of mental health disparities in the United States prison population has dramatically risen over the last two decades. The rising incarceration rates have seen a steady increase in the previous 50 years and have grown to house 2.23 million people in prison and jail populations (Torrey et al., 2014). Consequently, the job requirements and scope of the correctional officers who manage this challenging population have also significantly changed to meet the rising demand. Correctional officers play a unique role in the life of prisoners, not only by offering safety and security but also by collaborating with all disciplines involved in a prisoner's daily life. The prison environment negatively exacerbates the mental health symptoms of those with previously diagnosed mental illnesses (McNeeley & Donley, 2021). It also dramatically impacts the mental health of stable individuals with no prior mental health history. Prisoners with mental illnesses are perceived as challenging and dangerous and pose a high risk of injury to correctional officers. Providing practical mental health training and psychoeducation for correctional staff can be a critical component of the overall treatment plan of inmates and greatly assist in reducing recidivism rates across the country.

Problem Statement

Today's correctional facilities continue to lack the ability to serve the dual purpose of a safe prison and a therapeutic, rehabilitative environment for prisoners. According to Torrey et al. (2014), in 44 out of 50 states, prisons or jails hold more individuals with serious mental illness than the most prominent remaining state psychiatric hospital. At the center of this complex issue are the correctional officers who engage daily with the mental health population and impact their environment significantly. The influx of inmates with mental health illnesses is overwhelming to the untrained correctional officers who receive minimal preparation to understand, interact, and

manage this population. The adverse outcomes negatively impact the prisoner population and the correctional staff members tasked with enforcing rules and regulations and can lead to high-risk incidents that can cause injury to prisoners and correctional staff (McNeeley & Donley, 2021).

Compared to police officers in the community, correctional officers are at least three times more likely to encounter people with a severe mental illness (Torrey et al., 2014). Nevertheless, there continues to be a lack of formalized training for correctional officers to deal effectively and appropriately with this population (Torrey et al., 2014). The correctional officers who initially accept these positions expect that they will be enforcing law and order within the confines of a prison. However, many are untrained or unequipped to deal with mentally ill individuals who have mental illnesses. The consequences of having unqualified correctional staff deal with special populations such as mentally ill inmates can have serious adverse effects if not addressed. A collaborative approach between our current justice system, mental health agencies, and congressional authorities is necessary to make meaningful long-term change in the area of prison mental health.

The misuse of force against prisoners with mental illness speaks to a complex issue within the prison system. The lack of training, supervision, and poor reporting leads to the misuse of physical and chemical force on the mentally ill. Correctional officers' perceptions of inmates with mental illness can be stigmatizing and inaccurate. This lack of education can lead to biased behaviors and incorrect interpretations of events and behaviors. Correctional officers are the front-line staff who frequently are the first to observe escalation of symptoms and changes in behavior. Current prisoner victimization estimates vary from 5.8 to 21% of inmates experiencing physical assault during the first 6 to 12 months in custody (Teasdale et al., 2016).

Background and Significance

The Health Maintenance Organization (H.M.O.) act of 1973, whose goal was to balance healthcare delivery against cost, introduced managed mental health care systems (Deleon et al., 1991). The consequences of this act changed the delivery of mental health care and decreased accessibility to mental health services. Organizations that wanted to receive federal funds would need to provide a comprehensive set of eight essential services, including outpatient mental health care and crisis intervention services (Deleon et al., 1991). Consequently, subsidizing the creation and expansion of H.M.O.s, the 1973 H.M.O. Act also allowed the inclusion of profit-making corporations as part of the health care program (Deleon et al., 1991). During the 1960s, 70s, and 80s, there was a period when mentally ill individuals were released from mental health asylums, state hospitals, and other mental health institutions into community-based mental health care systems (Deleon et al., 1991).

This shift impacted state and local communities in an unprecedented way by shifting psychiatric care from state-run mental health hospitals to community outpatient clinics. One example of the impact of this law passed in Arizona, where the Arizona State Hospital saw a significant shift in mental health care delivery. In 1970, The Arizona Legislature passed Senate Bill 1057 (A.R.S. 3655), requiring that patients be dangerous to themselves or others to be admitted to the Arizona State Hospital. Due to this and other restrictions placed on admissions, the hospital patient census dropped from around 2,000 to 300 patients (Arizona Department of Health Services, 2022). Community mental health programs were unable to meet the increased need. Over twenty million Americans are currently or have been incarcerated, the highest rate globally. In the United States in 2013, there were approximately 2.3 million people incarcerated in prisons and jails, or one in every 110 adults (Glaze & Kaeble, 2014). The community was unable to cope with the increase of mentally ill persons. It caused arrest rates among offenders

with serious mental illness to be higher than offenders' arrest rates in general (Abracen et al., 2016). Mentally ill inmates are overrepresented in correctional settings at four times the general population (Glaze & Kaeble, 2014). The rise in sick mentally ill being incarcerated has led to prisons and jails housing more mentally ill persons than the mental health state hospitals (Allison et al., 2018).

Major National Incentives

A national executive order that positively impacted incarcerated jail and prison populations was enacted during President Barrack Obama's term. On December 18, 2014, an Executive Order establishing a Presidential Task Force for 21st Century Policing was created to be advisory solely. It required a report to be submitted the President by March 2, 2015 (U.S. Department of Justice, 2015). The task force made several recommendations to police departments and correctional facilities. They also published best practices for police departments and correctional facilities. Three significant recommendations should be noted from this report. The first was a review of commutations that modeled the Fair Sentencing Act of 2010. This approach reviewed current prison sentences, specifically identifying non-violent crimes and releasing offenders (U. S. Department of Justice, 2015). Another significant impact was the elimination of federal prison contracts with private correctional facilities. This resulted in a substantial shift in the private prison industry. In 2016, the Obama administration decided to phase out the federal government's use of private prisons (Yates, 2016). The Department of Justice concluded that private prisons failed to maintain the same level of rehabilitation, safety, and security compared to public prisons. Also, cost savings were not substantial. Recently, the Trump administration has recanted the Obama administration's decision (Sessions, 2017).

Lastly and most importantly specific to mental illness in prison was a recommendation from the Task Force to reduce or eliminate solitary confinement in prison. This resulted in a directive from president Barrack Obama explicitly calling out the overuse of solitary confinement. In 2015 President Obama implemented reforms to include banning solitary confinement for juveniles, prohibiting its use as a response to low-level infractions, expanding treatment of those with mental illness, increasing the number of time inmates spend out of their cells and ensuring inmates are not released into communities directly from solitary confinement (National Archives and Records Administration, 2019). The report sets out more than 50 guiding principles, which cover a range of essential reform areas, including the use of the restrictive housing as a form of punishment, the appropriate conditions of confinement in restrictive housing, and the proper treatment of vulnerable inmate populations, such as juveniles, pregnant women, LGBTI inmates, and inmates with serious mental illness (National Archives and Records Administration, 2019).

Access to care continues to be a struggle for many Americans, especially for vulnerable populations such as those who are mentally ill. Stigma can be a barrier for individuals who experience psychiatric illness by making them hesitant to help-seek due to the fear of being labeled and discriminated against (Kular et al., 2019). The lack of access to mental health services available in the community, increases the risk of reincarceration. The challenge that communities face appears to be a revolving door for inmates and populations at higher risk of committing crimes, such as the mentally ill.

Without changing the outpatient community care paradigm, access to care and lack of mental health services leading to increased recidivism rates will continue to be an issue that local communities will have to manage. Limited access to community mental health services

unfavorably impacts released inmates and exacerbates symptoms that lead to criminal activity. Recently released prisoners have several immediate challenges when released to the community that increases the likelihood of re-arrest. The two most challenging obstacles are obtaining employment and securing safe, permanent housing. Without those two key collateral pieces, it is difficult for them not to fall back into a life of crime and drug use that leads to incarceration. The most troubling correlation is the increased successful suicide rate and the increased recidivism rate that continues to burden society (Kaufman et al., 2020).

Large-scale recidivism studies have shown significantly higher re-arrest, re-conviction, and reincarceration rates among released inmates with psychiatric disorders than their counterparts without a psychiatric diagnosis (Brown, 2020). Besides, the impact of the Affordable Care Act and the direct correlation between the cost of insurance and services has also negatively impacted mental health services in the community (Kaufman et al., 2020). Public insurance typically has more generous benefits than private insurance for people with mental health problems. Those with mental disorders have substantial out-of-pocket expenditures for medical care, accounting for about 29 percent of mental health and substance abuse outpatient costs nationally (Galbraith et al., 2011).

Purpose and Rationale

The primary concern regarding correctional officer training is the lack of it. Training for correctional officers is comprehensive in many aspects, including a physical, physiological, and intense lecture on policy and procedure followed by a short on-the-job orientation. This expedited process fills vacancies and gets correctional officers to staff shortages. Correctional staff are not equipped to handle the behaviors of mental illness and highlight the inadequate community resources that contribute to incarcerated persons cycling in and out of jails. More

recently, research has suggested that correctional officers' experience of adversity in prisons exceeds that of many community occupations and is equivalent to those in other high-risk professions (Trounson et al., 2016). Although community law enforcement fares better, probation and parole officer vacancy rates have been reported as high as 20%, and in some state prisons, annual correctional officer turnover rates are as high as 55%; this constantly tests the system's essential functionality (Trounson et al., 2016). The significance of low retention rates for correctional officers in prisons, jails, and detention centers adversely impacts the prison workforce. Low retention rates are a significant issue due to the continued entry of uneducated staff, critical for the high vacancy rates previously mentioned (Suliman et al., 2018). An examination among 300 correctional officers' identified key protective factors to burnout resilience. Results showed hope, optimism, and social support are significantly associated with reduced burnout, and that this relationship is mediated by resilience. These results suggest that personal strengths can reduce burnout in correctional officers by increasing resilience (Klinoff et al., 2018).

Currently, strategies such as Justice and Mental Health Collaborative Program (JMHCP) and (Smart De-incarceration) are desirable to increase educational requirements for jails and prisons. Immediate resources are needed to train correctional officers within existing facilities to support appropriate mental illness and trauma responses among incarcerated persons (DeHart and Iachini, 2019). The concern of access to care for mentally ill inmates in the community is the last piece of this puzzle that needs attention. Prisoners are expected to rehabilitate while in prison and be ready to re-establish themselves in the community upon release. However, due to the lack of services within the prison and lack of rehabilitation, released prisoners are at high risk of returning. Furthermore, those inmates with mental illness have difficulties establishing essential

services in the community, such as obtaining healthcare insurance and prescribed medications. Skeem et al., 2011, conducted a study based on 44, 987 offenders and found that parolees with mental illness (52–62%) were about two times more likely than parolees without illness to return to prison within one year of release (30%). The mentally ill are not receiving critical mental healthcare inside and outside the prison system.

Internal Evidence

The goal of jail authorities is to ensure the security and safety of staff and offenders while providing a safe and rehabilitative environment. However, the correctional staff is increasingly responsible for providing rehabilitation and treatment-type services to offenders, simultaneously serving punitive, protective, and rehabilitative functions (Dvoskin & Spiers, 2004). Caring for mentally ill prisoners who have severe mental illness has been a challenge for a society that has not changed much. Advocacy groups have led to the decriminalization of the mentally ill, but not much has changed in public opinion and correctional facility care. In 2015, Mental Health America released a position statement underscoring the necessity of vigorously defending prisoners' rights with mental health conditions; the statement included a call to action and specifically stated the need for staff training on the mental health of prisoners (Mental Health America, 2015). Furthermore, prisoners may become stigmatized and victimized due to mental illness and may also be vulnerable to bullying, exclusion, and victimization by others.

The current prison environment and mental health status of incarcerated persons are challenging and complex to navigate due to the malingering and intentional behavior of inmates. The consequence is that many of the inmates with a significant mental illness fall through the cracks and do not receive adequate psychiatric care. An increased risk of suicide was also associated with a conviction for criminal homicide, sexual offenses, and other violent offenses.

The most vital clinical risk factors were suicidal ideation during the current prison sentence, a history of attempted suicide or self-harm, and being prescribed psychotropic medications. Institutional factors associated with an increased risk of suicide included being in a single cell and having no social visits (Rosenberg, 2021).

Correctional officers nationally receive approximately 13.54 hours of mandated yearly mental health training (Kois et al., 2020). With respect to mental health training duration, diverse mandatory requirements vary from state to state but range anywhere from 1.5 (Tennessee) to 80 (Florida) hours of instruction (Kois et al., 2020). Arizona currently mandates four hours of mandatory correctional officer training completed during their new correctional officer training academy prior to becoming correctional officers. The diverse populations incarcerated throughout the country require unique programming and supervision. This inadequate training paired with an increased mentally ill population cause an unnecessary risk factor for suicide and exacerbation of symptoms by mentally ill inmates. In the United States prison system, suicide is the second leading cause of death. Suicide rates in U.S. jails are three times higher than in prisons and nine times higher than in the general U.S. population, with over 350 jail inmates complete suicide each year (Schaefer et al., 2016). This led to the specific question examine the use of mental health education for correctional officers. The following question was used to guide an evidence-based search through professional medical databases.

PICOT Question

In correctional officers (P), how does mental health training (I), compared to the correctional officers who do not receive training (C), reduce mental health stigma, and improve prisoner care outcomes (O), three months after training delivery (T).

Search Strategy

This literature review included a search of the following databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsycINFO, and PubMed. Keywords had: new correctional staff, prison staff, prison, private prison, mental health stigma, mental health awareness, mental illness, mental health for service, educational intervention, workshops, training, programs, and course. The initial search of correctional officers AND mental health AND training yielded five results in CINAHL, 35 marks in PubMed, and 76 results in PsycINFO. Search limits were set to include publication dates between 2015 – and 2021, research articles, and English language. This resulted in a yield of 5 in CINAHL, 32 in PubMed, and 60 in PsycINFO. To further narrow the search, a combination of the keywords was changed to include mental health awareness, prison employees, psychiatric illness, workshops or training or program or course.

Additionally, the search was narrowed to show studies specific to training to yield a final result of 23 in CINAHL, 24 in PubMed, and 29 in PsycINFO. Grey literature of government publications from the Centers for Disease Control and Prevention and Arizona State government policies were also searched. After reviewing the abstracts and titles of the final yield, inclusion criteria included articles addressing intervention training programs. Rapid critical appraisals were then completed for 20 peer-reviewed articles, and the final ten articles were then chosen for this literature review. This included four qualitative studies, one observational study, two randomized controlled trials, one cross-sectional study, three mixed-method studies, and two systematic reviews. Exclusion criteria included articles written before 2015, studies from countries other than the United States, public safety personnel, dissertations, and articles with continuing education unit (C.E.U.) as the principal purpose (Appendix A and Appendix B).

Evidence Synthesis

The systematic search using the Iowa Model Revised as the framework led to finding three evidence-based methodologies that applied to correctional officers. The rest of the evidence-based implementation projects were designed for police officers and first responders and could not be applied to correctional settings. The first of the three studies conducted by Mcneeley & Donley (2021) reviewed 4,800 prison incidents following crisis intervention training for correctional officers. This study suggests that Crisis Intervention Team (C.I.T.) equips correctional officers with the knowledge they need to help deescalate using force. The conclusion of the study was based on a review of 4,800 incidents over 10 years. This study identified education as a significant factor in training. The second study specific to correctional officers was a 6-day workshop that targeted cognitive, psychoeducation, and behavioral components of publicly expressed stigma(s) of correctional officers (Melnikov et al., 2017). The study was implemented and completed in prison in Israel in 2014. This study also highlighted psychoeducation as a significant factor in the participants' survey(s) received, as well as a call for

The last study specific to correctional officers was completed by Dr. Dana Dehart and Aidyn Iachini (2019) at the University of South Carolina. The project was a three-step process for developing and implementing a curriculum for training correctional officers in mental illness in prison. Of the three studies, the third study was chosen as the model to follow for the Doctor of Nursing (DNP) evidence-based project for several key reasons. In all three studies, there was a statistical significance in the change in the attitude of correctional officers regarding inmates who are mentally ill. Lastly, all of the studies show statistical significance when measuring a change in knowledge, perception, and stigma of mental illness.

The purpose of the training was to enhance correctional officer knowledge using the evidence that best supported understanding mentally ill inmates in prison. The first study conducted by

Mcneely & Donley (2021) was excluded due to the potential change in practice that it would cause at the correctional facility where the project site would be implemented. The use of Crisis Intervention Teams (C.I.T.) would not be usable at the project site due to current policy and practice. This would cause a change in routine and would discourage the project site from approving a D.N.P. practice project from being completed. The second study conducted by Melnikov et al., 2017, was also excluded because the project was completed in a different country and had a prison demographic population that would significantly differ from the United States prison population(s). The third project completed by Dehart & Iachini (2019) was chosen as the evidence-based model for implementation of the current D.N.P. practice project due to the significant change in pre/post-tests of knowledge and the emphasis on delivering education to subjects.

Theory and Framework

The Theory and framework implementation serve as a guide to organize and disseminate information following a tested methodology. Identifying patterns in human behavior and being able to articulate those behaviors into processes is theory and framework at work. Evidence-based models furthermore support the use of guided research and implementation following current nursing theory (Bates et al., 2018). Interdisciplinary team approaches to care is an efficient way to guide nursing research toward investigating mechanisms through which disease and health disparities develop, offering a powerful means of primary prevention during early life. The integration of using This forward-thinking mentality is desperately needed in our compartmentalized and overburdened health system (Bates et al., 2018).

Theory of Planned Behavior

The Theory of Planned Behavior developed by Ajzen and Madden (1985), gives a foundation for theoretical guidance for the project (Appendix C). The negative learned behavior toward inmates with mental health comes from a lack of knowledge about the population and its needs. The Theory of Planned Behavior attempts to break down actions and behaviors by explaining the underlying foundations that lead to a behavior. The learned knowledge will change the attitude towards a particular issue and impact behaviors. According to Ajzen & Madden (1985), attitudes towards the behavior, subjective norms, and perceived behavioral control can predict behaviors accurately. These intentions work together with perceptions of behavioral control and account for the considerable variance in actual behavior. The topics outlined in the Theory of Planned Behavior can be represented by correctional officers and their current perception of inmates with mental illness.

Attitude towards behavior: Negative attitude towards inmates who are mentally ill.

Subjective Norm: Correctional officers will have each other's back and not intervene due to established group norms and fear of retaliation.

Perceived Behavioral Control: Correctional officers perceive themselves as authority figures and must establish safety through disciplinary action.

Intention: Correctional officers have the intention to treat inmates with empathy but have strong biases directed correlated to several years working in prison.

Behavior: the correctional officer's behavior toward mentally ill inmates is not standard; therefore, work needs to be done to improve knowledge in the population who manages the majority of this country's mentally ill.

Furthermore, the theoretical framework is the underpinnings of this project and will be based on changing correctional officer attitudes toward mentally ill inmates. Key concepts and relationships are the way that theories are made and developed. Explaining phenomena and the world around us through patterns, key concepts, and norms helps us better understand our world and, more importantly, predict changes in our field. The foundational concepts in the Planned Behavior Theory are specific and measurable, particularly in a population of correctional officers.

Iowa Model of Evidence-Based Practice

The Iowa Model is a widely used framework for implementing an evidence-based practice developed in the early 1990s by a team of nurses from the University of Iowa Hospitals and Clinics (UIHC). The goal of the model was to promote quality care to guide clinicians in evaluating and infusing research findings into patient care. The Iowa Model was based on Roger's Theory, Diffusion of Innovations, and was an outgrowth of the Quality Assurance Model Using Research (Buckwalter et al., 2017). This framework was chosen due to the scientific underpinnings of practice and the model to implement evidence-based practice. The Iowa Model covers several of the essentials of Doctoral Education for Advanced Nursing Practice proposed by the American Association of Colleges of Nursing (ANCC). This framework is straightforward and promotes using the best evidence available to make improved healthcare decisions for our patients. The model offers a systematic approach to finding research and implementing the findings. Lastly, the Iowa model provides a step-by-step protocol to be followed that starts with identifying current issues/opportunities and ends with the integration of practice change followed by dissemination of results (Appendix D). Following the protocol has been similar to the educational foundations currently mandated by the ANCC, emphasizing evidence-based practice.

Methods

Project Site

The project site was a prison located in the Southwestern United States which housed approximately 1900 inmates at any given time with a max capacity of 2000 inmates. One hundred fifty-two-man cells (~300 inmates) are available for vulnerable populations and consist of the following: Administrative Segregation: Gang, Drug, Violation, Investigation; Protective Custody: Inmates owe money to other inmates, inmates convicted of sexual crimes, domestic abuse against women/children/elderly; Mental Health Observation Overflow; 2 single-man cells are reserved for mentally unstable inmates. These two cells have been equipped with an enhanced security door and with windows to improve continuous visual observation of the inmate. Additionally, beds are lower to the ground to reduce the risk of hanging or serious injury. Based on the above description, approximately 1600 inmates are in the general population and account for most of the encounters that correctional officers have daily.

Internal Review Board Approval

The Internal Review Board (I.R.B.) for the prison granted approval for the implementation of the Doctor of Practice project in July of 2021. The prison I.R.B. requested that any publication of the project note that this training was provided as supplemental education and did not change or replace the current prison policy. Arizona State University I.R.B. approval was granted in October of 2021 with expedited approval.

Participants

Participants for this project were recruited during the correctional facilities new correctional officer training program. Participants were provided with a description of the project and then signed an informed consent. To insure the privacy of the participants, no identifying

information was placed on the project documents. Participants were assigned a number to allow paired analysis of data. Data was stored on a password protected laptop. Only the project coordinator had access to the data. Once data analysis was completed, the data was destroyed.

Inclusion criteria for participants included new correctional officers over the age of 18, with less than three months of experience. Exclusions included employees who were not correctional officers, such as medical, kitchen, and maintenance. Participation in this project was not paid, and the training was categorized as supplemental training by the private correctional facility. Participants were asked to take a demographic survey identifying age, gender, experience, and education levels. Participants were provided a National Institute of health resource. The resource gave participants community mental health resources if needed (Appendix E).

The curriculum developed by Dr. DeHart has a total of 20 modules that encompass the complete training curriculum based on the needs assessment that was done in 2018 for 50 prisons in her area. However, only four modules were delivered to new correctional officers. The four chosen modules were picked based on the overall general knowledge they provide. A need for a basic understanding of mental health was the focus of the training to promote the reduction of mental health stigma. The four topics were taught in a classroom setting as part of their new hire orientation training program (Appendix F). The information was presented over a period of six hours with the first and last hours used to conduct pre/post-tests to assess knowledge. The participants also completed the MAKS assessment related to stigma and attitudes towards mental health in prison before and after the education sessions. Permission to utilize these modules was obtained by Dr. Dehart. The curriculum and module content is outlined below (table 1).

Table 1

Modules & Corresponding Competencies for Correctional Officers

	Question	Outcome	Outcome
Module 1	What is mental health?	Recognize that mental health includes multiple dimensions, such as emotional, psychological, and social aspects.	Describe and compare criteria for defining a mental disorder versus serious mental illness.
Module 2	De-Institutionalization and Criminalization	Recognize the roles that de-institutionalization and criminalization (e.g., addiction, hopelessness, poverty) play in increasing the number of people in correctional institutions who have mental disorders and histories of trauma and adversity.	
Module 3	Understanding Trauma	Recognize that the correctional setting can mirror or trigger past traumatic experiences of the person who is incarcerated	Describe contextual stressors that can cause traumatic stress for people who are incarcerated.
Module 4	Managing Workplace Stress	Identify sources of workplace stress and burnout.	Describe resources and strategies for addressing workplace stress.

Statistical analysis was completed for the Pre-test and Post-tests and MAKS results using a paired-*t-test* to compare pre/post data.

Measurement/Tools

The Mental Health Knowledge Schedule (MAKS) is an instrument to assess stigma-related mental health knowledge among the general public. The MAKS is a straightforward and feasible method for evaluating and tracking stigma-related mental health knowledge and can facilitate the evaluation of large-scale anti-stigma interventions, and will allow for better understanding in the future of how knowledge, attitudes, and behavior interrelate. The 12 items of the MAKS are scored on a Likert scale (from 1: "Strongly Disagree" to 5: "Strongly Agree"). "Do not know" is coded as neutral (value of 3). The MAKS questionnaire is articulated into two parts (Appendix G). The first six statements are related to mental health knowledge, which gives the possibility to calculate a total score. Items from 7 to 12 refer to six clinical conditions to identify the levels of recognition and familiarity with those clinical situations (Thornicroft et al., 2015). The MAKS was found to be a brief and feasible instrument for assessing and tracking stigma-related mental health knowledge. The MAKS demonstrated overall moderate to substantial test–retest reliability (Evans-Lako et al., 2010). In addition to the MAKS questionnaire, a 10-question trauma quiz provided by Dr. DeHart in order to assist her with her continued research (Appendix H). The quiz was reviewed for face validity by Doctor of Nursing Practice professors and peers.

Results

Participants were primarily male (57%), Caucasian (42%), with an average age of 31-40 years old. More than 42% of participants had some college education (table 2). Statistical improvement was seen for pre and post test scores for the 10 item quiz (table 3 and table 4).

There was also a mean change in the MAKS scale from 54 pre-survey and 63 post-survey for the MAKS questionnaire**.** Improvement in knowledge was seen following the education compared to pre-education quiz scores. Also, the mean MAKS score improved form 54 pre-

education to 63 post education demonstrating an improvement in stigma related mental health knowledge (table 5).

Table 2

Frequency Table for Nominal Variables

Variable	*n*	*%*
Gender		
Male	4	57.14
Female	3	42.86
Missing	0	0.00
Race		
Pacific Islander	1	14.29
African American	2	28.57
White American	3	42.86
Hispanic	1	14.29
Missing	0	0.00
Education		
High School	2	28.57
Some College	3	42.86
Graduate Degree	1	14.29
College Degree	1	14.29
Missing	0	0.00
Relationship_Status		
Divorced	2	28.57
Married	3	42.86
Single	1	14.29
Dating	1	14.29
Missing	0	0.00
Age		
31-40	2	28.57
51-60	2	28.57
>60	1	14.29
22-30	2	28.57
Missing	0	0.00
Political_Affiliation		
Republican	2	28.57
Independent	4	57.14
I prefer not to say	1	14.29
Missing	0	0.00
Armed_Forces		
Marines	3	42.86
None	3	42.86
Federal Employee	1	14.29

Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

Table 3

Summary Statistics Table for Interval and Ratio Variables

Variable	*M*	*SD*	*n*	SE_M	Min	Max	Skewness	Kurtosis
Participants	4.00	2.16	7	0.82	1.00	7.00	0.00	-1.25
Pre	7.71	1.38	7	0.52	5.00	9.00	-1.10	0.22
Post	10.00	0.00	7	0.00	10.00	10.00	-	-

Note. '-' indicates the statistic is undefined due to constant data or insufficient sample size.

Table 4

Two-Tailed Paired Samples t-Test for the Difference Between Participants and Pre

Participants		Pre				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
3.00	1.83	8.50	0.58	-5.74	.010	2.87

Note. N = 4. Degrees of Freedom for the *t*-statistic = 3. *d* represents Cohen's *d.*

Two-Tailed Paired Samples *t*-Test

Table 5

Two-Tailed Paired Samples t-Test for the Difference Between MAKS_PRE and MAKS_POST

MAKS_PRE		MAKS_POST				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
59.29	4.46	64.00	2.83	-3.67	.010	1.39

Note. N = 7. Degrees of Freedom for the *t*-statistic = 6. *d* represents Cohen's *d.*

The results of the pre and post-test are clinically significant, showing improved knowledge for correctional officers. The results of the project show how brief psychoeducation can increase mental health knowledge of participants. However, due to the small number of participants, statistical significance not met. Due to the small sample size, descriptive statistics are limited and do not show significant correlations. This intervention provides mostly positive results with psychoeducation training in corrections.

Discussion

The primary goal of this study was to identify how brief evidence-based education would impact new correctional officers' stigma toward mentally ill inmates. The participants showed significant improvement in baseline knowledge which was reflected in the post-surveys. Correctional officer mental health stigma also improved following psychoeducation as evidence by improved MAKS scores. Examining the role of a correctional officer in relation to mental health in prison also allows us to review critical situations that could be improved. For this reason, a module on understanding trauma was delivered to participants. It was critical for participants to understand inmates' previous trauma and their role in reducing triggers that could exacerbate situations and cause negative events. Larger groups of participants are necessary for future research in order to identify the statistical importance of this intervention. This shift to a trained correctional officer is valuable and supported by evidence. Additional potential positive impacts of this project include an improved correctional environment, reduction in recidivism, improved inmate outcomes, and reduction of suicide in jail/prisons.

Participants also reported that the training was beneficial, and they would recommend this to peers and all correctional staff. One of the major positives that were reported was the use of an instructor led curriculum that made a difference in the delivery of information. The instructor led training was better received than self-paced participant module training. Large prevalence studies show that when comparing correctional officers to other occupations, prison employees are exposed to a higher risk of injury than any other job (McNeely, 2021). The application of this training program produces officers who are more knowledgeable and able to navigate difficult conversations with mentally ill inmates. This alone has a potential to reduce injury to inmates and correctional officers by reducing the use of force events. Current literature recommended increased training for correctional officers in order to reduce staff and inmate

injury. The review of literature identified that correctional officer stigma played a major role in incident outcomes. Furthermore, the literature highlighted the need for increased mental health training in the prison system.

Mcneely and her team suggest inmate-on-staff assaults could be reduced through ongoing, intensive training on recognizing common signs of violence, deescalating situations, and effectively using protective measures such as physical force, restraints, and chemical irritants (Mcneely, 2021). The curriculum in this project is web-based and can be rapidly distributed to any correctional facility in the country. The potential rapid distribution of this web-based information makes this curriculum unique to other training programs. Lastly, the education that this training provides is completely free, which eliminates the need to purchase this training.

Furthermore, correctional facilities attract many military veterans who can easily transition from military to civilian life yet have their unhealed trauma (Moran et al., 2019. Baseline knowledge scores of new correctional officers who have never set foot behind the steel bars have less bias. Significant findings from this exploratory project showed that psychoeducation training had a positive impact on correctional officer knowledge with no adverse outcomes. Correctional officers showed overall positive changes in their knowledge of mental illness and their knowledge of mental health disparities within the prisons. In addition, significant improvement in trauma knowledge was assessed when comparing pre/post-test scores.

Limitations/Barriers

Limitations to this study must be acknowledged. First, the sample was small ($n = 7$). Duplication of this project with a larger group is needed to determine the effectiveness of this training. The modules utilized for this project only account for less than 25% of the total

curriculum available for presentation. The impact of utilization of the total curriculum should be investigated. Longitudinal studies of the use of force incidents post psychoeducation intervention would be helpful to identify the effectiveness of increased correctional officer mental health knowledge on the frequency of these incidents.

COVID-19 impacted the number of participants for this project due to the low number of correctional officer applicants to the correctional facility. The usual average class sizes for new correctional officers is fourteen participants. More participants for this project may have yielded different results.

Sustainability/Feasibility

The project could be sustained by local training managers at each correctional facility. Training managers ensure that all employees who work at the prison complete required training and are current with accreditations and state/local laws. Use of the training modules can be added to yearly required training. Furthermore, if correctional facilities choose to be accredited by the National Commission on Correctional Health Care (NCCHC), they must provide yearly correctional officer mental health training. By implementing the curriculum for this project delivered at this facility, correctional facilities would meet NCCHC standards and deliver evidence-based education to all correctional staff.

Conclusion

Utilizing evidence based, instructor-led mental health training can improve knowledge and reduce stigma. Stigma reduction could significantly improve negative mental health perceptions and reduce adverse outcomes related to managing mentally ill inmates. Essential training topics related to mental health must be part of the training provided to correctional officers and, at the very minimum, should include the following. Currently, every state has a

minimum mandatory of mental health education for correctional officers. Exploring ways to improve mental health education to correctional officers is key to decrease mental health stigma.

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Appendix A

Ten Studies Supporting enhanced education for Correctional Staff.

Citation	Theory/ Conceptual Framework	Design/ Method/ Sampling (Grounded Theory, phenomenology, Narrative…)	Sample/Setting (describe)	Major Themes Studied/ Definitions	Measurement/ Instrumentation (focus group, 1:1, open-ended survey)	Data Analysis	Findings/ Themes	Level/Quality of Evidence; Decision for practice/ application to practice/ Generalization
Kubiak et al., (2019). Enhancing knowledge of adolescent mental health among law enforcement: Implementing youth-focused crisis intervention team training. **Funding:** Provided by the Governor's Mental Health Diversion Council and the Michigan Department of Health & Human Services. **Bias:** Informal	Theory of Planned Behavior (Ajzen, 1991) Intervention Research Framework (Fraser, Richman, Galinsky, & Day, 2009)	**Design:** 143 Officers in County A/B received Crisis Intervention Training for Youth (CRT-Y) (Pre/Post Test with 26 item questionnaire and 6 month follow up **Purpose:** This initial investigation of CIT-Y implementation was conducted in two counties in a	**N:**129 **n:** County A 85 officers **n:** County B 58 officers **Setting:** Midwestern State, Baltimore County Police Department **Sample:** 143 Police Officers received CIT-Y training. **Demographics:** 92 males (79%), 25 females (21%) Of the	**IV:** Crisis Intervention Teams for Youth (CIT-Y), aimed at addressing these concerns. CIT-Y is an advanced training model that aims to divert youth with mental health problems from the criminal/legal	**Scale:** The percent of missing values varied from 0.8% to 3.1% per variable. Fifteen questions were reverse coded to ensure consistency of the scale for data analysis. Pre- and post-test scores were calculated by summing all 26 items in the questionnaire, resulting in a possible range of scores between 26 and 130. Change scores were also calculated by	Paired samples t-tests were used to assess pre- and post-test change. To identify potential factors associated with uptake — bivariate analyses (e.g., Pearson correlation test; independent sample *t*-test) were run to test for differences in outcomes by officer demographics.	The findings of this study confirmed that CIT-Y training was feasible in these counties and acceptable to the officers who participated. Outcomes from the pre/post-tests show that 86% of officers	**Strengths:** Overall, the pre- and post-test instruments showed significant positive outcomes resulting from the CIT-Y training **Weaknesses:** small sample, only 2 counties, unable to correlate officer knowledge and

CIT-Y- Crisis Intervention Tool- Youth **County A**- urban county in the Southwest area of the state and has a population just above 200,000. **County** B- large metropolitan region with population over 1 million in the Southeast area. **IRR**- inter-rater reliability. **SD**- Standard Deviation, **FERPA**-Family Educational Rights and Privacy Act of 1974. **DV**-Dependent Variable. **IV**- Independent Variable. **CO**: Correctional officer working in a jail, detention center, or prison. **Wardens:** executive manager over jail/prison population and staff. **CIT:** crisis intervention training. **IBS SPSS Version 25:** Statistics is the world's leading statistical software used to solve business and research problems by means of ad-hoc analysis, hypothesis testing, and predictive analytics. **CIT:** Crisis Intervention, **ASU:** Administrative Control Unit where those who pose a threat to others or to the orderly operation of a correctional facility are placed. **MHU:** Mental health unit designated to assist all incarcerated males with severe mental health needs. **TSU:** that serves incarcerated males who need intensive medical care. **MHHF**: Ministry of Health to the Health Funds, **HMO:** Israeli Health Maintenance Organizations, 6- Day Workshop: 48 hr spread over 2 weeks. PW: Psychiatric Wards, **V1:** Stigmatization, **V2:** Perceived Knowledge, **V3:** Negative feelings, **V4:** Positive Feelings, **V5**: Perceived ability to manage interaction. **MI** = mental illnesses; **ANCOVA** = analysis of covariance. A-Paired t test conducted on CIT pre- and post-data. b **ANCOVA** utilized to test differences between post-CIT and non-CIT data; pre-CIT and non-CIT data are not presented in this table. **COs**: Correctional Officers. **MI**: Mental Illness. **CIPSRT:** Canadian Institute of Research and Treatment, **PSSC:** Public Safety Personnel, **MAKS:** The Mental Health Knowledge Scale, **RCMP:** Royal Canadian Mounted Police, **MHSUQ:** Mental Health Service Use Questionnaire, **MANCOVA:** Multivariate analysis of covariance. **IMI:** Individuals with Mental Illness. **DOC:** Department of Corrections, **MHP:** Mental Health Professionals, **NVivo v.12:** Software to conduct statistical data analysis. **LEO:** Law Enforcement Officers, **MBRT:** Mindfulness-Based Resilience Training; **NIC:** no intervention control, **AAQ-II:** The Acceptance and Action Questionnaire-II, **(FFMQ-SF):** Questionnaire-Short Form: The Five Facet Mindfulness, **(OLBI):** The Oldenburg Burnout Inventory **OSI:** Occupational Stress Injury, **EMS** emergency medical services, **PTSD:** post-traumatic stress disorder, **RCT:** randomized controlled trial, **TRiM:** trauma risk management, **EMDR:** Eye movement desensitization and reprocessing, **BEP:** brief eclectic psychotherapy, **CISD:** critical incident stress debriefing, **NR:** not reported, **NRCT:** non-randomized controlled trial, **CISD:** Critical incident stress debriefing. **BOS:** Behavioral Outcome Scale

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observations **Country:** Southwestern area, United States. Urban County in the Southwest area (just above 200,000) & County in Metropolitan regional in the Southwest area (population over 1 million		Midwestern state. Feasibility, acceptability, fidelity, and outcomes of this supplemental training were assessed using multiple methods, which included researcher observations of training sessions, interviews with law enforcement training participants, and pre/post-test instrument analysis. A review of the project by the university's institutional review board (IRB) deemed this evaluation	129 officers, one-third were from County B (n = 46, 35.7%) and two-thirds from County A (n = 83, 64.3%). The majority of officers were male (75.8%, n = 97) and a minority had a graduate degree (11.7%, n = 15). Officers who participated in the training varied in their tenure in law enforcement, averaging 14 years (SD = 8.4) and ranging from less than	system	taking the difference between post and pre-test scores. Paired samples t-tests were used to assess pre- and post-test change.	The transcripts were coded by two team members, and 33% of the transcripts were dually coded to establish inter-rater reliability (IRR). Initially, 84% IRR was established and after a review by the team and discussion of the differences, the two team members coded two additional interviews, with a new score of 90% IRR. A case-level ordered meta-matrix was	positively changed their knowledge and attitudes regarding youth with mental health problems.	outcomes in community.

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		research as exempt from human research oversite.	one year to 38 years of experience. Two out of every three officers (64.8%, n = 81) are currently raising or have previously raised an adolescent child.			developed to present and cluster the data, which allowed for the testing of assumptions of the *acceptability* of the training and a deeper understanding of the data		

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DeHart, D., & Iachini, A. (2019). Mental Health & Trauma among Incarcerated Persons: Development of a Training Curriculum for Correctional Officers. *American Journal of Criminal Justice*, *44*(3), 457–473. https://doi.org/10.1007/s12103-019-9473-y **Funding:** United States Department of Justice, Bureau of Justice Assistance **Bias: 10 item pre/post-test,**	Strauss, A., & Corbin, J. (1991). Basics of qualitative research: Grounded theory procedures and techniques	Qualitative **Grounded Theory;** Three Phase Process. **Needs Assessment:** research review. Interviews included correctional officers, prison administrators, prison medical personnel. **Media Development:** Creation of curriculum to include PDF facilitator's manual,	**N:** 50 prison staff ***n*:** Correctional officers ***(30),*** clinical staff ***(7),*** Wardens ***(7),*** and advisory board staff ***(6).*** **Setting:** 20 different locations throughout the state. **Sample:** Training participants included one group of 29 officers with prior training in crisis	Correctional officers who attended a pilot test of the training demonstrated increased knowledge from pretest to posttest, and officers rated the training positively. Their oral and written feedback indicated that the training was helpful both in alerting them	Analyses of pilot data were conducted using IBM SPSS Statistics (Version 25). Descriptive statistics for participant demographics and course evaluation ratings. Analyses of variance were used to examine between-group differences in knowledge scores and within-group knowledge from pre-test to post-test.	Mean ratings on course content and delivery methods were positive overall, with the content being perceived as clear (M = 4.23, SD = 0.78), applicable on the job (M = 4.17, SD = 0.87), meaningful (M = 4.10, SD = 0.90), and to a lesser extent, appropriate to the length of time allocated for the training	Greater knowledge and awareness of mental health of offenders may assist these officers to be more effective collaborators with mental health personnel in universal screening, referral for assessment, identifying special circumstances	**Level II Evidence-based material applied as intervention. Strengths:** Curriculum went through a specific needs assessment prior to development, multifaceted delivery methods, at home delivery available. **Weaknesses:** small size, biased demographic factors may

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notetaking for recordkeeping. Interviews were led by a project staff member with prior experience using shorthand-style notes in correctional settings, only 2 interviewers. **Location: unknown** 50 officers attending came from 20 different locations across the prison system.		participant handouts, activity cards, and PowerPoint presentations with brief videos and animations. **Pilot Testing:** Pilot testing included testing of prototypes and technology, piloting activities and videos with staff and professional colleagues, classroom delivery of selected portions of the training to two different audiences, and	intervention and one group of 21 officers with no such prior training. **Demographic:** 66% were women, 86% were African American, 14% Caucasian Within our sample, 4 % of officers had been on the job less than 1 year, 23 % between one and 5 years, and 73 % more than 5 years (no comparable demographic is	to signs of trauma as well as in managing their own stress on the job.		(M = 3.88, SD = 1.08) and new to the learner (M = 3.27, SD = 1.33). Qualitative responses were reviewed by the first author, and representative quotes were selected to illustrate overarching themes mentioned on evaluation forms.	for exemption from discipline, and identifying least restrictive options to avoid seclusion and restraint. This online curriculum may also be suitable for training student interns or those studying for corrections-based work in fields of	have implications for generalizability of findings, particularly if women, persons of color, or experienced officers may be more receptive to training on issues of trauma, self-care, or mental health in general. Thus, piloting additional modules and training a range of participant groups—including men,

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		analyses of data from pre/post-tests and course evaluations.	available in state administrative data).				social work, psychology, and public health.	whites, Latinx, Asians, American Indians, Hawaiians, and Alaskan Natives—will help establish utility of the training for broader purposes.

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Mcneeley, S., & Donley, C. (2021). Crisis Intervention Team Training in a Correctional Setting: Examining Compliance, Mental Health Referrals, and Use of Force. *Criminal Justice and Behavior*, *48*(2), 195–214. https://doi.org/10.1177/00938548209593 94 **Funding:** Minnesota	Logistic regression using the SAS system: Theory and Application . SAS Institute.	**Design:** This study compares outcomes of prison incidents involving CIT officers to incidents without CIT-trained officers. **Purpose:** Crisis Intervention Team (CIT) training was introduced in MnDOC facilities in 2011 (see Minnesota Department of Corrections, 2015). The training is intended to expand correctional officers' understanding of mental illness, provide tools to	**N:** Reports on 4,812 incidents that appeared to be eligible for the study were written during the study period. **N:** This study analyzes reports from 500 incidents that occurred at Minnesota Correctional Facility (MCF)-Oak Park Heights between October 12, 2016, and March 31, 2018. **Setting:** Minnesota Correctional Facility Oak Park Heights which contains the Administrative Control Unit (ASU). Mental Health Unit (MHU). Transitional Care Unit (TCU)	**Intervention:** Evaluation of use of CIT interventions by correctional officers. **DV: Immediate Compliance** (62.2%) **Eventual Compliance** ((34.4%) **Mental health referral** (5.4%) **Use of Force** (19%). **IV:** Use of CIT technique during incident Proportion of employees present during incident who had received CIT training. **CV: Situational Characteristics from**	**Scale:** In particular, since there are 65 incidents with eventual compliance, 95 incidents with use of force, and 27 incidents in which staff made referrals, there should be no more than 13, 19, and five predictors in these models, respectively. To account for this, we used backward elimination	The use of CIT techniques was positively related to whether, after initially being noncompliant, an incarcerated person eventually agreed to comply with instructions ($r = .184$, $p = .011$). Both the use of CIT	The results suggest CIT training can in some ways be beneficial in a prison setting, as it is related to gaining compliance from unruly incarcerated people and is associated with officers' use of mental health referrals.	**LEO: Level II** **Strengths:** This suggests CIT training equips correctional officers with the knowledge they need to help incarcerated people obtain appropriate mental health care. This is beneficial not only for the health of the incarcerated person but also for the safety of other incarcerated people and staff and for the

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Department of Corrections. **Bias:** Single events in maximum security facility. Unable to generalize to facilities with lower custody levels. All male prison facility. **Location:** Minnesota Department of Corrections.		support intentional communication between officers and incarcerated people, and educate officers on interventions for those experiencing mental health crisis (Dupont & Cochran, 2000).	**Sample:** 308 employees who responded to incidents. **Demographic:** Nearly three quarters (72%) of employees were male, while 28% were female. The majority of employees identified as White (78%), while 4% were Black, 4% were Asian, 2% were Hispanic, 1% were American Indian, and 12% were unknown or other. The employees ranged in age from 19 to 66 years, with an average of 38 years. The employees had worked for MnDOC for an average of 8 years; the length of employment ranged from less than 1 year to 33 years.	**situations:** **Time of day** Morning Watch (0645-1434) Second Watch (1435-2224) Third Watch (2225-0644) **Location:** cell, ASU,MHU, TCU, kitchen, medical, recreation, commissary.	stepwise regression (likelihood ratio) to select the best fitting models with the appropriate number of predictors.	techniques ($r = .196$, $p < .001$) and the proportion of employees with CIT training ($r = .142$, $p = .002$) were positively related to mental health referral.		operation of the facility. **Weaknesses:** Subjective Officer Choice to submit incident report: brief conversation before an incarcerated person acted out, officers may not have felt it necessary to submit an incident report. Therefore, it is possible that CIT officers have a more positive impact than could be detected in this study. It is

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								important to note that incident reports are only recorded when employees perceive a threat to staff or resident safety or to the proper operation of the facility.

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Melnikov, S., Elyan-Antar, T., Schor, R., Kigli-Shemesh, R., & Kagan, I. (2017). Nurses Teaching Prison Officers: A Workshop to Reduce the Stigmatization of Prison Inmates With Mental Illness. *Perspectives in Psychiatric Care*, *53*(4), 251–258. https://doi.org/10.1111/ppc.12165 This study is based on a convenience	A unitary theory of stigmatization: Pursuit of self-interest and routes to stigmatization.	The 6-day workshop targeted the cognitive, psychoeducational, and behavioral components of publicly expressed stigma. It combined theoretical learning with practical experience in identifying the symptoms and coping with the manifestations of mental illness. Across 4 days of theoretical learning (32 study hours) and 2 days of observational	This study is based on a convenience sample of 83 prison officers from various prisons in Israel who attended the workshop between December 2013 and February 2014. Participation in the workshop gave the officers credits for continuous education compensation. Four workshops took place altogether, with an average of 20–25 participants in each group. V1: SD Preworkshop: 2.94, post 2.72	Major Themes: Stigmatizing attitudes lead to improved professional practice with respect to the persons with mental illness in prison facilities Perhaps such workshop interventions ought to be incorporated into the training of novice prison officers, especially in prisons that provide psychiatric care services, such as outpatient clinics and psychiatric wards.	The structured self-administered questionnaire was designed to explore the cognitive, affective, and behavioral elements of stigmatization according to the Haghighat (2001) model of public stigma.	Pearson's correlation coefficients were used for testing intervariable relationships. t-Tests for independent samples and paired samples were calculated to compare variables. Multiple regression analyses quantified the unique	The main finding is the decrease in levels of postintervention stigmatization. The psychoeducational, psychiatric nurse-led intervention seems to have achieved positive results in a relatively short space of time.	**LOE: Level II** **Strengths:** Psychiatric Nurse delivery of education with extensive experience in field. Cost effective Rapid universal training statewide **Weaknesses:** Sample size (N= 83). M= 60, W= 20 Gender bias. Significant gender differences suggest underlying gender

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sample of 83 prison officers from various prisons in Israel who attended the workshop between December 2013 and February 2014. **Funding:** Ministry of Health to the Health Funds MHHF (Israeli health maintenance organizations [HMOs] that provide healthcare services to citizens).		experience in psychiatric wards (16 study hours), workshop activities included frontal lectures, case reviews, general and panel discussions, peer supervision, simulations in class, observational training in psychiatric wards (PW).	V2: SD Preworkshop: 3.00, post 3.68 V3: SD Preworkshop: 2.25, post 2.25 V4: SD Preworkshop: 3.04, post 3.14 V5: SD Preworkshop 3.7, post 3.72			contribution of independent variables to dependent ones	It is noteworthy that the level of stigmatization among male officers was much higher than among female officers, both before and after the workshop.	bias that needs to be further explored in order to see if curriculum presented to officers needs to be gender appropriate.

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Canada, K., Watson, A., & O'kelley, S. (2021). Utilizing Crisis Intervention Teams in Prison to Improve Officer Knowledge, Stigmatizing Attitudes, and Perception of Response Options. *Criminal Justice and Behavior*, *48*(1), 10–31. https://doi.org/10.1177/0093854820942274 The University Institutional Review Board reviewed and approved the study. **Funding:** This project was funded by the Fahs	Quasi-experimental, concurrent triangulation mixed-method design using a pre- and posttest (Creswell et al., 2003).	The use of mixed-methods, multiple data sources, and triangulation is critical in this project due to the complexity of intersecting factors within prisons that impact people with MI. Survey and interview data were collected from COs between 2016 and 2018.	A total of 235 COs completed a pre- and/or postsurvey. In the recruitment window, 403 COs received CIT training, making the response rate approximately 58% of eligible COs, which is just under the standard threshold of 60% noted by some scholars (Johnson & Wislar, 2012). Due to staffing, changes in attendance were made, which resulted in some eligible COs not receiving the survey link prior to the training.	No distinct differences between CIT and non-CIT COs. No differences between age ranges. Mental Health Knowledge significantly increased at the post-test Participants perceived greater effectiveness of the mental the mental health system following CIT	All variables described were collected from both CIT and non-CIT COs. Demographic variables included age, sex, education level, marital status, race and ethnicity, years in position and working for DOC, shift, facility, work assignment, and if someone	COs using analysis of variance (ANOVA) and Pearson chi-square. ANOVA was used to explore differences between CIT and non-CIT COs in all dependent variables.	Findings suggest that CIT may promote change in officer knowledge, stigmatizing attitudes, and perception of response options. These changes should theoretically lead to officer behavior change in encounters involving people	**LOE:** Level II **Strengths:** Providing COs with additional training and support to more accurately respond to people with MI improves officer interactions with people experiencing **Weaknesses:** CIT COs work alongside non-CIT COs. It is possible that CIT COs could

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Beck Fund for Research and Experimentation and the Hammond Institute.			Randomly selected CIT COs completed interviews 6 to 9 months following training (n = 17). CIT COs had significantly lower stigmatizing attitudes.		close to them has an MI.		displaying MI symptoms or having mental health crises. Based on attribution theory and previous.	impact nonCIT COs (i.e., contamination).

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Krakauer, R., Stelnicki, A., & Carleton, R. (2020). Examining Mental Health Knowledge, Stigma, and Service Use Intentions Among Public Safety Personnel. *Frontiers in Psychology*, *11*, 949–949. https://doi.org/10.3389/fpsyg.2020.00949 Online survey between September 2016 to January 2017. The survey	The study was designed to determine the relationship among mental health knowledge, stigma against peers in the workplace, and service use intentions in a nationally representative sample of Public Safety Personnel (PSP).	The Mental Health Knowledge Scale (MAKS; Evans-Lacko et al., 2010) is a 15-item self-report questionnaire. The first six items assess beliefs about mental health.	In total, *n* = 8,520 began the survey and *n* = 4,108 (48.2%) completed all of the survey questions associated with the current analyses. PSP participants were assigned to one of six categories for analyses: communication officials (e.g., 911 call center operators/dispatchers), correctional workers, federal police (i.e., Royal Canadian Mounted Police: RCMP), firefighters, municipal/provincial police, and paramedics.	Major Themes: Stigmatizing attitudes lead to improved professional practice with respect to the persons with mental illness in prison facilities Perhaps such workshop interventions ought to be incorporated into the training of novice prison officers, especially in prisons that provide psychiatric care services, such as outpatient clinics and psychiatric wards.	Mental Health Knowledge Scale Open Minds Survey for Workplace Attitudes Mental Health Service Use Questionnaire The MHSUQ is derived from the 76-item CAF-R-MHSUQ (Fikretoglu et al., 2019a) and consistent with questions	(MANCOVA) Multivariate analysis of covariance was conducted to determine whether there were significant differences in mean mental health.	Paramedics reporting high mental health knowledge might intuitively suggest that paramedics will also have a high willingness to engage in help-seeking; The current results demonstrated that correctional workers also	**LOE: Level II** **Strengths:** Supports the need for correctional staff mental health education by comparing to other PSP. First, a large, representative sample of Canadian PSP was identified in the current study and allowed for comparisons across public safety occupations rather than focused attention to one

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was collaboratively designed by researches from the University of Regina and the Public Safety Steering Committee (PSSC) of the Canadian Institute for Public Safety Research and Treatment (CIPSRT).					regularly used in Statistics Canada surveys to assess mental health service use. The Cronbach's α for the MHSUQ was α = 0.95 in the current sample.		reported the highest mental health knowledge, lowest stigma, and highest intentions to seek mental health services.	category. **Weaknesses:** Self-report via online survey. High potential of bias. Several PSP agencies with diverse population settings.

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Kois, L., Hill, K., Gonzales, L., Hunter, S., & Chauhan, P. (2020). Correctional Officer Mental Health Training: Analysis of 52 U.S. Jurisdictions. *Crimi nal Justice Policy Review*, *31*(4), 555–572. https://doi.org/10.1177/0887403419849624 October 2017 through March 2018 data collected on mental health	Qualitative Study The study was designed to determine the amount of mental health training or in-service that is provided to correctional staff at all 52 U. S. Jurisdictions.	Department of Corrections (DOC) in all 50 states, the District of Columbia, and the Federal Bureau of Prisons using information gathered from respective websites from October 2017 through March 2018.	For each jurisdiction, we requested (a) instruction method (e.g., instructor qualifications), (b) hours of preservice mental health training, and (c) the title of mental health courses required	Major Themes: Overall, it appears mental health training comprises a small portion of CO training. Research indicates CO mental health training is an important endeavor that can help maintain safety and security in jails and prisons. The next most frequent course topics are general psychoeducation (n = 24, 46.15%), special populations (n = 12,	Data were collected via telephone and email contacts with administrative and training staff and/or Freedom of Information Act requests. Two researchers, a licensed clinical psychologist and clinical psychology doctoral student, independently coded method of instruction and course title data.	NVivo v.12 (2018) software to conduct thematic analyses with our qualitative (instruction method and course title) data.	With respect to mental health training duration, hour requirements range from 1.5 (Tennessee) to 80 (Florida) hr of instruction. Diverse Mental health Training requirements among states. Average	**LOE: Level II** **Strengths:** It appears that all COs in the jurisdictions surveyed receive some mental health training, although duration and course content varies. Great similarities in psychoeducation requirements from comparisons. all jurisdictions require some form of mental health

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training programs in all 52 U.S. Jurisdictions.				23.08%), specific clinical interventions (n = 7, 13.46%), institutional procedure specific to mental health (n = 6, 11.54%), and CO mental health and self-care (n = 4, 7.69%).			Correctional Officer MH Training: Across jurisdictions, COs are required to complete a mean of 13.54 hr Training programs most often utilize mental health professionals (n = 37, 71.15%) and training academy personnel (n =	training, and many requirements were recommended by Parker (2009): **Weaknesses:** These data were collected from October 2017 through March 2018, and the requirements reported here might not be in place at this time COs serving in individual jails may receive different or

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							31, 59.62%) for course instruction.	additional training within that state (e.g., as reported by Louisville Metro staff, personal communication), and these training practices should be documented in the future

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Christopher, M., Hunsinger, M., Goerling, L., Bowen, S., Rogers, B., Gross, C., Dapolonia, E., & Pruessner, J. (2018). Mindfulness-based resilience training to reduce health risk, stress reactivity, and aggression among law enforcement officers: A feasibility and preliminary efficacy trial. *Psychiatry Research*, *264*, 104–115.	Mixed-Methodology: Based on a Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990) framework, MBRT was delivered in eight weekly 2-hour sessions with an extended 6-hour class in the seventh week.	LEOs were recruited from law enforcement agencies in a large urban area and surrounding metro region in the Pacific Northwestern United States through emails, fliers, and in-person presentations	MBRT Group (N) = 31 NIC Group (N) = 30 Randomized (N) = 61	Major Themes: MBRT participants endorsed a lower composite E/CQ score of responses assessing the degree to which they felt the intervention would improve job stress, job performance, and resilience.	Several Measurements were conducted. Treatment expectancy and credibility Expectancy/Credibility Questionnaire (E/CQ). PROMIS® (v1.0) short form versions were used to assess sleep disturbance (6 items), alcohol use (7 items), anxiety (6 items), and depression (6 items). 7-item Concise Health Risk Tracking Scale	Pre-training Post-training Three-month follow-up showed statistical improvement in knowledge and self - measurement tests conducted.	Relative to NIC, MBRT participants endorsed improvements in psychological health outcomes (burnout, organizational stress, and sleep disturbance [trend-level significance]) and potential mechanisms (psychological flexibility	**LOE: Level III** **Strengths:** Results suggest MBRT is feasible and acceptable to LEOs, evidenced by meeting benchmarks for participant enrollment (n = 61), acceptance of randomization (97%), class attendance (79%), and overall attrition rate (20%).

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https://doi.org/10.1016/j.psychres.2018.03.059 **Funding:** Research reported in this publication was supported by the National Center for Complementary & Integrative Health of the National Institutes of Health under Award Number R21AT008854. The content is solely the responsibility of the authors and does not necessarily represent the official views of the					(CHRT). Police Stress Questionnaire (PSQ) The Oldenburg Burnout Inventory (OLBI) The Five Facet Mindfulness (Questionnaire-Short Form (FFMQ-SF) The Acceptance and Action Questionnaire-II (AAQ-II)		and non-reactivity). This replicates previous MT meta-analyses of RCTs across various healthy and clinical populations	**Weaknesses:** 45% withdrew due to a change in work schedule preventing them from attending MBRT sessions. The enrollment and attrition rates are consistent with previous MT research among high-stress cohorts, including military personnel.

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Antony, J., Brar, R., Khan, P., Ghassemi, M., Nincic, V., Sharpe, J., Straus, S., & Tricco, A. (2020). Interventions for the prevention and management of occupational stress injury in first responders: a rapid overview of reviews. *Systematic Reviews*, *9*(1), 1–121. https://doi.org/10.1186/s13643-020-01367-w	An overview (i.e., a synthesis of systematic review findings) is an effective method to systematically gather, appraise, and summarize existing evidence on a broad topic that has been well-studied, and identify gaps in the research efforts to date	Systematic Review of current research and practice of interventions for first responders. This overview includes systematic reviews targeting first responders or frontline community safety personnel, including police officers, firefighters, correctional officers, and coroners, with a focus on	Search strategy was developed by an information specialist and peer-reviewed by another using the Peer Review of Electronic Search Strategies (PRESS) checklist MEDLINE, EMBASE, PsycINFO, CINAHL, Web of Science, and Cochrane Library databases were searched on February 17, 2019, for relevant reviews.	Major Themes: A total of 23 studies reported rehabilitation strategies and programs, including 16 targeting police officers, 6 targeting firefighters, and 1 focusing on correctional officers. Interventions Focused on the following: Psychotherapy Drug Therapy Other Therapies (EMDR) (Exposure Therapy) (CISD) (BEP) (ETCR) (CBT) (TRiM) (Drug Therapy)	AMSTAR 2 (A Measurement Tool to Assess Systematic Reviews version 2. Within the 14 reviews, we identified 47 unique primary studies, examining both a relevant first responder population and an intervention targeting OSI. The majority of the studies focused on police (78.7%) and firefighters (17%) with only a small percentage focusing on correctional services (4.3%)	The 47 unique primary studies reporting any intervention are organized by study population. Clinical interventions for diverse groups show promising interventions ranging from EMDR to yoga and show clinical statistically improvements	Findings will serve as a basis for the MCSCS to develop an evidence-based strategy to tackle OSI in frontline community safety personnel and first responders. The suggested next step would be to conduct a systematic review of primary	**LOE: Level IIII** **Strengths:** Systemic Review of several studies across various first-responder agencies; including correctional officers. The results from this overview suggest that potentially effective prevention and rehabilitation strategies exist targeting first

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Funding: Strategy for Patient-Oriented Research (SPOR) Evidence Alliance which is supported by the Canadian Institutes of Health Research (CIHR) under the SPOR initiative and the generosity of partners from 41 public agencies and organizations across Canada.		prevention and rehabilitation of OSI.	(n = 1895 initial search) (n = 1377 after duplicates removed) (n = 1393 records screened) (n = 121 Full-test articles assessed for eligibility) (n = 14 unique relevant studies included)	(Resilience Training) (Stress Management)		for OSI in first responders.	studies to help inform the development and examination of interventions targeted to this population.	responders at high-risk of developing OSI. **Weaknesses:** Low number of studies to evaluate that were unique. Only 4.3% of studies were relevant to target population (correctional officers).

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Comartin, E., Wells, K., Zacharias, A., & Kubiak, S. (2020). The Use of the Crisis Intervention Team (CIT) Model for Corrections Officers: Reducing Incidents within a County Jail. *The Prison Journal (Philadelphia, Pa.)*, *100*(5), 581–602. https://doi.org/10.1177/00328855209563 34	An overview (i.e., a synthesis of systematic review findings) is an effective method to systematically gather, appraise, and summarize existing evidence on a broad topic that has been well-studied, and identify gaps in the research	This study investigated the use of CIT in a county jail in a large metropolitan area in the Midwest. The county is home to 1.2million individuals (U.S. Census Bureau, 2016). Eight, 8-h sessions were held between May and July of 2017 by a certified CIT trainer who adapted the training to the	Three data sources were used to assess CO knowledge, attitudes, and behavioral changes. Knowledge and attitude changes were assessed through two sources: (1) pre/post surveys for all COs who took the training and (2) pre/ post-interviews with a stratified sample of ten COs. Administrative data in the form of officer reports were used to assess whether CIT training impacted COs' behavior	Major Themes: Two out of three COs (67%, 6/9) exhibited a positive change in overall perception of mental health. COs showed increased understanding for medication effects on behavior along with greater understanding of why individuals might not be able to control their behaviors.	Overall, 255 (83.3%) were successfully matched. Some questions were reverse coded, with a positive reported mean change score meaning that COs used more appropriate de-escalation techniques or their feelings toward individuals with mental illness became less stigmatizing and more understanding of their needs. Each question on the instrument was assessed individually using paired samples t-	Of the 255 COs matched on the pre/post-survey instruments, the majority were male (73.3%, n=187). The average years spent working in the field was 12.2 years (SD=9.7), and ranged from zero to 45 years. At pre-survey, 70.1% (n=178) agreed that they had a	Major findings from this exploratory study showed that CIT training had a positive impact on COs and their experiences with SMI-related situations. COs exhibited overall positive changes in their knowledge of	**LOE: Level II** **Strengths:** Improved mental health perceptions of COs. Improved mental health stigma. Positive qualitative feedback from intervention for CO staff. **Weaknesses:** To date, this is the first study to assess the use and

CIT-Y- Crisis Intervention Tool- Youth **County A**- urban county in the Southwest area of the state and has a population just above 200,000. **County** B- large metropolitan region with population over 1 million in the Southeast area of the State of Baltimore. **IRR**- inter-rater reliability. **SD**- Standard Deviation, **FERPA**-Family Educational Rights and Privacy Act of 1974. **DV**-Dependent Variable. **IV**-Independent Variable. **CO**: Correctional officer working in a jail, detention center, or prison. **Wardens:** executive manager over jail/prison population and staff. **CIT:** crisis intervention training. **IBS SPSS Version 25:** Statistics is the world's leading statistical software used to solve business and research problems by means of ad-hoc analysis, hypothesis testing, and predictive analytics. **CIT:** Crisis Intervention, **ASU:** Administrative Control Unit where those who pose a threat to others or to the orderly operation of a correctional facility are placed. **MHU:** Mental health unit designated to assist all incarcerated males with severe mental health needs. **TSU:** that serves incarcerated males who need intensive medical care. **DV:** Dependent Variable, **IV:** Independent Variable, **CV:** Control Variable. **MHHF**: Ministry of Health to the Health Funds, **HMO:** Israeli Health Maintenance Organizations, 6- Day Workshop: 48 hr spread over 2 weeks. PW: Psychiatric Wards, **V1:** Stigmatization, **V2:** Perceived Knowledge, **V3:** Negative feelings, **V4:** Positive Feelings, **V5**: Perceived ability to manage interaction. **SD:** Standard Deviation. **N:** Sample Size 83 Israeli Correctional Officers. **M**: Men: 60 **W:** Women: 20. **CIT** = crisis intervention team; **MI** = mental illnesses; **ANCOVA** = analysis of covariance. aPaired t test conducted on CIT pre- and postdata. b AN**COVA** utilized to test differences between post-CIT and non-CIT data; pre-CIT and non-CIT data are not presented in this table. **COs**: Correctional Officers. **MI**: Mental Illness. **CIPSRT:** Canadian Institute of Research and Treatment, **PSSC:** Public Safety Personnel, **MAKS:** The Mental Health Knowledge Scale, **RCMP:** Royal Canadian Mounted Police, **MHSUQ:** Mental Health Service Use Questionnaire, **MANCOVA:** Multivariate analysis of covariance. **IMI:** Individuals with Mental Illness, **COs:** Correctional Officers, **CIT:** Crisis Intervention Training, **DOC:** Department of Corrections, **MHP:** Mental Health Professionals, **NVivo v.12:** Software to conduct statistical data analysis. **LEO:** Law Enforcement Officers, **MBRT:** Mindfulness-Based Resilience Training; **NIC:** no intervention control, **AAQ-II:** The Acceptance and Action Questionnaire-II, **(FFMQ-SF):** Questionnaire-Short Form: The Five Facet Mindfulness, **(OLBI):** The Oldenburg Burnout Inventory **OSI:** Occupational Stress Injury, **EMS** emergency medical services, **PTSD:** post-traumatic stress disorder, **RCT:** randomized controlled trial, **TRiM:** trauma risk management, **EMDR:** Eye movement desensitization and reprocessing, **BEP:** brief eclectic psychotherapy, **CISD:** critical incident stress debriefing, **NR:** not reported, **NRCT:** non-randomized controlled trial, **CISD:** Critical incident stress debriefing. **CIT:** Crisis Intervention Training **CO:** Correctional Officer **SD:** Standard Deviation **Pre/Post-Instrument:** The same survey instrument was given to all COs immediately before and after the 8-h training session. The survey asked for their gender (male/female) and the number of years of service. **BOS:** Behavioral Outcome Scale

Citation	Theory/ Conceptual Framework	Design/ Method/ Sampling (Grounded Theory, phenomenology, Narrative…)	Sample/Setting (describe)	Major Themes Studied/ Definitions	Measurement/ Instrumentation (focus group, 1:1, open-ended survey)	Data Analysis	Findings/ Themes	Level/Quality of Evidence; Decision for practice/ application to practice/ Generalization
	efforts to date	correctional setting. The training program covered various mental health diagnoses (schizophrenia, bi-polar, etc.) and symptomology, as well as information about psychotropic medications and their side effects. Suicide in correctional settings was also a training topic.			tests. Total scores for each scale are also presented; however, these should be interpreted with caution due to low reliability scores on the BOS (pre=.26, post=.40) and attributions scale (pre=.34, post=.25; Officer Efficacy (pre=.85, post=.85).	strong desire to take the training, and 96.9% (n=246) believed that mental health issues were a serious problem for law enforcement. At post-survey, both of these proportions had increased (desire=89.7%, n=226; and serious problem=98.0 %, n=249)	mental illnesses, as well as in their attitudes toward individuals with SMI.	impacts of CIT in a jail setting. And similar to the recent evaluation study of CIT training in prison (Canada et al., 2020), there were similar positive outcomes

Appendix B

Author	Kubiak	DeHart	Anthony	Comartin	Christopher	Kois	Krakauer	Canada	Melnikov	Mcneeley
Year	2019	2019	2020	2020	2018	2020	2020	2021	2017	2021
LOE	2-RCT	1-QE	1-SR	1-SR	1-RCT	1-SR	1-SR	1-QE	1-QE	1-RCT
<<< Interventions >>>										
Platform										
Web-based			X	X		X	X			
Telehealth										
In-person	X	X			X			X	X	X
Methods										
Counseling/emotional support	X									
Patient education	X	X		X	X	X		X		X
Patient surveys	X	X	X	X			X	X	X	X
Provider training/education		X			X		X	X	X	
Self-paced learning modules										X
<<< Outcomes >>>										
Variables										
Mindfulness Based Resilience Scale					⇑					
Special Populations			⇑							
Crisis Intervention Training					⇑	⇑		⇑		⇑
Perceived Knowledge					⇑				⇑	
Psychoeducation			⇑					⇑	⇑	
Mental Health Knowledge	⇑	⇑		⇑	⇑		⇑		⇑	⇑
Measurement Tools for Outcomes										
Attitudes Toward Disorder and non-Disordered			X					X		X
Behavioral Outcome Scale (BOS)				X						
Social Distance Scale					X				X	
Training Duration (Total Hours)						X				X
Mental Health Knowledge Scale					X		X		X	
Pre-Post Test		X	X	X				X		
Surveys	X	X		X				X		X
Use of Force Incidents	X									X

Appendix C

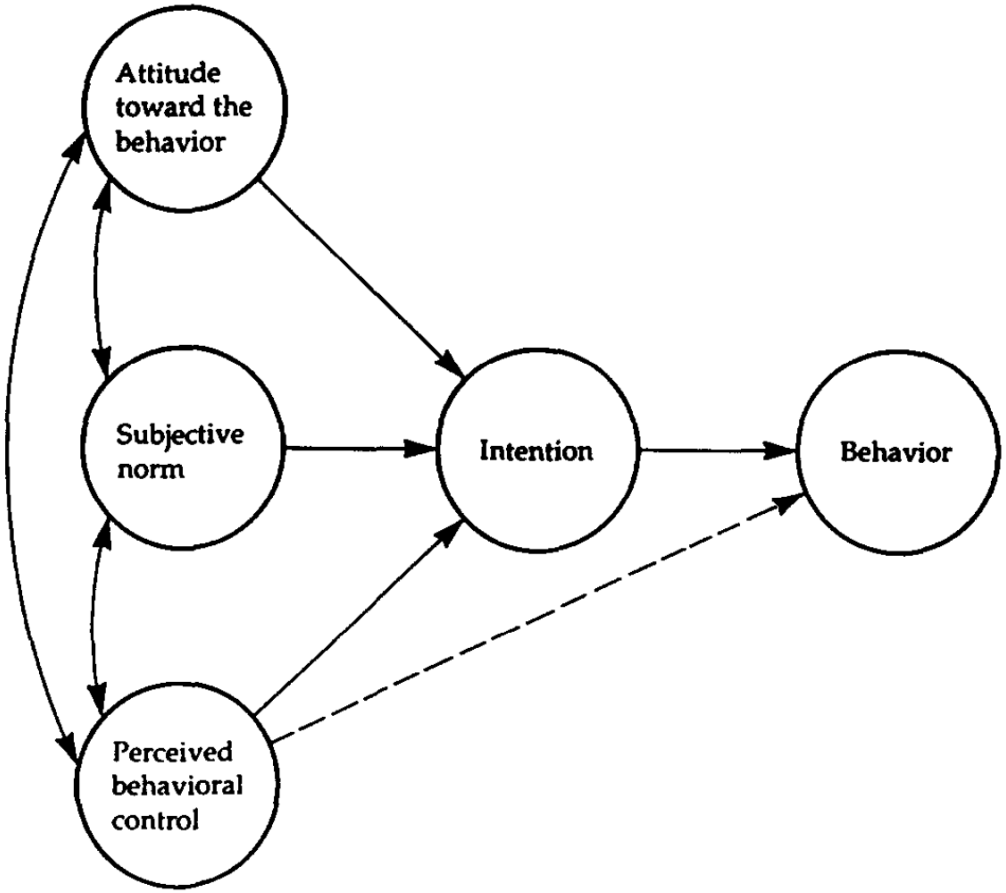
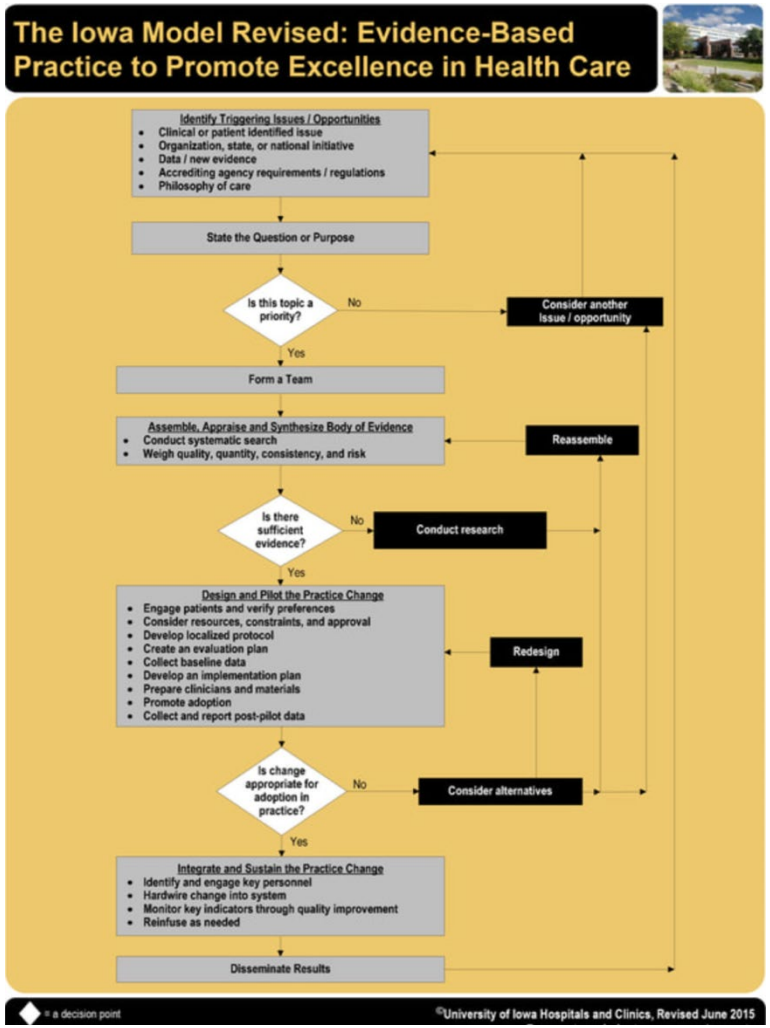


FIG. 1. Theory of planned behavior.

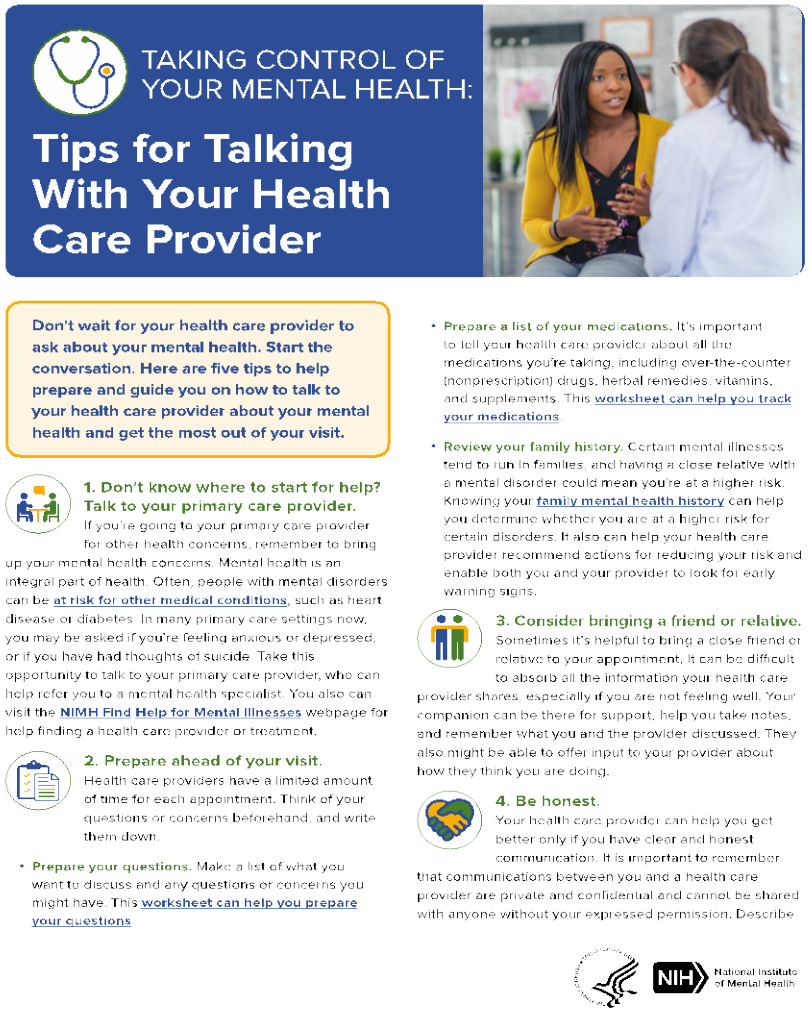
Ajzen, (2011)

Appendix D



(Buckwalter et al., 2017)

Appendix E



TAKING CONTROL OF YOUR MENTAL HEALTH:

Tips for Talking With Your Health Care Provider

Don't wait for your health care provider to ask about your mental health. Start the conversation. Here are five tips to help prepare and guide you on how to talk to your health care provider about your mental health and get the most out of your visit.

1. Don't know where to start for help? Talk to your primary care provider.
If you're going to your primary care provider for other health concerns, remember to bring up your mental health concerns. Mental health is an integral part of health. Often, people with mental disorders can be at risk for other medical conditions, such as heart disease or diabetes. In many primary care settings now, you may be asked if you're feeling anxious or depressed, or if you have had thoughts of suicide. Take this opportunity to talk to your primary care provider, who can help refer you to a mental health specialist. You also can visit the NIMH Find Help for Mental Illnesses webpage for help finding a health care provider or treatment.

2. Prepare ahead of your visit.
Health care providers have a limited amount of time for each appointment. Think of your questions or concerns beforehand, and write them down.

- **Prepare your questions.** Make a list of what you want to discuss and any questions or concerns you might have. This worksheet can help you prepare your questions.
- **Prepare a list of your medications.** It's important to tell your health care provider about all the medications you're taking, including over-the-counter (nonprescription) drugs, herbal remedies, vitamins, and supplements. This worksheet can help you track your medications.
- **Review your family history.** Certain mental illnesses tend to run in families, and having a close relative with a mental disorder could mean you're at a higher risk. Knowing your family mental health history can help you determine whether you are at a higher risk for certain disorders. It also can help your health care provider recommend actions for reducing your risk and enable both you and your provider to look for early warning signs.

3. Consider bringing a friend or relative.
Sometimes it's helpful to bring a close friend or relative to your appointment. It can be difficult to absorb all the information your health care provider shares, especially if you are not feeling well. Your companion can be there for support, help you take notes, and remember what you and the provider discussed. They also might be able to offer input to your provider about how they think you are doing.

4. Be honest.
Your health care provider can help you get better only if you have clear and honest communication. It is important to remember that communications between you and a health care provider are private and confidential and cannot be shared with anyone without your expressed permission. Describe

NIH National Institute of Mental Health

National Alliance on Mental Illness Mental Health Handout
(NAMI, 2020)

Appendix F

Correctional Mental Health

1: What Is Mental Health?

Time:	45 min.
Format:	Lecture, video, discussion
Materials:	PowerPoint, Video: "Meet Kim," flip chart and markers
Competencies:	• Recognize that mental health includes multiple dimensions, such as emotional, psychological, and social aspects. • Describe and compare criteria for defining a mental disorder versus serious mental illness.

Description

This is a foundational module that emphasizes the importance of attention to mental health and its complexities. With an animated story, participants will use criteria to determine the overall mental health of a justice-vulnerable character.

During Training

Mental Health

Set Up

Introduce the topic by using the following question to facilitate discussion:

- What does "mental health" mean to you? (NOTE: Write responses on flip chart.)

Present lecture:

Module One: What is Mental Health (DeHart & Iachini, 2019)

Mental Health Knowledge Schedule (MAKS) (Thornicroft et al., 2015)

Appendix G

Participant ID: _____

Mental Health Knowledge Schedule **MAKS**

Instructions: For each of statements 1– 6 below, respond by **ticking one box only.** Mental health problems here refer, for example, to conditions for which an individual would be seen by healthcare staff.

		Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
1	Most people with mental health problems want to have paid employment.						
2	If a friend had a mental health problem, I know what advice to give them to get professional help.						
3	Medication can be an effective treatment for people with mental health problems.						
4	Psychotherapy (eg counseling or talking therapy) can be an effective treatment for people with mental health problems.						
5	People with severe mental health problems can fully recover.						
6	Most people with mental health problems go to a healthcare professional to get help.						

Instructions: For items 7-12, say whether you think each condition is a type of mental illness by **ticking one box only.**

7	Depression						
8	Stress						
9	Schizophrenia						
10	Bipolar disorder (manic depression)						
11	Drug addiction						
12	Grief						

Thank you very much for your help.

Contact: Professor Graham Thornicroft. Email: graham.thornicroft@kcl.ac.uk

Appendix H

Participant ID:

QUIZ ON TRAUMA IN CORRECTIONS

1) Persons who experience trauma can get "stuck" in a state of alertness.
   a. True
   b. False
2) The effects of trauma last about two weeks.
   a. True
   b. False
3) Effects of trauma are easily controlled with the right medications.
   a. True
   b. False
4) The brain cannot heal from PTSD.
   a. True
   b. False
5) The effects of PTSD are
   a. Mental
   b. Emotional
   c. Physical
   d. All of the above
   e. Answers a & b only
6) Which of the following can be a "trigger" for persons who had traumatic experiences?
   a. Isolation
   b. Supervision
   c. Visits from family members
   d. All of the above
   e. None of the above
7) Trauma-informed correctional practices can improve
   a. Inmates' ability to sleep at night
   b. Inmate attendance of programs
   c. Correctional officer job satisfaction
   d. All of the above
8) Trauma-informed correctional practices have been associated with decreases in
   a. Inmate suicide attempts
   b. Inmate assaults on officers
   c. Inmate assaults on other inmates
   d. All of the above
   e. Answers b & c only
9) Trauma-informed correctional practices require major changes in all aspects of inmate supervision.
   a. True
   b. False
10) Principles of trauma-informed corrections require that officers reduce the number of choices that inmates make in daily routines.
   a. True
   b. False

10-Item Trauma Quiz (DeHart & Iachini, 2019)