Article

Mental Health Professionals' Attitudes Toward Offenders With Mental Illness (Insanity Acquittees) in Ghana

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Abstract

Mental health professionals' attitudes toward offenders with mental illness have significant implications for the quality of care and treatment rendered, making it imperative for these professionals to be aware of their attitudes. Yet, this topical issue has received little research attention. Consequently, the present study investigates attitudes toward offenders with mental illness (insanity acquittees) in a sample of 113 registered mental health nurses in Ghana. Using a cross-sectional survey and self-report methodology, the participants respond to measures of attitudes toward offenders with mental illness, attitudes toward mental illness, conviction proneness, and criminal blameworthiness. The results show that mental health nurses who reportedly practiced for a longer duration (6 years and above) were more likely to be unsympathetic, while the male nurses who were aged 30 years and above were more likely to hold offenders with mental illness strictly liable for their offenses. Importantly, the nurses' scores in conviction proneness and criminal blameworthiness significantly predict negative attitudes toward the offenders even after controlling for their attitudes toward mental illness. Yet, when the nurses' conviction proneness and criminal blameworthiness were held constant, their attitudes toward mental illness failed to predict attitudes toward the offenders. This initial finding implies that the nurses' views regarding criminal blameworthiness and conviction may be more influential in understanding their attitudes toward offenders with mental illness relative to their attitudes toward mental illness.

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The number of persons with mental illness coming into contact with the public and the criminal justice system has reportedly increased over the years for several reasons, including deinstitutionalization of mental health services (Hansson & Markström, 2014; Lamb & Weinberger, 2001) and economic crisis (e.g., recession) and its detrimental impacts on mental health (see Van Hal, 2015). Given the somewhat modest association between symptoms of mental disorder and the tendency to engage in criminal activities (Dixon, 2012; Harris & Lurigio, 2007), several jurisdictions, including Ghana, have enacted insanity defense legislations to absolve from criminal liability defendants satisfying the elements of the legislations (Adjorlolo, Agboli, & Chan, 2015; Adjorlolo, Chan, & Agboli, 2016; Yeo, 2008). Because the treatment need of offenders with mental illness takes precedence over prescribing punishments (e.g., incarceration) for their criminal conducts, they are committed for mandatory treatment (Adjorlolo, Agboli, and Chan, 2015; Adjorlolo et al., 2016; Steadman, Monahan, Hartstone, Davis, & Robbins, 1982). Offenders with mental illness in this context refer to *insanity acquittees*, although the term has been applied broadly to encompass other categories of offenders with mental illness, namely, those who are incompetent to stand trial, and prisoners with mental health problems prompting intervention (Renzaglia, Vess, Hodel, & McCrary, 2004; Steadman et al., 1982).

Mental health professionals, particularly mental health nurses and psychiatrists, are extremely important in the management of this vulnerable group of offenders. Given the (potential) adverse impact of negative attitudes on the quality of care, management, and treatment (Caldwell & Jorm, 2001; Hugo, 2001), these professionals need to be aware of their attitudes toward those they provide care to, including offenders with mental illness. Yet, this topical issue has received little research attention. This preliminary study was, therefore, undertaken to investigate the attitudes of mental health nurses toward offenders with mental illness in Ghana.

Adjudication and Disposal of Offenders With Mental Illness in Ghana

Ghana, formerly known as the Gold Coast because of the abundance of gold, is a West African State sharing borders with neighboring countries such as Togo to the East, Cote d'Ivoire to the West, and Burkina Faso to the North. Occupying a geographical area of 92,100 sq miles (238.533 sq kilometers), the country is home to about 25 million people (Ghana Statistical Service [GSS], 2012). The predominant religion is Christianity (71.2%), followed by Islam (17.6%), no affiliation with any religion (5.3%), and finally subscribers of traditional faiths (5.2%; GSS, 2012). Ghana is a heterogeneous society with more than 46 different ethnic groups such as Akan,

Mole-Dagbani, and Ewe, and between 50 and 100 languages and dialects spoken by the various ethnic groups (GSS, 2012). Administratively, the country is divided into 10 regions, 170 districts, and 275 constituencies (GSS, 2012). As a multiparty democratic state, the highest office is occupied by the president followed by the vice president. Members are also elected from each constituency to form the legislative arm of Ghana. Agriculture is the most predominant economic activity, employing 41.5% of the economically active population (i.e., 15 years and above). This is followed by wholesale and retail trade (18.9%), and last, manufacturing (10.8%; GSS, 2012). For further information on Ghana, please refer to existing sources (see Adinkrah, 2014, 2015; GSS, 2012).

Ghana ceased to be a British colony on March 6, 1957 when she became the first sub-Saharan country to gain independence. Consequently, Ghana's judicial system is directly mirrored after that of Britain, although there have been some changes since independence. Specifically, the insanity defense legislation is influenced by the M'Naughton insanity defense rules formulated by the House of Lords in England in 1943 (Adjorlolo et al., 2016). Section 27 of the Criminal Offences Act, 1960 (Act 29) underscores two conditions in which the insanity defense can be invoked. Accordingly, a person can raise the defense

> (a) If he was prevented, by reason of idiocy, imbecility, or any mental derangement or disease affecting the mind, from knowing the nature or consequences of the act in respect of which he is accused
>
> or
>
> (b) If he did the act in respect of which he is accused under the influence of an insane delusion of such a nature as to render him, in the opinion of the jury or of the Court, an unfit subject for punishment of any kind in respect of such act.

When the insanity defense is raised, the presiding judge or magistrate normally requests for psychiatric assessment per Section 137 of the Criminal and Other Offences (Procedure) Act, 1960 (Act 30). The evaluator, normally a psychiatrist, having recourse to all the available evidence, including mental state examination and collateral sources of information, shall furnish the court with the evaluation report (for discussions on mental state assessment in Ghana, see Adjorlolo, Agboli, and Chan, 2015). The report may be subjected to cross-examination insofar as a party to the case is not satisfied with it. According to Section 204 of Act 30, all trials on indictment shall be undertaken by a jury, or by a judge with the help of assessors. Section 2 of Act 30 defines indictable offenses as those punishable by death or those codified in the relevant statutes as first-degree felonies, or triable on indictment. For trials involving indictable offenses, first, there is the need for a preliminary hearing to determine whether there is a prima facie case against the accused. In contrast, summary offenses (e.g., misdemeanors) shall be tried by a judge or magistrate in a court of summary jurisdiction (e.g., District Court), or in a High Court or Circuit Court.

It is not the responsibility of a medical expert to decide the issue of insanity, although the decision by the court is aided by expert testimonies and, where necessary, non-expert testimonies (e.g., families, friends, and neighbors; see *Kwadwo Mensah v. The Republic*, 1959). Although the defendant has the burden of proof in establishing insanity, the proof is based on a balance of probabilities, which is lower than what the prosecution bears (Mensa-Bonsu, 2001). When the court is satisfied that a defendant meets the requirements of the insanity defense test, the "special verdict," guilty but insane, shall be returned. Consequently, the defendant shall be given orders for treatment at any of the three public psychiatric institutions, but mostly at Accra Psychiatric Hospital because it appears more secured, thus reducing the incidence of patients absconding (for details, see Adjorlolo et al., 2016; Adjorlolo, Agboli, & Chan, 2015). This arrangement makes the organization and delivery of mental health services very pertinent in the quest to respond to the mental health needs of offenders with mental illness.

Mental Health Care Delivery in Ghana

Mental health care is provided by the government of Ghana. In other words, mental health services are delivered freely to patients admitted to the psychiatric hospitals at the expense of government with support from charitable organizations. A review of the mental health literature in Ghana revealed that schizophrenia/psychosis, depression, suicide, and self-harm were the most investigated disorders, suggesting a high prevalence of these disorders (Read & Doku, 2012). Reporting on the mental health situation in Ghana, the WHO estimated that about 650,000 people had severe mental disorders (e.g., major depression, psychosis), whereas 2,166,000 had moderate to mild mental disorders (e.g., anxiety disorders; WHO, 2007). The WHO further noted that about 10% of people suffer from psychiatric conditions at any point in time, translating into about 2.5 million Ghanaians with mental illness. Although relatively little is known about offenders with mental illness in Africa, due to dearth of empirical studies (Adjorlolo et al., 2016), a study in Ghana by Turkson and Asante (1996) found that out of 138 offenders with mental illness, 31% were diagnosed with schizophrenia, 20.2% with drug-induced psychotic disorder, and 13.3% with non-specified psychosis. Nearly half (48.6%) of the offenders charged with murder or attempted murder were diagnosed with schizophrenia. Similar findings have been reported by studies conducted in Western countries (e.g., the United States; Dirks-Linhorst, 2014; Vitacco, Vauter, Erickson, & Ragatz, 2014).

Recently, a new impetus for mental health care in Ghana has brought changes to the organization and delivery of mental health services. For example, several non-governmental organizations have been established, a new mental health law has been passed (i.e., Mental Health Act 2012, 846), and there is an increased training for psychiatrists and mental health nurses (see Adjorlolo et al., 2016; Read & Doku, 2012). Notwithstanding this, there are conspicuous challenges besetting mental health care delivery in Ghana. For instance, although the health care system in Ghana operates on a five-tiered system—community, sub-district, district, regional, and national levels

(Ministry of Health, 2008)—it is interesting to note that the provision of mental health services is mainly concentrated at the regional or national levels. There are currently three public psychiatric hospitals in Ghana, two of which are located in the capital city, Accra (i.e., Psychiatric Hospital and Pantang Mental Hospital) and one in the Central region (i.e., Ankaful Psychiatric Hospital). The northern and other parts of the country have been neglected with respect to the provision of mental health services.

The psychiatric institutions have forensic units where all categories of offenders with mental illness (e.g., insanity acquittees, defendants who are incompetent to stand trial, and prisoners who have been administratively transferred to the hospitals) are accommodated, catered for, and treated. These individuals are brought together in the same unit because of their involvement in the criminal justice system without recourse to the nature of their crimes and mental disorders. That is, extremely violent and aggressive offenders with severe mental disorders (i.e., psychosis with bizarre delusions and hallucinations) are camped in the same units with nonviolent offenders (e.g., thieves) with less severe mental disorders (e.g., anxiety disorders). The situation is more worrying at the Accra Psychiatric Hospital forensic unit where patients on voluntary admission, vagrants, and offenders with mental illness are accommodated. Because of the modest association between symptoms of (severe) mental disorder (e.g., hallucinations) and aggressive tendencies (Dixon, 2012), this particular development raises grave concern with respect to violence directed toward fellow inmates.

Regarding human resources, a report produced in 2011 revealed that there were 18 psychiatrists, 1,068 registered mental health nurses, 72 community mental health officers, and 21 social workers (Roberts, Mogan, & Asare, 2014). Clinical psychologists and neuropsychologists are not only inadequate, but they do not have the required resources and environment to practice (Adjorlolo, 2015). Financial constraints, with less than 1% expenditure on mental health (K. Jacob et al., 2007), and other organizational challenges such as shortages of hospital beds, supplies, and psychotropic medicines are also evident (Read & Doku, 2012; Roberts et al., 2014).

The unwillingness of some family members to accept individuals treated for mental disorders back, partly due to the stigma associated with mental illness, has largely contributed to the difficulties in attempting to reintegrate these individuals into the communities (Adjorlolo, 2016). As a result, several patients stay longer at the treatment centers than expected, further putting constraints on the limited and overused resources. Notably, offenders with mental illness are sometimes hospitalized much longer than if they had been convicted and imprisoned. This is also because the Criminal Offences Act (Act 29) and the Criminal Procedure Act (Act 30) did not provide a statutory limit on the duration of commitment after a finding of guilty but insane. Although Section 47 of the recently enacted Mental Health Act 2012 (Act 846) states that "The period of prolonged treatment shall not exceed twelve months at a time," it is not clear whether this provision applies to defendants admitted for treatment under Section 76 (i.e., offender with mental disorder). In response, Accra Psychiatric Hospital in 2012 embarked on a project dubbed "600 patients" with the overarching goal of reducing the population of patients from about 1,200 to 600. However, because of poor transitional planning and difficulties of reintegration, some

of the patients sent home find their ways back to the hospital while the fates of others are not known due to lack of a systematic follow-up (Adjorlolo, 2016). The underdeveloped community mental health services also present another challenge in terms of continuity of care at the community level, albeit some general hospitals located in some communities have recently been resourced to some extent to provide psychiatric care, mostly on outpatient basis.

Notwithstanding the above, the attitudes of the few mental health professionals in Ghana can affect the quality of care rendered to mental health patients, including offenders with mental illness (see Beech & Fordham, 1997; Caldwell & Jorm, 2001; Hugo, 2001; Marshall et al., 2003). Thus, while studies have been interested in investigating intervention programs and their effectiveness in offenders with mental illness in general (Knabb, Welsh, & Graham-Howard, 2011; Lipsey & Cullen, 2007), another useful and insightful area of enquiry is mental health professionals' attitudes toward these offenders.

Attitudes Toward Mental Illness, Offenders, and Offenders With Mental Illness

Attitude, for the purpose of this study, is construed as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor" (Eagly & Chaiken, 1993, pp. 1). Attitudes persist over time and are stored in memory, plausibly in the form of objects (e.g., offenders with mental illness) and their evaluations (e.g., dangerous; Van Overwalle & Siebler, 2005). The strong beliefs in the existence and manipulations of witches, ancestral spirits, sorcerers, and other demonic forces as causes of traumatic events such as death and mental illness among many West Africans, including Ghanaians, can significantly influence their attitudes toward offenders with mental illness (Adinkrah, 2015; Meyer, 2015). It is commonly believed that some supernatural forces such as ancestral spirits, gods, and deities visit wrongdoers or people who have committed heinous "cultural sins" or violated cultural taboos (e.g., tempering with ancestral forest, stealing the properties of gods) with mental illness. These beliefs are so prevalent that they are frequently broadcasted by the media. Scenes of witches, wizards, and other forces wreaking havocs in the night are commonly shown in movies such as "Kyeiwaa" (a Ghanaian movie depicting the uncompromising stance of a supposed witch noted for causing various distractions) in Ghana (for more details, see Meyer, 2015).

In a validation study of the Insanity Defense Attitude Scale–Revised (IDA-R; Skeem, Louden, & Evans, 2004) in Ghana conducted by Adjorlolo, Abdul-Nasiru, Chan, and Bentum (unpublished manuscript), the participants (University students in Ghana; $N = 253$) were also asked whether mental illness is caused by biological factors (e.g., genetics, unbalanced neurochemistry), psychosocial factors (e.g., stress and relationship problems), and supernatural forces (e.g., demons, witchcraft, and evil spirits). Although the majority agreed that mental illness is caused by psychosocial factors (90%) and biological factors (71%), it is interesting to note that 46% agreed that mental illness is caused by supernatural forces. This finding partly corroborates the suggestion

that beliefs in the supernatural forces pervade the minds of many individuals regardless of their education and professional background, especially in times of distress or disaster (Aina, 2004). This raises the possibility that mental health professionals may subscribe to these supernatural beliefs, which, in turn, may have negative effects on their attitudes. In this regard, a preliminary study in Zambia, West Africa, found that primary mental health providers held discriminatory and stigmatization attitudes toward mental illness and patients with mental illness (Kapungwe et al., 2011). Interestingly, a similar finding has been reported by studies conducted in Western countries (Björkman, Angelman, & Jönsson, 2008; Hansson, Jormfeldt, Svedberg, & Svensson, 2013), although others found evidence of positive attitudes (Stuber, Rocha, Christian, & Link, 2014). Linden and Kavanagh (2012), for instance, found that inpatient mental health nurses held socially restrictive attitudes toward patients diagnosed with schizophrenia, regarding them as dangerous individuals who should be avoided. Perhaps, a key difference in the evaluation of mental illness and those afflicted with mental illness between Westerners and sub-Saharan Africans is that the former's evaluation may be influenced by the bizarre and highly distorted symptoms of mental illness (e.g., hallucinations and delusions) whereas the latter may focused on the sociocultural causes, as well as symptoms of mental illness.

Studies examining mental health professional attitudes toward offenders are comparatively scarce globally. The few studies investigating this topical issue have also focused on sex offenders (Gakhal & Brown, 2011; Jones, 2013). These studies have concluded that professionals (e.g., psychologists, forensic staff) who provide treatment to sex offenders and who maintain greater and more direct contact with these offenders were generally less negative in their attitudes, relative to those who do not work directly and regularly with the offenders (e.g., police officers, students). However, considering the fact that most sex offenders are thought to have acted voluntarily and willingly on their sexual fantasies, and not necessarily under the influence of symptoms of mental disorders, studies of staff attitudes these offenders may have little utility in explaining and understanding attitudes toward offenders with mental illness, especially those whose crimes resulted from mental disorders (i.e., insanity acquittees). This conspicuous gap in the literature obviously deserves research attention.

In another point of discussion, studies investigating mental health professionals' attitudes toward offenders with mental illness are limited. Earlier studies have found that clinicians have challenges establishing caring relationships with offenders with mental illness who have committed horrendous crimes, believing that they should be incarcerated rather than treated (Kent-Wilkinson, 1993; Kettles & Robinson, 1998). In another study, mental health professionals working with offenders with mental illness were more likely to show empathic responses when they perceive the offenders to be mentally ill compared with when they perceive them to be evil (Mercer, Mason, & Richman, 2001). These findings highlight the point that mental health professionals can focus more on the criminal backgrounds of offenders with mental illness compared with their clinical backgrounds. This development can be detrimental to the nature and quality of the therapeutic relationships and treatments, as noted above. Interestingly, one study that compared mental health nurses and prison officers'

attitudes found that the officers reported more positive and favorable attitudes toward offenders with personality disorders than did the nurses (Carr-Walker, Bowers, Callaghan, Nijman, & Paton, 2004). Moreover, the prison officers were reportedly less fearful and less frustrated when dealing with personality disordered offenders. By contrast, the psychiatric nurses expressed greater vulnerability and more concerns with respect to caring and managing these offenders.

Reiterating earlier comment, mental health professionals' views of offenders with mental illness can influence the overall organization and provision of treatment to these individuals. For example, mental health staff (i.e., therapists) with negative attitudes toward offenders were reportedly less willing to accept them for treatment, and also rated them as less motivated for change, compared with non-offenders (Graham, 1980). Some authors (Beech & Fordham, 1997) have similarly noted that mental health professionals' positive attitudes significantly influenced the changes experienced by offenders undergoing treatment, perhaps over what was induced by the characteristics of the treatment program. In keeping with the above, Marshall et al. (2003) reported that therapists' positive attitudes such as empathy and warmth contributed significantly to the positive changes experienced by sex offenders undergoing treatment, compared with the use of confrontational style.

From the above discussions, there is a pressing need to develop a better understanding and insight into mental health professionals' attitudes toward offenders with mental illness not only in Ghana but globally. Specifically, explicating factors capable of shaping, influencing, or predicting these professionals' attitudes is important for a number of reasons. First, although attitudes may (Kong, Zhang, & Chen, 2013) or may not predict behaviors, they are reportedly responsive to planned and deliberate intervention programs (e.g., training program to reduce the stigma associated with mental illness; see Craig, 2005; Hansson & Markström, 2014; Lavoie, Connolly, & Roesch, 2006). A meta-analytic investigation reported that the quality of interpersonal relationships between mental health professionals and offenders with mental illness, the extent of sympathy shown to the offenders, and the extent of engagement in treatment by the offenders largely determine the quality and efficacy of treatment received by the offenders, and ultimately the effect of treatment in reducing recidivism (Dowden & Andrews, 2004). It is plausible to state that these professional–patient interactions and behaviors can be affected by the attitudes of the professionals.

Notably, staff negative attitudes, views, and perceptions can adversely affect the therapeutic process, which is sometimes construed as a learning process, and an avenue through which offenders can develop positive interpersonal or interactional skills needed to engage in treatment, experience positive treatment outcomes, and facilitate their integration into communities after discharge from the hospital (Lerner & Fiske, 1973; Wampold, 2001). Kozar and Day (2012) noted that there are strong theoretical and practice grounds for professionals to develop strong therapeutic alliance with offenders in general. Offenders with mental illness stand to benefit substantially from this alliance given that they are prone to impaired insight and distorted cognitions; thus, establishing good working alliance can facilitate their engagement in treatment.

Therefore, identifying mental health professionals' (negative) attitudes, which can predict their real-world (negative) behaviors, would be instrumental in designing appropriate intervention programs to correct these attitudes. Moreover, as studies examining mental health professionals' attitudes toward offenders with mental illness are relatively scarce, the present study also serves scholarly purpose by way of contributing to the literature and opening up new areas for further investigations.

To this end, it will be informative and insightful to investigate the views of mental health professionals' attitudes toward offenders with mental illness who are committed for treatment. To achieve this goal, the study investigates mental health nurses' attitudes toward mental illness, as well as punishment-oriented attitudes (i.e., conviction proneness and punitiveness) as predictors of their attitudes toward offenders with mental illness. Second, the study examines whether mental health nurses' demographic backgrounds, namely, gender, age, and years of practice, have significant influence on their attitudes toward offenders with mental illness. This study, therefore, deviates significantly from previous studies of related topic that have compared these professionals with others (e.g., community samples).

Method

Participants

The small number of psychiatrists in Ghana means that the mental health nurses have greater responsibilities in terms of providing care and treatment to individuals in need of mental health services. Besides, the nurses also have daily and frequent encounters and interactions with individuals with mental illness than the psychiatrists. Consequently, data were collected from 113 registered mental health nurses recruited from two of the three public mental health institutions: Accra Psychiatric Hospital (n = 54) and Pantang Mental Hospital (n = 59). These two hospitals were chosen mainly because of accessibility as they are located in the capital city of Ghana. Second, they receive referrals from courts and have a large number of offenders with mental illness as patients. All the participants were graduates with a diploma from nurses' training colleges in Ghana. They were recruited from the following units and departments: forensic units (n = 25), female wards (n = 28), male wards (n = 30), geriatric wards (n = 20), and children's wards (n = 10). It should be noted that with the exception of the forensic units, none of these wards admit offenders with mental illness. Therefore, the participants were selected on the basis that they were trained mental health nurses and not necessarily because they provide care and treatment to offenders with mental illness. There were 35% (n = 50) males and 65% (n = 63) females. The participants were asked to select one of the two age ranges: less than 30 years (n = 85, 75%) and 30 years and above (n = 28, 25%). Pertaining to years of practice, we grouped the participants into those who had practiced for less than 1 year (n = 28, 25%), 1 to 5 years (n = 61, 54%), and 6 years and above (n = 24, 21%). This categorization enabled us to compare the newly recruited mental health professional graduates to those who have practiced for 1 year and more.

Research Design and Procedure

A cross-sectional survey questionnaire was administered to the participants. Participation was strictly limited to qualification as a registered mental health nurse with the Nurses and Midwives' Council of Ghana. The hospitals do not have their own ethics review boards. However, researchers must seek ethical clearance from other recognizable ethics boards in the country. This study received ethical approval from the Institutional Review Board, Noguchi Memorial Institute for Medical Research, University of Ghana. Institutional permission was obtained from the hospital administrations, as well as from the heads of the various wards and units. No member of the research team was affiliated to or had a working relationship with the mental health hospitals prior to the data collection. After explaining the purpose of the study to the participants, written informed consent was obtained from those who expressed willingness and interest to participate in the study. The study adhered strictly to the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct. For instance, participation was strictly voluntary, with no incentive provided. The participants were informed that they could withdraw from the study without being penalized. Responses were kept anonymous to protect confidentiality and privacy. They were each provided with a pack of questionnaires that consisted of the measures described below.

As noted previously, the participants were recruited from different wards and units at the hospitals, including the forensic units. Given that the study was interested in assessing attitudes toward offenders with mental illness, the data collection process included a case vignette of one of the insanity defense cases decided by the courts in Ghana (*Collins v. The Republic*, 1987). This was to ensure that attitudes toward offenders with mental illness and not individuals with mental illness in general were captured. The same vignette was used for all the participants. Briefly, the defendant in the vignette was a male, with a diagnosis of schizophrenia, who allegedly committed murder. At trial, the defendant was found guilty but insane, and subsequently committed for treatment. This case was chosen not only because schizophrenia is a major and severe mental disorder but also because it appears to be a common diagnosis in offenders with mental illness in Ghana (Turkson & Asante, 1996). Besides, murder is a serious and violent crime in Ghana and other jurisdictions (Adjorlolo, 2016; Dirks-Linhorst, 2014). The sex "male" reflected the fact that in Ghana (Adinkrah, 2014) and elsewhere (Adjorlolo & Chan, 2015), males commit more crimes than females, and also that offenders with mental illness in Ghana are mostly males (Turkson & Asante, 1996).

The participants were instructed to return the completed questionnaires, sealed in an envelope, to designated persons at the various units and wards. A total of 170 nurses were approached at the two institutions. Twenty declined to participate, citing reasons such as lack of time and interest. In all, 150 packs of questionnaires were administered, out of which a total of 115 were returned. The response rate, taking into account the number of nurses approached, was approximately 68%. Two packs of questionnaires were substantially uncompleted and were excluded, leaving a total of 113 pack of questionnaires for the analyses.

Measures

Insanity Defense Attitude–Revised (IDA-R). Attitudes toward offenders with mental illness were assessed with the IDA-R (Skeem et al., 2004). The IDA-R is a 19-item scale that was developed and standardized using participants from the United States. In their validation study, Skeem et al. (2004) identified two distinct factors: strict liability, and injustice and danger. The strict liability factor assesses the attitude of holding defendants pleading insanity at the time of offense accountable for their crimes (sample item includes, "we should punish people who commit criminal acts, regardless of their degree of mental disturbance"). The injustice and danger factor, however, illustrates the degree to which an individual believes that the insanity defense is misused or posed a threat to public safety (sample item includes, "the insanity defense returns disturbed, dangerous people to the streets").

In a related validation study in the United States by Vitacco et al. (2009), two factors emerged. These were strict liability, as previously discussed, and unprofessional behavior and safety concern. This new factor reflects the perceived roles of mental health professionals in helping defendants to escape punishment (e.g., for the right price, psychiatrists will probably manufacture a "mental illness" for any criminal to convince the jury that he is insane). It also assesses individuals' safety concerns (e.g., many of the crazy criminals that psychiatrists see fit to return to the streets go on to kill again). Given that the IDA-R is a commonly used measure in the United States (see also Kivisto & Swan, 2011) and Canada (see Maeder, Yamamoto, & Fenwick, 2015), a validation study was undertaken by Adjorlolo et al. (unpublished manuscript) to examine its utility in Ghana. Three distinct factors were identified: (a) strict liability (five items; Cronbach's alpha = .82), (b) unprofessional behavior and safety concern (eight items; Cronbach's alpha = .89), and (c) expression of sympathy (six items; Cronbach's alpha = .84). The first two factors were consistent with the previous validation studies in the United States (Skeem et al., 2004; Vitacco et al., 2009). The identification of the third factor also validates Skeem et al.'s (2004) assertion that "it is possible that a dimension was under-represented and not identified" . . . "in fact, it is possible that the IDA-R does not possess a two-factor structure" (p. 643). This factor conveys participants care and concern for the defendants pleading insanity at the time of offense (e.g., most defendants who use the insanity defense are truly mentally ill, not fakers; it is wrong to punish people who commit crime for crazy reasons while gripped by uncontrollable hallucinations or delusions). In this study, the three subscales identified in a Ghanaian sample and the IDA-R total score (internal consistency [α] of .86), which was produced by summing the three subscales, were used for the analyses. High scores on all the four scores denote negative attitudes.

Community Attitude Toward Mental Illness (CAMI) questionnaire. The CAMI questionnaire (Högberg, Magnusson, Ewertzon, & Lützén, 2008) is a 20-item scale that assesses participants' attitudes toward mental illness. It has three subscales: Open-Minded and Pro-Integration (nine items; Cronbach's α = .77), Fear and Avoidance (six items; Cronbach's α = .81), and Community Mental Health Ideology (five items; Cronbach's α = .67). The items are scored on a 6-point Likert-type scale, ranging from

1 (*strongly disagree*) to 6 (*strongly agree*). A high score on the subscales and the total scale indicates positive attitudes toward mental illness. The internal consistency (Cronbach's α) of CAMI total in the study was .79.

Legal Authoritarianism. Legal Authoritarianism (Kravitz, Cutler, & Brock, 1993) was used as a measure of conviction proneness. Legal Authoritarianism is a subscale of the Revised Legal Attitude Questionnaire–23 developed by Boehm (1968) and revised by Kravitz et al. (1993). It measures the likelihood of convicting or acquitting suspects, with high scores suggesting the tendency to convict (i.e., conviction proneness). The Authoritarianism subscale (eight items; Cronbach's $\alpha = .68$) was scored using a 6-point Likert-type scale, ranging from 1 (*strongly disagree*) to 6 (*strongly agree*).

Punitiveness Scale. Punitiveness Scale (Falco, 2008) was used as a measure of punitive attitudes. This scale consisted of 12 items (Cronbach's $\alpha = .82$) that measure participants' perception regarding the degree of punishment deemed appropriate to offenders. The items were scored on a 5-point Likert-type scale, from 1 (*strongly disagree*) to 5 (*strongly agree*). The total score on the scale ranges from 12 to 60, with higher scores indicating more punitive attitude.

Data Analysis

All data were analyzed with SPSS Version 21 (IBM.corp). A two-tailed statistical significance was set at 0.05, unless otherwise indicated. We performed a series of statistical analyses. First, Pearson product moment correlation was used to examine the intercorrelations among the scores of IDA-R, CAMI, Legal Authoritarianism, and Punitiveness.

Second, to predict attitude toward offenders with mental illness from attitudes toward mental illness, conviction proneness, and punitiveness, a hierarchical regression was performed using the enter method. The outcome variable was the IDA-R. The minimum sample size required for the regression analysis was determined based on Tabachnick and Fidell's (2007) sample determination: $N > 50 + 8\ m$, where N and m refer to the number of participants and predictors, respectively. The relatively small sample size precludes the inclusion of several variables in a single regression equation. Consequently, four separate regression analyses were performed. Regression Equations 1 and 2 examined the extent to which CAMI and punishment-oriented attitudes (i.e., punitiveness and conviction proneness) predicted the outcome variable, respectively, after controlling for demographic variables (e.g., gender and age). Regression 3 was used to investigate the predictive effects of punitiveness and conviction proneness on the participants' attitudes toward offenders with mental illness after holding their attitudes toward mental illness constant. Finally, in Regression 4, we estimated the predictive relationship between the participants' attitudes toward mental illness and offenders with mental illness after controlling for their punishment-oriented attitudes.

Last, a 2 × 2 × 3 MANOVA was used to investigate the effects of gender (male and female), age (less than 30 years, and 30 years and above), and years of practice

Table 1. Bivariate Correlations and Descriptive Statistics of IDA-R, CAMI, Punitiveness, and Conviction Proneness.

Variable		1	2	3	4	5	6	7	8	9	10
IDA-R											
1.	Strict liability										
2.	Unprofessional behavior and safety concern	.29**									
3.	Expression of sympathy	−.30**	−.16								
4.	Total score	.54**	.73**	.19*							
CAMI											
5.	Open-minded and pro-integration	−.09	.10	29**	.20*						
6.	Fear and avoidance	−.33**	.03	18	−.06	.37**					
7.	Community mental health ideology	−.24*	.16	23*	.07	.38**	.39**				
8.	CAMI total	−.29**	.09	29**	.06	.81**	.76**	.70**			
9.	Punitiveness	.43**	.42**	−.13	.45**	−.18	−.45**	−.25**	−.38**		
10.	Conviction proneness	.48**	.41**	−.01	.55**	.20*	.03	.06	.09	.52**	
M		12.06	20.73	21.16	54.76	38.42	32.81	20.06	90.82	35.65	32.58
SD		3.45	4.21	3.77	5.59	6.80	5.81	3.88	12.80	7.92	5.50

Note. $N = 113$. IDA-R = Insanity Defense Attitude–Revised; CAMI = Community Attitudes toward Mental Illness.
*$p < .05$. **$p < .01$.

(less than 1 year, 1-5 years, and 6 years and above) on attitudes toward offenders with mental illness. In this analysis, Strict Liability, Unprofessional Behavior and Safety Concerns, Expression of Sympathy, and IDA-R total were used as the dependent variables. A Bonferroni-adjusted univariate analysis of variance (ANOVA), with significance level at 0.012 (.05/4), was used as a follow-up on the significant MANOVA results. Effect sizes were estimated with partial eta squared (η^2) and interpreted based on Cohen's formulation of .10 representing small effect, .30 medium effect, and .50 large effect (Field, 2011).

Results

Intercorrelations Among the Study Variables

As can be seen in Table 1, there were significant intercorrelations among the study variables. Open-minded and pro-integration correlated significantly with expression of sympathy ($r = .29$, $p < .01$) and insanity defense total ($r = .20$, $p < .05$). Fear and avoidance also showed significant correlation with strict liability ($r = -33$, $p < .05$). Similarly, community mental health ideology correlated significantly with strict liability ($r = -24$, $p < .05$) and expression of sympathy ($r = 23$, $p < .05$). Likewise, the CAMI total score was related to strict liability ($r = -.29$, $p < .01$) and expression of sympathy ($r = 23$, $p < .05$). Punitiveness was significantly related to strict liability ($r = .43$, $p < .01$),

unprofessional behavior and safety concern ($r = .42$, $p < .01$), and expression of sympathy ($r = .45$, $p < .01$). Moreover, authoritarianism showed significant correlations with strict liability ($r = .48$, $p < .01$), unprofessional behavior and safety concern ($r = .41$, $p < .01$), and, finally, expression of sympathy ($r = .55$, $p < .01$). Punitiveness was also related to fear and avoidance ($r = -.45$, $p < .01$), community mental health ideology ($r = -.25$, $p < .01$), and CAMI total ($r = -.38$, $p < .01$). However, authoritarianism showed significant correlation with only open-minded and pro-integration ($r = .20$, $p < .05$). Expectedly, conviction proneness was significantly related to punitiveness ($r = .52$, $p < .01$)

Predictors of Attitudes Toward Offenders With Mental Illness

The results of the four regression analyses were summarized in Table 2. In Regression 1, attitudes toward mental illness significantly predicted the outcome variable, accounting for 22% of the variance, $R^2 = .22$, $F(5, 97) = 4.57$, $p < .001$. The CAMI total score showed high singularity and was excluded from the analysis. Attitudes toward mental illness subscores significantly predicted attitudes toward offenders with mental illness; open-minded and pro-integration, $\beta = .24$, $t(96) = 2.12$, $p = .05$; fear and avoidance, $\beta = .49$, $t(96) = 3.86$, $p < .001$; and community mental health ideology, $\beta = .42$, $t(96) = 3.88$, $p < .001$. In Regression 2, punishment-oriented attitudes significantly predicted and explained 35% variance in the outcome variable, $R^2 = .35$, $F(4, 98) = 10.54$, $p < .001$. Specifically, both conviction proneness, $\beta = .43$, $t(97) = 4.06$, $p < .001$, and punitiveness, $\beta = .23$, $t(97) = 2.37$, $p = .02$, significantly predicted the outcome variable. The results from Regression Equations 1 and 2 suggest that attitudes toward mental illness, conviction proneness, and punitiveness, respectively, predicted negative attitudes toward offenders with mental illness.

In subsequent analyses, we investigated whether conviction proneness and punitiveness were significantly predictive of attitudes toward offenders with mental illness after controlling for attitude toward mental illness and vice versa. In Regression 3, when attitudes toward mental illness were controlled for, the punishment-oriented attitudes explained 37% of the variance in the outcome variable, $R^2 = .37$, $F(5, 107) = 12.59$, $p < .001$. Both conviction proneness, $\beta = .35$, $t(106) = 3.57$, $p = .001$, and punitiveness, $\beta = .31$, $t(106) = 2.88$, $p = .005$, significantly predicted attitudes toward offenders with mental illness. In contrast, it was observed in Regression Equation 4 that when the participants' conviction proneness and punitiveness were held constant or controlled for, their attitudes toward mental illness did not significantly predict the outcome variable: open-minded and pro-integration, $\beta = .16$, $t(106) = 1.80$, $p = .075$; fear and avoidance, $\beta = -.02$, $t(106) = -.15$, $p = .880$; and community mental health ideology, $\beta = .07$, $t(106) = .83$, $p = 0.411$. Taken as a whole, the findings of the Regression Equations 3 and 4 suggest that the participants were more likely to be concerned with the punishment of the offenders when their attitudes toward mental illness were held constant. However, the participants' attitudes toward mental illness did not significantly predict and explain their attitudes toward offenders with mental illness after controlling for their punishment-oriented attitudes.

Table 2. Hierarchical Regression of Attitudes Toward Mental Illness, Punitiveness, and Conviction Proneness as Predictors of Attitudes Toward Mentally Disordered Offenders.

Predictor	R^2	ΔR^2	β
Regression 1			
Step 1	.06		
Control variables[a]			
Step 2	.22***	.16***	
Open-minded and pro-integration			24*
Fear and avoidance			.49***
Community mental health ideology			.41***
Regression 2++			
Step 2	.35***	.29***	
Conviction proneness			.43***
Punitiveness			.23*
Regression 3			
Step 1	.06*		
Open-minded and pro-integration			.24*
Fear and avoidance			−.16
Community mental health ideology			.04
Step 2	.37***	.31***	
Open-minded and pro-integration			.19
Fear and avoidance			−.02
Community mental health ideology			.07
Conviction proneness			.35**
Punitiveness			.31**
Regression 4			
Step 1	.34***		
Conviction proneness			.43***
Punitiveness			.23*
Step 2	.37***	.03	
Conviction proneness			.35**
Punitiveness			.31**
Open-minded and pro-integration			.16
Fear and avoidance			−.02
Community mental health ideology			.07

Note. $N = 113$, ++ = Step 1 of the regression is the same as step of Regression Analysis 1.
[a]Control variables included gender (female = 0, male = 1) and age (Age: less than 30 years = 0, 30 years and above = 1)
*$p < .05$. **$p < .01$. ***$p < .001$.

Gender, Age, Years of Practice, and Attitudes Toward Offenders With Mental Illness

For simplicity, only the significant MANOVA and univariate results were reported. The MANOVA analysis showed a significant main effect for years of practice, Wilks' $\lambda = .82$, $F(8, 180) = 2.40$, $p = .018$, $\eta^2 = .10$, and a significant interaction between

gender and age, Wilks' $\lambda = .91$, $F(4, 90) = 2.17$, $p = .042$, $\eta^2 = .13$, on attitudes toward offenders with mental illness.

A follow-up with ANOVA revealed that years of practice had significant effects on the expression of sympathy attitude, $F(2, 93) = 5.55$, $p = .005$, $\eta^2 = .11$. Using Bonferroni procedure, adjusting for multiple comparisons, it was observed that nurses who reportedly practiced for 6 years and above were significantly unsympathetic ($M = 23.90$, standard error [SE] = 0.93) compared with those with less than 1 year of practice ($M = 20.48$, $SE = 0.73$, $p = .010$), as well as 1 to 5 years of practice ($M = 19.93$, $SE = 0.79$, $p = .005$). In a similar vein, the ANOVA result showed a significant gender and age interaction effect on strict liability attitude, $F(1, 93) = 4.98$, $p = .008$, $\eta^2 = .07$. Post hoc analysis revealed that the male nurses who were aged 30 years and above ($M = 15.25$, $SE = 1.34$) scored significantly higher on strict liability attitude (i.e., holding mentally disordered offenders with mental illness strictly liable for their crimes) than their female counterparts ($M = 12.00$, $SE = 0.98$, $p = .009$). In summary, the participants who reportedly practiced for 6 years and above were unsympathetic toward the offenders, while male participants who were aged 30 years and above were more likely to hold the offenders strictly liable for their offenses.

Discussion

This study investigated attitudes toward mental illness, punitiveness, and conviction proneness as predictors of mental health nurses' attitudes toward offenders with mental illness. It also examined the effect of demographic factors (i.e., gender, age, and years of practice) on their attitudes. First, partly consistent with previous reports of negative staff attitudes (Hansson et al., 2013; Kapungwe et al., 2011), the study found that the mental nurses' attitudes toward mental illness significantly predicted their negative attitudes toward offenders with mental illness. However, the nurses' punishment-oriented attitudes (i.e., conviction proneness and punitiveness) appeared very influential than their attitude toward mental illness in predicting attitudes toward the offenders. Notably, those who were high in these punishment-oriented attitudes were more likely to view the offenders negatively after controlling for their attitude toward mental illness. Meanwhile, when the mental health nurses' punishment-oriented attitudes were held constant, their attitudes toward mental illness did not significantly predict attitudes toward the offenders.

Impliedly, the mental health nurses' attitudes regarding punitiveness (criminal blameworthiness) and conviction proneness may be more influential in understanding their attitudes toward offenders with mental illness, relative to their attitudes toward mental illness. Worthy of note is the decades of investigations suggesting a heightened fear of crime by the public (Box, Hale, & Andrews, 1988; Chon & Wilson, 2016; Rollwagen, 2016; Tseloni & Zarafonitou, 2008). Although the activities of criminals (e.g., physical harm) invoke different responses such as fear and disgust in people, these responses are more likely to culminate in negative attitudes (Gakhal & Brown, 2011). In keeping with the tenet of the mere exposure hypothesis (Zajonc, 1968), attitude can be created through personal experiences such that exposures can alter

attitudes negatively (increase hostility). Attitudes can also be shaped via indirect sources such as the media. Indeed, these mental health nurses are part of the larger Ghanaian society where the media provide information concerning the horrific and despicable behaviors of criminals (Adinkrah, 2013, 2014). This development undeniably can precipitate and fuel negative and stigmatizing attitudes toward criminal offenders in general. Although the activities of criminals with mental illness are frequently broadcasted by both print and electronic media, mostly for financial reasons as appealing stories draw more readership and audiences, discussions regarding the possible causes or predisposition factors are rare (Jewkes, 2015). Because the situation may not be different in Ghana, the findings reported here raised the possibility that the mental health nurses were more likely to pay attention to the offense or criminal backgrounds of the offenders rather than to the factors (e.g., mental illness) contributing to their criminal acts. In other words, they are more likely to view offenders with mental illness as individuals who should be punished rather than as patients in need of psychiatric care, thus supporting previous studies (Kent-Wilkinson, 1993; Kettles & Robinson, 1998). It is, therefore, unsurprising that those who strongly believe in holding the offenders criminally liable and convicting them of their crimes were more likely to be negative in their attitudes.

In another point of discussion, the study did not find significant main effects of gender and age on attitudes of the nurses toward offenders with mental illness, partly corroborating previous reports (Johnson, Hughes, & Ireland, 2007; Jones, 2013; Kjelsberg & Loos, 2008; Nelson, Herlihy, & Oescher, 2002). On the contrary, it was observed that the interaction between gender and age, as well as the number of years of practice, had significant effects. Specifically, the study found that male mental health nurses who were aged 30 years and above were more likely to hold the offenders strictly liable for their offenses, relative to their female counterparts. Certain sociocultural practices may contribute to this finding. Precisely, Ghanaian cultures are predominantly patriarchal where boys are mostly socialized to be physically strong and tough in the face of adversities while girls are seen as a weaker sex and so deserve protection from aggressors (Adjorlolo, Adu-Poku, Andoh-Arthur, Botchway, & Mlyakado, 2015). Because of this, the male nurses are mostly the first to be called when patients exhibit aggressive behaviors. In fact, these nurses mostly carry out the difficult aspects of mental health nursing (e.g., restraining violent and aggressive patients) where they may have had negative experiences or may be frustrated with the behaviors of the patients. It is not uncommon for more male nurses to be stationed at wards with aggressive patients (e.g., forensic units and other male wards). It should be noted that although the female nurses do offer some support to restrain, control, or calm aggressive patients, this is not comparable with the efforts of the male nurses, partly in keeping with the supposed physical strength of males in Ghana (Adjorlolo, Adu-Poku et al., 2015). Also, based on their interactions with the offenders, these professionals may have the belief that some of them are cognitively competent and should therefore be held criminally liable. This may stem from their interactions with the offenders who perhaps have malingered or feigned psychiatric symptoms to escape justice. Although this perception was not examined in the study, malingering and feigning are commonly reported in forensic populations (for example,

see Paradis, Solomon, Owen, & Brooker, 2013; Wasyliw, Grossman, Haywood, & Cavanaugh, 1988).

Indeed, there is a global perception that the insanity defense is abused, or those pleading insanity at the time of offense are not truly insane. As a result, acquittals based on the insanity defense have generated major public uproar and outcry worldwide (Raimundo Oda, Banzato, & Dalgalarrondo, 2005; Skeem et al., 2004). This perception may be held by some Ghanaians, including the nurses, who believe that defendants who are capable of exhibiting symptoms of mental illness such as bizarre, distorted behaviors (e.g., sporadic shouting), and unintelligible responses (answering different questions with the same response) in the courtroom can escape punishment. The above perception is predicated on another perception that such individuals easily abscond from the treatment centers and/or are rarely referred back to the court after successful mental health treatment. In support of the above, preliminary data from an ongoing study evaluating the demographic, clinical, and criminological backgrounds of defendants referred from courts at Accra Psychiatric Hospital suggest that majority do abscond from the forensic unit. Because some mental health nurses may have encountered some of these defendants or subscribe to this perception, it is unsurprising that some reported that these offenders should be held strictly liable for their offenses.

Relatedly, nurses who reportedly practiced for 6 years and above were unsympathetic toward the offenders, compared with those practicing for less than 6 years. As reported elsewhere (Caldwell & Jorm, 2001; Dallender & Nolan, 2002; Hugo, 2001; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Wilkins & Shields, 2009), longer years of practice may be associated with increased frustrations and dissatisfactions with the mental health system. For instance, a study in Australia found that psychiatric nurses were dissatisfied with their work (33%) compared with the medical staff (3%; Hugo, 2001). In a related study in the United States, McHugh et al. (2011) reported that nurses who were directly involved in the care and management of patients in the hospitals and nursing homes reported higher job dissatisfactions and burnout relative to their counterparts in other settings such as the pharmaceutical industry. Factors contributing to the dissatisfactions, which have been identified as precursors to mental health nurses' negative attitudes, related specifically to uncertainty with regard to the prognosis and long-term outcomes for people receiving treatment for (severe) mental disorders (e.g., schizophrenia, psychosis).

The situation may not be different in Ghana given that offenders with mental illness and civil mental health patients are mostly diagnosed with severe mental disorders, mostly schizophrenia, and psychosis (Turkson & Asante, 1996). In addition to the challenges affecting the delivery of mental health services in Ghana, as noted previously, the continuous use of typical (e.g., haloperidol and chlorpromazine) rather than atypical antipsychotic (e.g., clozapine and olanzapine) medications in the treatment and management of patients with mental illness deserves a commentary. These medications not only prolong the treatment period but also induce unpleasant side effects, prominent among which are the extra-pyramidal symptoms such as Parkinsonism. These symptoms generally make it extremely difficult for patients to adhere to treatment while on admission and even after discharge, thus affecting the outcome of

treatment, both in the short and long term. The limited use of psychotherapy and other psychosocial interventions to complement the pharmacological treatment is another notable issue (Adjorlolo, 2015). These challenges, coupled with the disproportionately high number of patients relative to mental health staff, may induce excessive stress and burn out among some of the mental health nurses (McHugh et al., 2011).

The foregoing clearly illustrates that prolonged interactions with individuals with mental illness may result in frustrations and dissatisfactions with one's profession. Granted the above, those who have practiced for several years are more likely to experience the brunt of the frustrations and dissatisfactions, which can affect their attitudes severely. The longer nurses stay in the field, the higher the probability that they are socialized through clinical practice and sociopolitical forces to incorporate representations of patients, including offenders with mental illness, as dangerous (J. D. Jacob & Holmes, 2011). These representations may not be confined to the patients' immediate violent behavior but also to the crimes committed, with heinous crimes such as murder more likely to invoke fear, disgust, and negative attitudes. It is therefore unsurprising that the nurses who had practiced for 6 years and above were more likely to be unsympathetic toward offenders with mental illness. Conversely, the nurses who have been working for 5 years or less may not have had as many of these experiences, and also may be more enthused and determined to take up a new challenge in their life, making them more likely to be positive in their attitudes.

Taken as a whole, this preliminary study has found that mental health nurses' punishment-oriented attitudes and some demographic backgrounds (e.g., years of practice) negatively influenced their attitudes toward offenders with mental illness. A very important area of discussion relates specifically to the effect of these factors (e.g., punishment-oriented attitudes) on the performance of the nurses' professional duties and responsibilities. Albeit this was not investigated in the present study, previous studies have suggested adverse effects of staff's negative attitudes on therapeutic processes and outcomes (for example, see Beech & Fordham, 1997; Marshall et al., 2003). Notably, staff negative attitudes toward offenders can potentiate unfavorable, unfriendly, harsh, and stereotypical behaviors, which may manifest covertly or overtly in the form of rejection, confrontation, discrimination, and exclusion. Indeed, as noted by a previous study, mental health nurses are more likely to dehumanize patients who have committed heinous crimes (Rose, Peter, Gallop, Angus, & Liaschenko, 2011).

Inability to set aside personal values and opinions regarding the dangerousness of offenders and approach the task at hand (i.e., treatment of offenders) without prejudice, stereotypes, and judgmental attitudes have a negative impact upon the quality of therapeutic relationships with the offenders. These attitudes can result in untoward consequences such as noncompliance to treatment regimen, a phenomenon commonly reported in offenders with mental illness (Barbaree, 2005; Salekin, Worley, & Grimes, 2010), which in turn may account for mental health professionals' ratings of these offenders as less motivated for change compared with non-offenders (Graham, 1980). These behaviors may similarly deepen the offenders' dissatisfactions with mental health services, which may hinder them from seeking treatment (Morgan, Steffan, Shaw, & Wilson, 2007). Therefore, the findings of the present study and those of

previous studies (Kent-Wilkinson, 1993; Kettles & Robinson, 1998) suggest the need to develop strategies and programs (e.g., training workshops) to promote more positive attitudes among mental health nurses (see Craig, 2005; Hansson & Markström, 2014; Lavoie et al., 2006).

Limitations of the Study

The findings of the study should be considered in view of the following limitations. Although extant studies have used self-report attitudinal measures in measuring attitudes, it should, however, be noted that these measures are not necessarily a true reflection of the participants' actual or real behaviors. The use of these measures further makes it very difficult to check and verify the accuracy of the participants' responses, including detecting response bias and social desirability. Also, with the exception of the IDA-R, the other data collection measures have been not standardized on Ghanaian samples, limiting the validity and comparability of the results.

Moreover, the relatively small sample limits the generalization of the findings. Although we intended to recruit a more representative sample, the workload of these professionals did not permit the majority of them to participate in the study. Future studies are encouraged to use a larger and more representative sample. The use of an individual with schizophrenia who allegedly committed murder in the vignette may also influence the findings given that previous studies have reported negative staff attitudes toward severe and major mental illnesses, including schizophrenia (Hansson et al., 2013; Linden & Kavanagh, 2012). It is, therefore, important that the findings of the study are evaluated in the context of the mental health and offense backgrounds of the defendant in the vignette. Furthermore, the applicability of the findings reported here to other categories of offenders with mental illness (i.e., those found incompetent to stand trial, and administratively transferred prisoners to psychiatric hospitals) may be limited. By using vignette, we subscribe to the assumption that the participants' responses would be restricted to the content of the vignette. We similarly subscribe to the assumption that the participants' responses would be influenced by the two stimuli (schizophrenia and murder), rather than one of them (e.g., murder or schizophrenia). However, it is difficult to state emphatically that the participants' responses were based solely on the content of the vignette. There is the possibility that their responses were also influenced by distal factors that have not been accounted for such as level of satisfactions with the nursing occupation.

Consequently, we recommend more empirical studies to investigate staff punishment-oriented attitudes toward these offenders. A large-scale study of staff attitudes toward different population of offenders or suspects with mental illness will be highly informative. One innovative area of investigation is to ask the mental health nurses, in a simulated insanity defense trial, to register a vote of guilty or acquittal. Doing so will better help to unearth the extent to which they subscribe to punishment and punitive measures (i.e., a finding of guilt) or favor treatment as an option for offenders with mental illness (i.e., a finding of not guilty on the basis of insanity). Second, studies should consider examining the influence of staff negative attitudes resulting from demographic backgrounds (e.g., longer years of practice) and punishment-oriented

attitudes on the therapeutic process or the care rendered using multiple sources of data, such as from offenders with mental illness.

Conclusion

This study has found that the mental health nurses were more likely to be interested in convicting and punishing offenders with mental illness seeking or undergoing treatment. Furthermore, the nurses who reportedly practiced for 6 years and above were unsympathetic toward the offenders, while the male nurses who were aged 30 years and above were more likely to hold the offenders strictly liable for their offenses. These attitudes can affect behavior in a spontaneous manner without any conscious effort or intention on the part of the nurses. That is, they can "become active automatically on the mere presence or mention of the object in the environment" (Bargh, Chaiken, Govender, & Pratto, 1992, p. 893). Negative and unfavorable attitudes can exert negative and undesired consequences on the care and treatment rendered to this category of offenders, which, in turn, can affect their reintegration into communities and ultimately recidivism rate. Importantly, once these attitudes are activated, they inevitably guide subsequent information processing and behavior about the attitude object, in this case, offenders with mental illness (Bargh et al., 1992). Thus, measures to alleviate professionals' attitudes of perceiving these individuals as criminals rather than mental health patients are warranted.

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