

Understanding African American Male Inmates' Decisions to Seek Mental Health Treatment While Incarcerated

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UNDERSTANDING AFRICAN AMERICAN MALE INMATES' DECISIONS
TO SEEK MENTAL HEALTH TREATMENT
WHILE INCARCERATED

by

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Marquette University,
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the Degree of Doctor of Philosophy

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ABSTRACT
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Incarceration in United States correctional facilities has significantly increased in the past decade (The Pew Charitable Trust, 2009). African American adult males are more likely to be incarcerated compared to all other major ethnic groups (U.S. Department of Justice, 2010). One of the current challenges experienced within correctional facilities is the need to provide appropriate mental health treatment services (U.S. Department of Justice, 2011). Studies have noted the need for such services, however, African American adult males generally are not likely to utilize these services (Morgan et al., 2004). In the general (not incarcerated) population, research has found that cultural mistrust (Ward, Clark, and Heidrich, 2009) and mental health stigma (Deane, Skogstad, and Williams, 1999) are barriers to utilization of mental health services by African Americans. However, there is insufficient research examining reasons why African American adult male inmates underutilize mental health services while incarcerated.

The purpose of this study was to explore factors that influence African American male inmates' decisions to seek mental health treatment while incarcerated. Twelve African American males who reported depressive symptoms at intake but who had not sought mental health services were interviewed. Topics explored in the study included (a) how participants defined and described symptoms of mental health problems, (b) participants' experience of engaging in mental health treatment, (c) participants' awareness of mental health treatment options during current incarceration, and (d) participants' general views of mental health treatment for inmates. Grounded theory methodology (Strauss & Corbin, 1990) was used to analyze all data.

Results revealed several major themes, including: descriptions of symptoms commonly associated with mental health problems, positive benefits of mental health treatment, and barriers to seeking mental health treatment while incarcerated (e.g., participants' preference for alternative coping styles, a lack of trust and fear about mental health treatment staff). Participants' narratives and the overall themes that emerged helped to provide an understanding of the reasons why African American inmates may or may not choose to utilize services in prison when experiencing symptoms of depression. Limitations of the study, as well as implications and directions for future research will be discussed.

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Darnell A. Durrah Jr., M.S.

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CHAPTER I: INTRODUCTION

The American adult criminal justice system has experienced a dramatic increase of incarcerated individuals during the past three decades (Diamond, 2001; Western & Wildeman, 2009). As of 2010, the U.S. Department of Justice (DOJ) estimated 7.3 million adults were involved in the criminal justice system and approximately 1 in every 100 adults was currently incarcerated. Despite the African American U.S. population comprising only 14% in 2009 (U.S. Census Bureau), African American men were incarcerated at disproportionate rates (Blumstein, 2011; Department of Justice, 2010; London & Myers, 2006). Depending on geographical region, African American adult males represent over half of the incarceration population (DOJ, 2002). According to the U.S. Department of Justice (2010), 1 in 11 African American adult males was incarcerated and 9.2% have been involved in the criminal justice system at some point in their lifetime. African American men are four times more likely than Caucasians and two and half times more likely than Hispanics to be involved in the criminal justice system (Mauer, 1999; PEW center, 2006).

Incarceration is a significant concern in the United States due to increasing numbers of inmates and the social inequalities that result from incarceration (Western & Pettit, 2010). As Western and Pettit (2010), state: “The social inequality produced by mass incarceration is sizable and enduring for three main reasons: it is invisible, it is cumulative, and it is intergenerational” (p. 8). African American males are directly impacted by these social inequalities. The authors indicated that since those who are incarcerated are generally isolated from mainstream society, this results in an “invisible inequality.” For example, young African American males are more likely to be

incarcerated (DOJ, 2002; Sorensen & Stemen, 2002), come from lower SES communities (Mauer, 2011), and have lower educational attainment (Pettit & Western, 2004), none of which significantly impact society. The most impacted are, instead, the invisible African American males.

Besides the disproportionate rates of African American males incarcerated in the U.S., criminal justice facilities are experiencing an increase of mental health problems among inmates. According to the U.S. Department of Justice (2006), in 2005 an estimated 50% of inmates reported experiencing a mental health problem, compared to 6 percent of the general population (Substance Abuse and Mental Health Services Administration, 2003). Mental health in correctional facilities has recently caught the attention of law makers as well. In response to the growing concern of the mental health needs of incarcerated individuals, the 110th Congress (2008) passed the *Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008*, which allocated \$50 million in grant money for correctional mental health services (DOJ, 2011).

Even with recent political initiatives to increase mental health funding for services in correctional populations, literature has shown that African American males are still less likely to utilize mental health resources ((Brinson & Kottler, 1995; Richardson, Anderson, Flaherty, & Bell, 2003; Stuewig, Bagley, & Tangney, 2010; U.S. Department of Justice, 2006; Youman, Drapalski,). Thus, while African American inmates are likely to have mental health needs (Drapalski, Youman, Stuewig, & Tangney, 2009), they do not utilize available mental health services while in correction facilities (Anglin, Alberti, Link, & Phelan, 2008), which is concerning to prison administrators (Morgan et al.,

2004). The reasons for this underutilization, however, are still unclear. Therefore, an exploration of African American adult males' decisions to seek mental health treatment is critical to better addressing this issue.

Few empirical investigations of mental health service usage in correctional facilities exist (Morgan, Steggan, Shaw, & Wilson, 2007). In one of the few studies regarding inmate perceptions of mental health services, Deane, Skogstad, and Williams (1999), reported ethnic minority males expressed negative thoughts/attitudes about mental health treatment providers and had concerns about stigma associated with mental health. Similarly, in a study conducted by Ward, Clark and Heidrich (2009), which consisted of African American females in the general population with a history of incarceration, found that participants shared negative attitudes towards mental health services, experienced cultural mistrust towards providers, and shared concerns that mental health providers would not be able to understand them. Additional concerns expressed by participants in this study were: a) feeling misinformed regarding side-effects from prescribed medications, b) denying psychiatric symptoms, and c) a lack of awareness pertaining how to access services while incarcerated and in the community once released. Although this empirical investigation consisted of female inmates, their reasons for not utilizing mental health treatment are consistent with those of other samples including African American males in college (Brinson & Kottler, 1995; Duncan, 2003; Lincoln Taylor, Watkins, Chatters, 2011; & Watkins, Walker, & Griffith, 2010) and older African American adult males (Griffith, Allen, & Gunter, 2011; Sellers, Bonham, Neighbors, & Amell, 2009). There have been no similar empirical explorations of African American adult males who are currently incarcerated and their perceptions

about deciding to seek or not seek mental health treatment. Thus, questions remain about whether the findings from African American male college students, older males in general population, or previously incarcerated females can be applicable to African American male inmates, and what unique issues African American males might face as they make decisions about whether or not to utilize mental health services while incarcerated.

Purpose of the Study

The purpose of this study was to explore factors that influence African American male inmates' decisions to seek mental health treatment while incarcerated. A qualitative study was conducted with 12 African American male inmates. Topics explored included: (a) how participants defined and described symptoms of mental health problems (b) participants' experience engaging in mental health treatment (c) participants' awareness of mental health treatment options during current incarceration, and (d) participants' general views of mental health treatment for inmates. Also, this study explored factors that would increase the use of mental health treatment while incarcerated for this specific population of African American males. Grounded theory methodology (Strauss & Corbin, 1990) was used to analyze all data. Grounded theory is a qualitative methodology that allows for a more comprehensive understanding of a topic that has not been previously studied (Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003). Given the limited amount of researcher pertaining to how African American adult male inmates decide to seek mental health treatment while incarcerated, grounded theory was ideal.

Significance of the Study

This current project is important for several reasons. First, African Americans are disproportionately overrepresented in state prisons (DOJ, 2010). Additionally, African Americans, especially adult males have been found to underutilize mental health services (Brinson & Kottler, 1995), even though they are more likely to be exposed to psychosocial stress than their counterparts (Watkins & Neighbors, 2007 & Watkins et al., 2010). Given the growing concern of mental health needs within correctional facilities (Drapalski et al., 2009), and the lack of investigations that have been conducted about this unique issue (Watkins, Walker, & Griffith, 2010), further study of mental health service utilization with this vulnerable population is needed (Morgan, Rozycki, & Wilson, 2004).

Finally, a review of empirical literature suggests there is a positive outcome for individuals who utilize mental health treatment in prisons (Landenberger & Lipsey, 2005). Clark (2010) found cognitive behavioral therapy was an effective therapy in reducing criminal recidivism among juvenile and adult offenders, and improving problems related to criminal behavior.

The current study will therefore attempt to address a significant social issue by investigating perceptions about mental health treatment of adult African American incarcerated males. It is hoped that gaining a better understanding of the beliefs of this vulnerable population will help guide future research and intervention.

Definition of terms. The Bureau of Justice Statistics (BJS) is the primary source for criminal justice statistics. The BJS is responsible for defining terms directly associated

with correctional populations. Two particular terms significant for this study are *incarceration* and *state prison*. An incarcerated population is defined as:

“Incarcerated population is the population of inmates confined in a prison or jail. This may also include halfway-houses, bootcamps, weekend programs, and other entities in which individuals are locked up overnight (BJS, 2011, p. 1).”

State prisons are defined as:

“Prison facilities run by state correctional authorities. Prisoners housed in these facilities are under the legal authority of the state government and generally serving a term of more than 1 year (BJS, 2011, p. 1).”

Mental Health is another term that needs to be defined. The U.S. Department of Health and Human Services (1999) defined mental health as:

“A state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity” (DHHS, 1999, p. 4).

Meanwhile, *mental illness* is defined as:

“Mental disorders are health conditions that are characterized by alterations in mood, thinking, or behavior (or some combination thereof) associated with distress and/or impaired functioning” (DHHS, 1999, p. 5).

The definition of *White* will be used from the 2010 Census:

“According to OMB, ‘White’ refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It also includes respondents who reported entries such as Caucasian or White; European entries, such as Irish, German, and Polish; Middle Eastern entries, such as Arab,

Lebanese, and Palestinian; and North African entries, such as Algerian, Moroccan, and Egyptian.” (U.S. Census Bureau, p. 1)

The definition of *African American* will be used from the 2010 Census:

“According to the OMB, “Black or African American” refers to a person having origins in any of the Black racial groups of African. The Black racial category includes people who marked the “Black, African Am., or Negro” checkbox. It also includes respondents who reported entries such as African American; Sub-Saharan African entries, such as Kenyan and Nigerian; and Afro-Caribbean entries, such as Haitian and Jamaican.” (U.S. Census Bureau, p. 1)

The definition of *Hispanic* or *Latino* will be used in accordance with 2010 Census:

“Hispanic or Latino refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.” (U.S. Census Bureau p. 1-2)

CHAPTER II: LITERATURE REVIEW

The purpose of this study was to explore factors that influence African American male inmates' decisions to seek mental health treatment while incarcerated. There are three main sections to this literature review. The beginning of this literature review will consist of a brief history of incarceration in the United States followed by a discussion regarding African American incarceration disparities. Then, an overview of mental health and incarceration and the difficulties African Americans experience engaging in treatment will be reviewed. In the final section of this chapter, the benefits for individuals who seek mental health treatment along with the challenges African American males deal with will be discussed.

Brief History of Incarceration

Colonial Years. Incarceration in the U.S. can be traced back to the colonial era, which spans 1600 to 1790. During this period of American life, incarceration was typically dealt with by three primary institutions: community, church, and family (Blomberg & Lucken, 2010). In fact, similar to homelessness (Rossi, 1989) during colonial times, communities and families served as the sole disciplinarian for individuals that committed crimes against society (Blomberg & Lucken, 2010). During this era of incarceration, individuals felt criminal behavior was a crime towards God, rather than a social problem, thus, only God could provide just punishment (Blomberg & Lucken, 2010). As a result those individuals who committed criminal acts remained in isolation within their homes in order to repent and regain their moral dignity, manhood, and liberty (Kann, 2001).

Post Revolutionary Period. The post revolutionary period, from 1790 to 1830, is described by Blomberg and Lucken (2010) as a period of transition as society began to move into the 19-century. Unlike colonial years where society viewed crimes committed amongst its citizens as immoral acts against God, during the post-revolutionary years criminal activity became a social problems (Blomberg & Lucken, 2010). History suggest the first jails in the U.S. were built during this period, which primarily incarcerated individuals who committed crimes alcohol, gambling, prostitution, and robbery (Blomberg & Lucken, Lucken, 2010).

Age of the Penitentiary. Years after the colonial period and post-revolutionary war, Bostonians, New Yorkers and Philadelphians sparked a period marked by the development of penitentiaries (Blomberg & Lucken, 2010). The literature indicated penitentiaries initially were asylums for the insane, almshouses for the poor, and orphan asylums for homeless children. In the southern region, Blomberg and Lucken (2010), described this period as the beginning of “Southern Justice” in correctional settings. According to Martin (1985), many incarcerated African American males were not afforded the same opportunity for appropriate legal counsel, which resulted in controversial convictions and executions. Blackmon (2008) reported that during this era throughout southern states many African Americans were wrongfully arrested, received unnecessary fines and even charged for the costs of their own arrests.

Conservatism and Law-and-Order. The 1980s have been described by many researchers as the years of “conservatism and law-and-order” (Blomberg & Lucken, 2010; Fagan 2003; Kann, 2001). Then United States Presidential hopeful Ronald Regan geared his political platform campaign on getting tough on crime ideology, based on the

societal fear of crime at that time (Blomberg & Lucken, 2010; Fagan, 2003). After assuming office, President Regan was famously known for increased legislation regarding crime, resulting in harsher laws and sentencing. Some would suggest lawmaker used 'scare' tactics in order to approve funding for construction of prison rather than provide rehabilitation (Blumstein, 2011).

Current Incarceration. The next section will discuss current statistical information regarding incarceration. Since the early 1970s, incarceration rates have been increasing at alarming rates (Haney, 2001). Since the early 1990s, the growth rate of the U.S. prison system has surpassed all other industrialized countries (Blumstein, 2011; Haney, 2001; & Pew Charitable Trust, 2010). In fact, a sentencing project publication conducted by King (2008) reported an increase of incarceration during past three decades by an estimated 500%. In a California prison study, Peters (2007) reported that during a thirty year span the number of individuals incarcerated in California state prisons increased from 20,000 to 160,000, and in Texas from 1992 to 1997 an additional 70,000 individuals were confined.

Several disparities in race/ethnicity are routinely noticed in data regarding incarceration. The Prison Policy Initiative (2005) cited that as of June 2004 there were roughly over 2 million incarcerated individuals in the U.S., which was 726 per 1000,000 citizens. In this same study, researchers found that after controlling for ethnicity, Caucasians were incarcerated less than the national average at 393 per 100,000 and African Americans were more likely to be incarcerated at a rate of 2,531 per 100,000, which is well above the national average. Comparing ethnicity and gender, Caucasian males were still incarcerated below the national average at 717 per 100,000, compared to

African American males' rate of 4,919 per 100,000. Also of significance were young African American males age 25-29 who were significantly more likely to be incarcerated at a rate of 12,603 per 100,000 (BOJ, 2004). One implication of these findings is that young African American males are more likely to have criminal justice involvement than volunteer for military service or complete a college degree (Western & Wildeman, 2009).

African Americans and Incarceration. Incarceration is a reality for over 2 million Americans (Harrison & Beck, 2005). It is even more of a reality for African American males (Cooke, 2005). African American men are more likely to have multiple arrests and convictions than any other ethnicity (Case, 2008). In a life course analysis completed by Pettit and Western (2004), results revealed that 9% of all U.S. males would become incarcerated during their lifetime. Considering ethnicity, 20% of African American men under the age of thirty would become incarcerated, compared to only 3% of Caucasian adult men. Lichtenstein (2008) argued that for many African American males, incarceration has become a typical life event.

Impact of Incarceration on African American males. African American male incarceration is detrimental to both individuals (Golembeski, & Fullilove, 2005; Smith & Hattery, 2010; Turney, Wildeman, & Schnittker, 2012) and families (Haney, 2001; Cooke, 2005). Individually, researchers have found that incarceration impacts African American males by both primary (e.g., increased mistrust of others and personal safety concerns) and secondary (e.g., loss of social role, employment, and freedom) stressors (Turney et al., 2012). Research indicated the majority of incarcerated African American males usually are less educated (Western & Pettit, 2004), come from poorer communities (Mauer, 2011), and lack basic employment skills (Mauer, 1999). Therefore, combining a

lack of education, employments skills, family resources, and a criminal history, once released from prison, young African American males are destined to have challenges in pursuit of a new identity.

The impact of incarceration on families of African American males is even more devastating. African American men with an incarceration history report difficulties securing housing and suitable wages in order to provide for their families (Cooke, 2005), along with psychological stressors related to re-integration to life outside of prison (Haney, 2001). African American males who were removed from their families as a result of an incarceration have to re-learn or for many learn new social roles (e.g., father, husband, brother, etc) never taught while incarcerated (Haney, 2001). Incarceration also impacts families as children are more likely to live with a single mom.

Cost of Incarceration. Incarceration is a financial challenge state and national policy makers have had to deal with in the last several years. The average cost of incarceration is an estimated between \$20,000 to \$30,000 a year (Peters, 2007). As incarceration lengths have increased (Mauer, 2011), individuals are aging while in prison, which leads to additional financial responsibilities on correctional officials (PEW, 2009). As a result, policy makers are having to re-think previous “get tough” on crime laws established in the early 1980s (The Pew Center, 2009). Given the current correctional financial crisis (Haney, 2001); many state correctional facilities have been forced to release inmates back into the community in order to cut costs (The Pew Center, 2009). Despite attempts to vastly reduce the overall number of individuals incarcerated, many agree that the United States still incarcerates too many citizens (Magaletta & Boothby, 2003).

Mental Health Treatment and Incarceration

The history of mental health in the U.S. is similar to the history of incarceration, which also can be traced back to the colonial years (U.S. Department of Health and Human Services, 1999). Additionally, societal beliefs regarding mental health have also evolved greatly throughout history. This next section will discuss the emergence of individuals needing mental health treatment within the criminal justice system. As incarceration rates have significantly increased during the past three decades (DOJ, 2010), individuals requiring mental health treatment in prisons have as well (Fagan & Ax, 2003). In comparison to general population, Adams and Ferrandino (2008), reported incarcerated populations tend to experience the same mental health problems, though at “greater frequency and intensity” (p. 914).

The Bureau of Justice (2005), estimated at least 50% of incarcerated individuals have self-reported mental health related symptoms (e.g., depression, anxiety, sleep problems). Parson and Sandwick (2010) collected data from a cohort study of 2,874 adults for the Metropolitan Police Department of the District of Columbia and discovered 33% of these individuals were receiving mental health treatment either while incarcerated or post incarceration via community resources. Of note, in this cohort study those most likely engaged in mental health treatment were males 40 years or older. Conversely, the lowest reported mental health treatment engagement was males under the age of 40 (Parson & Sandwick, 2010). Kupers (2000) reported that approximately 250,000 incarcerated individuals suffered from a diagnosable mental disorder in U.S. prison and jails. The prevalence of mental health disorders in prison populations according to Fazel

and Baillargeon (2011) was 1 in 7 inmates. However, these authors indicated the necessary treatment available for those in need of mental health treatment was limited.

As a result of the increase of individuals currently needing mental health treatment in prison, Fagan (2003) identified three factors for this rapid growth: a) the “law and order” policies during the early 1980s, b) the development and implementation of psychotropic medications, and c) the war on drugs. Fagan (2003) associated “law and order” policies with law makers establishing mandatory sentencing (Sorensen & Stemen, 2002), which resulted in overcrowded prisons (Blumstein, 2011). The second contributing factor, according to Fagan (2003), was the development and implementation of psychotropic medications during the 1950s. Bachrach (1994) correlated the increase of psychotropic medications during this time period with the sudden release of patients from state psychiatric facilities, which has been considered the deinstitutionalization period (Adams, & Ferrandino, 2008; Dennis et al., 1994). Deinstitutionalization, as described by Dennis et al., (1994), failed to provide adequate community mental health resources, which resulted in additional challenges for those communities (Fagan, 2003). Rivas-Vazquez, Sarria, Rey, Rivas-Vazquez, and Rodriguez (2009) as well as McCuan, Prins, and Wasarhaley (2007) argued that the lack of community mental health resources post-deinstitutionalization has significantly attributed to an increase of mental health problems in correctional facilities.

Finally, “the war on drugs” (Fagan, 2003) is another reason for the increase in the need for mental health treatment in prisons. Farabee, Prendergast, Cartier, Wexler, Knight, and Anglin (1999) attributed the increase in incarceration for substance abuse primarily to harsh sentencing policies of the early 1980s. In a study of surveying the

criminal offenses of federal inmates, Mumola's (1999) discovered approximately 63% of were incarcerated for substance abuse. However, despite the effectiveness of substance abuse treatment (Bahr, Masters, & Taylor, 2012), many inmates in this study denied needing treatment for such services (Fagan, 2003), which will be reviewed further throughout this chapter and is one of the primary purposes for the current study.

Only a few studies have specifically explored attitudes of inmates and mental health treatment. Manderscheid, Gravesande, and Goldstrom (2004) compared mental health data from incarcerated individuals during a 12 year period (1988-2000). Between 1988 and 2000 more correctional facilities were available to incarcerate the increased demands of inmates requiring mental health treatment, however, data revealed a reduction in available mental health treatment services provided (Manderscheid et al., 2004).

In addition to the psychological distress of being incarcerated (Skogstad, Deane, & Spicer, 2006), inmates may also experience barriers to seeking mental health treatment related to stigma (Golberstein et al., 2008). Ward, Clark, and Heidrich (2009) found barriers preventing mental health care were knowledge of services, embarrassment, cultural perception, discrimination, and lack of awareness about mental illness.

Similarly, Morgan, Rozycki, and Wilson (2004) conducted a study investigating inmates' attitudes and perceptions towards mental health services and noted that those who did not seek treatment while incarcerated indicated a lack of knowledge about how to access services, the length of treatment, and who would be their potential therapist. Results indicated participants were also skeptical about seeking treatment from unlicensed providers (e.g., practicum student, intern, etc), and believed others would consider them

“weak” or a “snitch” as a result of accessing mental health treatment (Morgan et al., 2004).

Legal Impact on Incarceration and Mental Health Services. Despite dramatic increases of incarcerated males, mental health treatment has not been a focal point within U.S. correctional systems (Magaletta & Boothby, 2003). Although recommendations have been provided from multiple members of mental health reform movements, few if any changes have been made (Fagan, 2003). Sadly, in the past only class action law suits appeared to have had the most significant impact in increasing mental health treatment in correctional facilities (Diamond et al., 2001). For example, after the Supreme Court ruled in *Estelle v. Gamble* (1976), the court reported withholding medical care from prisoners constituted in cruel and unusual punishment and was a direct violation of the Eight Amendment. Therefore, it became mandatory for state correctional facilities to establish appropriate criteria for medical and mental health treatment.

Another example of the consequences of a federal lawsuit was the establishment of the Anti-Drug Abuse Act of 1996 (Magaletta & Boothby, 2003), which significantly impacted mental health treatment in corrections. This lawsuit resulted in federal mandated drug treatment programs in stated and federal correctional facilities. Lastly, in the case of *Bradley vs. Michael Haley* (2002), the state of Alabama Department of Corrections had to increase its mental health staffing by approximately 300% (The Associated Press, 2003). Additionally, the Bradley Act Agreement (2002) mandated monthly and quarterly quality assurance programs in order to ensure incarcerated individuals with mental health needs were being adequately treated.

Mental Health Treatment and African Americans

Three major epidemiological studies, the Epidemiologic Catchment Area (ECA), the National Comorbidity Survey (NCA), and the National Survey of American Life (NSAL), reported African Americans were less likely to experience mental health problems (e.g., depression, sadness, etc) compared to other ethnicities (Richardson, Anderson, Flaherty, & Bell, 2003). Authors based these results from a sample of 4,638 individuals from the general population (non-institutional), which included 666 African Americans. Results examining the frequency of services by ethnicity and type of treatment suggested African Americans were more likely to obtain mental health treatment in general population substance clinics compared to Caucasians who are more likely to receive mental health treatment from a primary care provider or designed mental health treatment facilities (Richardson, Anderson, Flaherty, & Bell, 2003).

The results suggesting African Americans were less likely to experience mental health problems compared to other ethnicities appear erroneous. Historically, African Americans have perceived medical or mental health treatment with providers as inadequate (Cokley, Hall-Clark, & Hicks, 2011), and other research indicates African Americans are less likely to utilize mental health treatment (Youman, Drapalski, Stuewig, Bagley, & Tangney, 2010). In conclusion, since African Americans are not well represented in empirical research, especially those incarcerated (Richardson et al., 2003) current data is inconsistent.

The challenges of engaging African Americans in mental health treatment have been documented by many authors. Hines-Martin (2002) noted how many scholars have increasingly discussed the need for further exploration within this specific population. As

mentioned above, African Americans generally do not seek primary care providers for mental health treatment. Even more challenging is the fact that many African Americans, particularly males often utilize informal support (e.g., friends, relatives, church members, or the use of prayer) as a replacement to mental health treatment (Cokley, Hall-Clark, & Hicks, 2011; Hines-Martin, 2002). Therefore, the need to further explore how African Americans, specifically males decide to seek or not seek mental health treatment is critical.

African Americans and Mental Health Treatment Engagement. There are several theories that have attempted to explain why African Americans might not seek mental health services. Cokley (2011) identified discrimination as a barrier preventing African Americans from utilizing mental health treatment. The author described critical race theory (Brown, 2003) as a possible framework for explaining what prevents African Americans from using mental health treatment. Brown (2003) noted that critical race theory suggests “racial stratification” or racism can and has had a significant impact on mental health related issues among African Americans. According to Brown (2003), “racial stratification” indicates African Americans should experience on average greater “race-related and generic stress relative to whites” (p.293). Cokley (2011) described examples of racial stratification as: “nihilistic tendencies, anti-self issues, and expression of suppressed anger” (p.244). Meanwhile, Cokley (2011) indicated how in general it is difficult to create and or develop a theory specifically for African American males in regards to their mental health treatment because of the challenges of finding a large enough sample..

In another study that explored if racial differences influenced African American males' decisions to seek mental health treatment, Youman et al. (2010) surveyed 229 jailed inmates. In this study, results revealed African Americans had just as much access to mental health treatment resources while in jail compared to Caucasians, though they remained less likely to engage in treatment (Youman et al., 2010). In a qualitative exploration of factors associated with effectively reaching African American males in a community sample, Plowden, Wendell, Vasquez, and Kimani (2011) discovered African American males valued: a) creating a trusting relationship, and b) treatment providers that established a non-judgmental and/or cultural sensitive atmosphere. Establishing patient-provider trust was also a significant finding in Kendrick's et al., (2007) ethnographic inquiry of young African American college male's decision to engage with a new therapist.

In a review of literature, Snowden (2001) indicated African American men often denied experiencing symptoms associated with mental health. Watkins and Neighbors (2007) found similar results from qualitative inquiries utilizing focus groups (N= 5), with a total of 46 African American men exploring how they described mental health. These studies were conducted within the general population, however, results revealed experiencing mistrust of providers as a key factor for participants lack of treatment engagement. This is significant because Woodward, Taylor, and Chatters (2011) reported only less than half of African Americans diagnosed with a DSM Axis I disorder actually received treatment.

In addition to methodological challenges with mental health studies of African Americans and likely underestimation of illness, there remain barriers to accessing

mental health treatment in this population (Golbstein, Eisenberg, & Gollust,2008). In a quantitative study of 418 adult males, Morgan, Steffan, Shaw, and Wilson (2007) found the following barriers in their study: self-preservation concerns, self-reliance and professional service provider concerns. A significant finding this study revealed was that individuals with a past history of mental health were more likely to self-refer for mental health services. However, individuals without a history of correctional or community mental health treatment were significantly less likely to self-refer for treatment. This correctional study did not specifically target African Americans, however, a small percentage were.

Mental Health, Incarceration, and Gender

Limited empirical studies have examined gender as it relates to incarceration and mental health, however, available research has important implications. Addis and Mahalik (2003) and Woodward et al. (2011) noted that within the general population, men are often hesitant to seek professional help, whereas, women are more likely to seek and receive mental health treatment in jails, state, and federal prisons (Department of Justice, 1999). In a survey conducted by Diamond et al., (2008) which explored who requested mental health services while incarcerated, found that males did request more mental health treatment opposed to females. Meanwhile, Drapalski et al. (2009) had inmates in a county jail (male, N = 360; female, N= 154) complete a Personality Assessment Inventory (PAI), and discovered female participants experienced significant elevations on clinical symptoms compare to men, endorsing symptoms of mania, antisocial features, alcohol problems, and drug problems. Taken together, these findings suggest that incarcerated men do experience mental health related symptoms, however,

different symptoms compared to female counterparts. Additionally, men typically exhibit more symptoms that would be considered Axis II features and more difficulty to treat clinically.

Mental Health Treatment is Effective

Despite the paucity of mental health treatment outcomes within correctional facilities, research with other populations has empirically demonstrated positive results of treatment. In fact, in 2001, the American Service Journal dedicated an entire journal to this issue. Agencies such as the Robert Wood Johnson Foundation, the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, the National Alliance for Mentally ill, and several other mental health agencies have invested into researching and providing mental health treatment because of its effectiveness (Drake, Goldman, Stephen, Lehman, Dixon, Mueser, & Torrey, 2001).

However, there are few empirical outcome studies on the effects of mental health treatment while incarcerated. Several Federal Bureau of Prison psychologists have conducted studies on the effectiveness of drug treatment programs. In fact, Wormith and colleagues (2007) meta-analyses investigated how correctional intervention correlated with offender recidivism. Authors suggested that despite methodological complications, their findings revealed significant results that cognitive behavioral interventions correlated positively with decreased recidivism within incarcerated populations. Cognitive interventions according to Clark (2008) have been proven to challenge the distorted thoughts, beliefs and attitudes offenders typically have.

Other treatments such as Therapeutic Community (TC) have been one of the most widely used evidence-based interventions in federal and state correctional facilities for

years (Wormith et al., 2010). According to Bahr et al. (2012), Therapeutic Communities provide “highly structured residence program where clients are organized into groups and leaders are chosen from within the group. The purpose is to give governance and accountability to the clients themselves” (p. 159). Literature revealed participants who participate in Therapeutic Communities are more likely to remain drug free during a 5 year follow up.

Literature Review Summary

This literature review briefly discussed the history of incarceration within the U.S. from the colonial years to current. Initially, incarceration was a local community effort of citizens identifying those societal violators and ensuring the public was protected from them (Blomberg & Lucken, 2010). Meanwhile, during the post revolutionary period with the development of jails and prisons, the responsibility transitioned of those that violated the law from a community initiative to more a local government program. This review highlighted aspects of the penitentiary period, which consisted of persons from marginalized communities (e.g., mental health ill, the poor, and homeless children) and increased rates of incarceration. Additionally, this period birthed the beginning of “Southern Justice” (Blomberg & Lucken, 2010). Next, was the “get tough on crime” period, which also is referred to as conservatism and law and order (Fagan, 2003). During the early 1980s, law makers would often campaign on toughening crime laws, specifically, drug laws. During the early 1980s crack cocaine was a significant problem that existed within poor inner-city communities. As a result, many African American males entered the criminal justice system during this period (Fagan, 2003).

The literature clearly reveals the disparity among ethnicities and gender regarding incarceration (DOJ, 2010; DOJ 2012; London & Myers, 2006; Mauer, 1999; Smith & Hattery, 2010; The Pew Center, 2009; & Western & Wildeman, 2009). African American males are incarcerated at disproportionate rates (Blumstein, 2011; Case, 2008; National Council on Crime and Delinquency, 2006). Finally, the impact of African American incarceration is also significant on an individual (Golembeski, & Fullilove, 2005; Smith & Hattery, 2010; Turney, Wildeman, & Schnittker, 2012) and family systems level (Haney, 2001; Cooke, 2005).

African Americans tend to underutilize mental health services much less compared to their Caucasian counterparts. Most of the studies found in the literature regarding African American men were mostly college samples and older middle class African American men, with limited studies that focused on perceptions of incarcerated individuals, and a few studies that explored women with a previous history of incarceration. Nevertheless, missing from empirical research are studies pertaining to African American men who are currently incarcerated and how they viewed treatment and or the decision to utilize mental health treatment. In fact, results from the Watkins et al. (2010) meta-analysis and from other qualitative studies revealed at least nine studies investigating mental health treatment, though none were specifically focused on African American men who were currently incarcerated.

The effectiveness of engaging in mental health treatment is limited in correctional samples, though data from general population studies suggest positive correlations between individuals who engage in treatment and recidivism. Of those studies conducted

within correctional facilities (Morgan et al., 2007) it is obvious that more studies are needed.

Together, the lack of data about African American males in prisons and their perceptions about and utilization of mental health treatment is concerning. Given the size of the population and some of the unique barriers that may prevent them from seeking treatment, more knowledge is needed to better understand how to help this vulnerable group. The current study is designed to further explore this issue.

Chapter III: Methods

The purpose of this study was to explore factors that influence whether or not African American male inmates decide to seek mental health treatment while incarcerated. Topics explored included: (a) How participants defined and described symptoms of mental health problems; (b) participants' experience engaging in mental health treatment; (c) participants' awareness of mental health treatment options during current incarceration; and (d) participants' general views of mental health treatment for inmates. In order to investigate this topic, the principal researcher conducted a grounded theory study (Glasser & Strauss, 1967) of 12 incarcerated African American males who reported depressive symptoms at intake, but did not request mental health services. This chapter will present and discuss the results of these 12 in-depth interviews.

The research methodology utilized for this study was qualitative inquiry. Since this study was an inquiry involving the understanding of African American male inmates' decisions to seek mental health treatment when experiencing feelings of depression, thus, a qualitative study was warranted. A qualitative study provides an opportunity for the researcher to obtain a richer context of participants' meaning (Merecek, 2002) and to discover further insight about individual lives, stories, behavior, social movements or interactional relationships (Strauss & Corbin, 1990). Additionally, it enables researchers to discover what is unknown (Strauss & Corbin, 1990). Given the dearth of prior empirical research regarding mental health treatment and its utilization amongst African American adult men who are incarcerated (Ward, 2005); a qualitative method provided the best opportunity to gather in-depth and insightful data.

Grounded theory methodology (Glaser & Strauss, 1967) in particular was used to analyze the data. Grounded theory methodology (Glaser and Strauss, 1967) was appropriate for this study because it allowed research participants to be the subject matter expert (Ward, 2005) and provided the researcher the necessary flexibility and freedom to explore a phenomenon in depth (Strauss & Corbin, 1990).

Target Population

This study's target population was adult African American men between the ages of 18 to 40 who were currently incarcerated at the Milwaukee Secure Detention Facility (MSDF). Another criterion that potential participants had to meet at intake was currently experiencing symptoms of depression or sadness but not requesting mental health treatment at the MSDF. Additionally, participants who were not currently on psychotropic medications, or expressed thoughts and or intent to harm themselves or others were included in this study. The principal researcher ensured participants did not have any cognitive disabilities informally (i.e., via professional judgment).

Participant Pool

The participant pool was limited to individuals incarcerated at the State of Wisconsin Department of Corrections (WDOC) facility MSDF for adults from February to May 2012. MSDF is a medium-security state correctional facility in downtown Milwaukee, Wisconsin. Although MSDF is an adult state correctional facility, its operations are similar to a jail since offenders are received for intake 24 hours, seven days a week. Individuals incarcerated at MSDF are currently pending probation or parole violations. MSDF has a capacity of 1,040 felony offenders, including a 42-bed female

unit. MSDF provides programming for Alcohol and Other Drug Addiction (AODA), which focuses on Alternatives to Revocation (ATRs). Individuals usually stay incarcerated for an average of 67 days for allegations and 3 months for drug programming.

The Psychological Service Unit (PSU) at MSDF provides mental health treatment for offenders who request services regardless of previous treatment experience. PSU staff includes: the Chief of Psychology Services, psychiatry, staff psychologist, psychological associates, doctoral clinical psychology interns, doctoral clinical psychology practicum students, and mental health technicians. According to the Wisconsin Department of Corrections online brochure, PSU provides crisis management services 24/7. At admission all inmates are provided a mental health screen at which those with a history of medications will be identified and properly treated. Staff of the PSU team provide several groups weekly ranging from psycho-educational to process oriented.

Participants

Twelve participants were recruited from MSDF and all 12 completed the study. All of the participants met the aforementioned inclusion criteria (i.e., adult African American men who were currently incarcerated, self-reported experiencing depression and/or sadness upon initial mental health intake screening but not currently receiving mental health services at MSDF). All intakes conducted at MSDF were completed on mental health screening interview forms (DOC-3472) within 24 to 48 hours. The age range of study participants was 18 to 33 years with a mean age of 25.3 (SD = 4.47).

The number of total incarcerations as an adult, which included MSDF and other WDOC facilities, ranged from 1 to 7 separate times, with a mean of 2.4 (SD = .91). The number of times participants were incarcerated specifically at MSDF ranged from 1 to 4, with a mean of 2.25 (SD =0). At the time of study, participants' reported current length of stay at MSDF was 5 to 150 days, with a mean of 48. Four of the 12 participants indicated having been offered psychological services at their current intake. Eight of the 12 participants reported not being offered psychological services at current intake. Of the 12 participants, six reported prior treatment engagement (e.g., mental health, family counseling, and substance abuse counseling), however, not during their current incarceration.

Participants' education levels ranged from 9th grade to 1 year of college. Four out of the 12 participants reported obtaining their General Educational Development Diploma (GED); five had not obtained their GED, two graduated from high school, and one completed college coursework prior to current incarceration. All 12 of the participants reported their current marital status as single and never married. A description of the participants' demographics and brief personal details are shown in Table 1.

Table 1

Research Participants' Demographic Information and Brief Personal Details

Pseudonym Selected by Participant	Demographic Information	Information related to Incarceration Status	Psychological Service Information
John Lee	Age: 29 Marital status: Single Education: 11 th grade GED: No	How many times have you been incarcerated either at MSDF or another state facility: 5 How many times have you been at MSDF: 3	Previous treatment: Yes Type of previous treatment: Substance Abuse

		<p>How long have you been at MSDF: 5 months</p> <p>Were you offered psychological services at MSDF: No</p>	
James Bond	<p>Age: 22</p> <p>Marital status: Single</p> <p>Education: 10th grade</p> <p>GED: Yes</p>	<p>How many times have you been incarcerated either at MSDF or another state facility: 2</p> <p>How many times have you been at MSDF: 2</p> <p>How long have you been at MSDF: 2 months</p> <p>Were you offered psychological services at MSDF: No</p>	<p>Previous treatment: No</p>
James1	<p>Age: 27</p> <p>Marital status: Single</p> <p>Education: 9th grade</p> <p>GED: Yes</p>	<p>How many times have you been incarcerated either at MSDF or another state facility: 5</p> <p>How many times have you been at MSDF: 4</p> <p>How long have you been at MSDF: 2 months</p> <p>Were you offered psychological services at MSDF: Yes</p>	<p>Previous treatment: No</p>
Anton Johnson	<p>Age: 18</p>	<p>How many times</p>	<p>Previous treatment:</p>

	<p>Marital status: Single</p> <p>Education: 11th grade</p> <p>GED: No</p>	<p>have you been incarcerated either at MSDF or another state facility: 2</p> <p>How many times have you been at MSDF: 2</p> <p>How long have you been at MSDF: 3 months</p> <p>Were you offered psychological services at MSDF: No</p>	No
John	<p>Age: 24</p> <p>Marital status: Single</p> <p>Education: 12th grade</p> <p>GED: N/A</p>	<p>How many times have you been incarcerated either at MSDF or another state facility: 4</p> <p>How many times have you been at MSDF: 3</p> <p>How long have you been at MSDF: 5 days</p> <p>Were you offered psychological services at MSDF: No</p>	<p>Previous treatment: Yes</p> <p>Type of previous treatment: Family therapy</p>
William	<p>Age: 20</p> <p>Marital status: Single</p> <p>Education: 10th grade</p> <p>GED: No</p>	<p>How many times have you been incarcerated either at MSDF or another state facility: 1</p> <p>How many times have you been at MSDF: 1</p> <p>How long have you</p>	<p>Previous treatment: No</p>

		been at MSDF: 5 days Were you offered psychological services at MSDF: Yes	
TJ	Age: 23 Marital status: Single Education: 12 th grade GED: N/A	How many times have you been incarcerated either at MSDF or another state facility: 2 How many times have you been at MSDF: 1 How long have you been at MSDF: 5 days Were you offered psychological services at MSDF: Yes	Previous treatment: Yes Type of previous treatment: Substance Abuse
James2	Age: 28 Marital status: Single Education: 11 th grade GED: Yes	How many times have you been incarcerated either at MSDF or another state facility: 3 How many times have you been at MSDF: 3 How long have you been at MSDF: 2 months Were you offered psychological services at MSDF: Yes	Previous treatment: Yes Type of previous treatment: Mental Health
Justin	Age: 29 Marital status:	How many times have you been incarcerated either	Previous treatment: Yes

	<p>Single (engaged)</p> <p>Education: 13</p> <p>GED: N/A</p>	<p>at MSDF or another state facility: 1</p> <p>How many times have you been at MSDF: 1</p> <p>How long have you been at MSDF: 2 weeks</p> <p>Were you offered psychological services at MSDF: No</p>	<p>Type of previous treatment: Substance</p>
Benji-man	<p>Age: 29</p> <p>Marital status: Single</p> <p>Education: 11th grade</p> <p>GED: Yes</p>	<p>How many times have you been incarcerated either at MSDF or another state facility: 7</p> <p>How many times have you been at MSDF: 3-4</p> <p>How long have you been at MSDF: 1 week</p> <p>Were you offered psychological services at MSDF: No</p>	<p>Previous treatment: No</p>
Johnny Garner	<p>Age: 22</p> <p>Marital status: Single</p> <p>Education: 9th grade</p> <p>GED: No</p>	<p>How many times have you been incarcerated either at MSDF or another state facility: 2</p> <p>How many times have you been at MSDF: 2</p> <p>How long have you been at MSDF: 2 months</p>	<p>Previous treatment: Yes</p> <p>Type of previous treatment: Substance Abuse</p>

		Were you offered psychological services at MSDF: Yes	
Young Jezzy	Age: 33 Marital status: Single Education: 10 th grade GED: No	How many times have you been incarcerated either at MSDF or another state facility: 4 How many times have you been at MSDF: 2 How long have you been at MSDF: 2 months Were you offered psychological services at MSDF: No	Previous treatment: No

The Research Team

A research team was established for the purpose of data analysis. The principal researcher conducted all participant recruitment, participant interviews, and data collection. Research team members were recruited to assist with all three steps of data analysis. According to Morrow (2005), one of the benefits of a research team is it fosters increased subjectivity, which is paramount in qualitative discoveries. Despite the principal researcher being responsible for reviewing all mental health screen interviews, participant recruitment, and data collection, other team members were involved in all three stages of data analysis and development of a grounded theory, which is helpful for potentially decreasing bias.

This study's research team consisted of the principal researcher, three masters-level and two doctoral-level graduate students from a university counselor education and counseling psychology department. After the principal researcher reviewed each mental health screening interview, recruited participants, and conducted interviews, two of the five members from the research team transcribed recorded interviews. Four of the five members from the research team were responsible for analyzing study data.

At the time of data analysis, the principal researcher was a 30-year-old African American male completing his third year of doctoral studies in counseling psychology at Marquette University. The principal researcher was born in Compton, California and personally knows of childhood friends and family members who have either been incarcerated as well as those who experienced mental health symptoms. Additionally, the principal researcher had clinical experience working with individuals in correctional facilities for 10 years. Other members of the research team included: a 24-year-old, European American woman, a 24-year-old, African American woman, a 26-year-old African American woman, and a 24-year-old Italian American woman. Two of the research team members had previous experiences with grounded theory research while three did not have any prior experience with grounded theory or qualitative research. Prior to conducting data analysis those team members with no qualitative experience were provided training by the principal researcher. Grounded theory training was provided for four of the five primary team members. Additionally, none of the research team members had any previous clinical experience working with individuals who were incarcerated. Three members from the research team had clinical experience working

with individuals previously involved with the criminal justice system as substance abuse counselors in training (SAC-IT).

After development of the protocol and data was collected, members of the research team were actively involved with the remaining process of data analysis. Once interviews were transcribed from the audio recording device, four members from the research team participated in two stages of data analysis process and three team members completed all three stages of coding. One member from the research team only participated in partial data transcription. This team member was not trained in grounded theory data analysis and only wanted minimal exposure to qualitative research. Four of the research team members conducted open and selective coding data analysis. One primary team member was not able to assist in the third stage of data analysis (e.g., selective coding). As a result, three of the five research team members shared credit for the development of the final grounded theory. The principal researcher was responsible for completion of this study and in coordinating training, recruiting, data collection, and data analysis.

In addition to the research team, this study also had external auditors. The benefit and purpose of an external auditor according to Hill et al., (2005) is that it allows the analysis process to develop into a theory that is not influenced or tainted by research members who might have been working collectively throughout the study. This study had two external auditors. One auditor was a recent graduate from a counseling psychology doctoral program who was completing a post-doctoral fellowship at a Veterans Administration (VA) Hospital and who completed a grounded theory doctoral dissertation on African American men who were homeless with multiple stigmas. The

second auditor was this study's dissertation advisor who is a tenured faculty member in a counselor education and counseling psychology graduate program department. This auditor has experience coordinating a research lab that focuses on multiculturalism and has been involved in several qualitative studies.

During this study, both auditors were utilized as consultants to the principal researcher. As the principal researcher conducted recruiting and data collection, the external auditor (dissertation chair) was consulted to ensure procedures were being followed accordingly. Once the research team members began conducting data analysis (open coding), both external auditors were consulted and solicited for feedback. During each stage of data analysis (open, axial, and selective coding), the principal researcher received auditor feedback and relayed it to members of the research team for further discussion. After the completion of all three stages of data analysis, research members had fulfilled their participation requirement.

Instruments

Mental Health Screening Interview Forms (DOC-3472). Psychological Service Unit staff members utilized this form when conducting mental health intakes for all inmates that are sent to MSDF. Specifically, the principal researcher reviewed question 8, which asked: "Have you been feeling really depressed or sad?" and "Have you been crying?"

Brief Demographic Form. Before conducting interviews, participants were asked to complete a brief demographic form (see Appendix B). The brief demographic form requested the following background information: participants' fake name, age,

ethnicity/race, marital status, education, number of times incarcerated as an adult, number of times incarcerated at MSDF, and any previous mental health treatment.

Interview Protocol. In conducting grounded theory research, interviewing is generally the preferred method for data collection method (Ward, 2005). Interviewing consisted of administering a semi-structured (see Appendix C), individual, face-to-face interview. All participants were interviewed by the principal researcher (Ward, 2005; Seal et al., 2004) in a secure, quiet room within the Milwaukee Secure Detention Facility. Prior to conducting an interview, the principal researcher reviewed and discussed informed consent procedures with each participant and provided a personal copy of the consent form. Participants were invited to create a fake name for the study.

The interview protocol consisted of 11 semi-structured questions (See Appendix C), with a Flesch-Kincaid Grade Level Readability of 6.0. Completed interviews ranged from 21 minutes to 50 minutes long. Interview protocol questions were developed by the principal researcher in consultation with his dissertation chair, and they were informed by previous research about African Americans and mental health treatment (Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003; Ward, Clark & Heidrich, 2009; Plowden, John, Vaxquez & Kimani, 2010).

Data Collection Procedures

Participant Recruitment. Participants were recruited directly from MSDF exclusively by the principal researcher. This research study was approved by the Wisconsin Department of Corrections Institutional Review Board (WDOC-IRB) and Marquette University Institutional Review Board (MU-IRB) prior to participant recruitment. The principal researcher was a doctoral-level practicum student at the site

and already had security clearance, which allowed him to enter the premise and review files. Prior to recruitment, the principal researcher reviewed mental health screening interview forms (DOC-3472) at least weekly. Items scanned for study appropriateness were age and a yes response to question 8, which asked: “Have you been feeling really depressed or sad?” and “Have you been crying?” If this one item was positively endorsed, the principal researcher reviewed the mental health referrals spreadsheet (note: external document maintain in PSU department) to ensure potential participant did not request mental health follow-up services. If they were not referred for PSU follow-up services, arrangements were made with security personnel on respective units to speak with potential participants regarding this study. After informing potential participants of study parameters and if they expressed interest in participating, a scheduled time for the interview was arranged with unit correctional officers.

Interviews were scheduled as quickly as possible given the dynamics of short notice releases or movements at a facility such as MSDF. Once a participant agreed to participate in the study, the principal research compensated each participant with a \$10 deposit to their institutional account. Compensation to participants’ accounts allowed them to choose freely how they wanted to spend it. If a participant did not spend his research participation compensation while incarcerated, they would be generated a check from the Milwaukee Secure Detention Facility upon their release.

Exclusionary criteria consisted of presence of any cognitive disabilities, current use of psychotropic medications, or expression of suicidal and/or homicidal ideations. This study did not have any recruited participants who were excluded.

Pilot Data Collection. Prior to completing this study, the research team completed two pilot studies, as was recommended by other researchers (Fassinger, 2005). This study utilized the two pilot studies for specific purposes. The first was to ensure the interview protocol was appropriate for the target population. Secondly, conducting pilot studies enabled the research team to estimate the amount of time needed for face-to-face interviews, data analysis, and provided a training opportunity for team members unfamiliar with a qualitative study. By utilizing the recruitment procedures discussed, the principal researcher found two individuals who met the study criteria. None of the data gathered during the pilot study was used in the final results.

Obtaining Informed Consent and Completing the Brief Demographic Form.

Incarcerated populations are described as vulnerable populations. Therefore, it is critical that the process of informed consent is clearly articulated and presented with a level of effective comprehension (Seal et al., 2004). To ensure informed consent procedures were read, the principal researcher read it aloud to each participant (See Appendix A for a copy of the Informed Consent Form). Each study participant was given a copy of the informed consent procedures and steps to contact MU IRB if needed. After completion of informed consent, participants completed a brief demographic form (See Appendix B for Brief Demographic Form).

Next, participants were provided with an acknowledgement form to be audio-taped strictly for research purposes (Appendix D for a copy of Consent/Refusal for Recording). It was discussed with all participants that any decisions made regarding this study had no impact on their current incarceration or any conditions of probation or

parole. The study participants were asked to select a fake name to be used during research in order to protect their privacy.

Interviewing. Participation in this study consisted of one individual, face-to-face semi-structured interview. A total of 12 study interviews were conducted (see Appendix C for Protocol Questions) and audio recorded.

Once each interview was finished the principal researcher completed an interview debriefing form (see Appendix F). This process consisted of general annotations of each interview (e.g., general reactions to the interview, anything that stood out, etc). Notes about interviews were shared with the research team members, a practice which is supported by Corbin and Strauss (2008) and Fassinger (2005) to ensure immediate reactions (e.g., key concepts, assumptions, uncertainties, etc) are captured for data purposes.

Transcribing. Completed interviews were transcribed primarily by the principal researcher, though one member completed three transcripts. Protocols were assigned a numerical code associated with each participant's fake name, which participants previously selected on their brief demographic form. Study participants' actual names were not recorded on any research study material; the only exception was the completed informed consent form with their signatures. Since the principal researcher conducted all the transcribing, none of the other primary team members were privileged to participants' legal names. Prior to primary team members receiving copies of a transcript to begin data analysis, the principal researcher reviewed them again for accuracy.

Data Analysis Procedures

In order to complete grounded theory data analysis, the research team members met weekly, excluding holidays, to analyze data. Prior to meeting collectively as a team, each member were provided copies of transcripts to review (Schwartz, 2002). Research team members conducted all three phases of analysis, which included: open coding, axial coding, and selective coding (Strauss & Corbin, 1990).

Open Coding. Open coding is the first step of data analysis, which incorporates a detailed examination of transcribed data which is obtained after interviewing.

Specifically, open coding is defined as the “part of analysis that pertains specifically to the naming and categorizing of phenomena through close examination of data” (Strauss & Corbin, 1990 p. 61). The data are referred to as concepts (Fassinger, 2005). Concepts are defined as “conceptual labels placed on discrete happenings, events, and other instances of phenomena” (Strauss & Corbin, 1990, p.61). After transcribing each interview, “the concepts are gradually grouped together into categories that encompass those concepts” (Fassinger, 2005, p.160). As additional data is gathered, “coded concepts continue to be compared to existing data and (re)categorized. The categories constantly undergo modification to incorporate new information and are continually interrogated for coherence and explanatory capacity” (Fassinger, 2005, p.160).

For this study, the research team completed line-by-line examination of the data during the open coding stage, as Strauss and Corbin (1990) and Fassinger (2005) suggested. Throughout the open coding process, four members of the research team individually read and labeled concepts from all 12 transcripts (Strauss & Corbin, 1990). Next, the members of the research team labeled the concepts in the transcript margins and

analyzed them for properties and dimensions. This process yielded a list of “concept units” (Strauss & Corbin, 1990), which would be utilized for axial coding. This process was completely repeated for each transcript until the primary team members reached consensus.

Once the research team reached consensus during open coding, the principal researcher consulted with both external auditors. Both auditors were provided a select number of open coded transcripts and asked to review them. After the principal researcher received their feedback, information was discussed and evaluated among the research team.

Prior to consultation with the external auditors, the research team produced 1,441 emerging open codes. The principal researcher consulted and reviewed emerging codes with external auditors, which prompted an evaluation of original data analysis with the research team. After discussing the external auditors’ feedback and recommendations with the research team, the team reviewed each transcript line-by-line, which evolved into 889 emerging open codes. Some examples of open coding include, “Someone who cannot cope with stress,” “If you provide services to people (talk therapy) they can overcome their mental health symptoms,” “Difficulty in life, you’ve tried to work things out and it didn’t work,” “Attempts to deal with problems on his own,” “Identifies several difficulties, but he has and is not trying to seek help, trying to do it on his own,” and “Being in prison is difficult and it effects different people in different ways.”

Axial Coding. The second phase of data analysis included axial coding. Strauss and Corbin defined axial coding as “a set of procedures whereby data are put back

together in new ways after open coding, by making connections between categories” (1990, p.96).

During axial coding, the team utilized the constant comparison method, which Fassinger (2005) described as comparing data within categories and subcategories while developing “the density and complexity of the categories by describing their properties and dimensions and exploring variations in the data and reconceptualizing the categories and their relationships as necessary” (p. 160). Similar categories were condensed in order to establish general themes for the meaning units associated within them. Once data was reviewed, related categories or themes were grouped together and given category or themes. Such themes included “people experiencing psychological/emotional distress,” “people who are different or crazy,” and “lack of information about mental health.” Each significant theme was endorsed by at least 5 of the 12 participants.

The research team members conducted axial coding until saturation occurred. Fassinger (2005) described saturation as “a time when no new information is being identified about the categories” (2005, p. 160). The principal researcher consulted both external auditors after each result were obtained. After external auditors provided feedback, recommendations, or suggestions, these were forwarded to the research team for further review. If recommendations were necessary, the primary team made them after continued discussion. This process resulted in 156 axial codes and 39 categories/themes.

Selective Coding. The final step of grounded theory data analysis was selective coding (Strauss & Corbin, 1990). Selective coding is defined as “the process of selecting the core category, systematically relating it to other categories, validating those

relationships, and filling in categories that needed further refinement and development” (p. 116). This has been further described by Fassinger (2005) as the “creation of substantive theory” (p. 161), where a brief narrative is developed with the most salient aspects of the data, which is referred to as the story line (Fassinger, 2005). The story line in the selective coding process was continually compared to collected data to ensure that it is grounded in research and participants’ experiences (Fassinger, 2005). Additionally, researchers should compare emerging themes with existing literature (Fassinger, 2005).

The research team in this study developed a name for the core category (Strauss & Corbin, 1990). Core categories are defined by Strauss and Corbin (1990) as “the central phenomenon around which all the other categories are integrated” (p. 116). After the research team arrived at a consensus, external auditors were consulted for further review. The story line that emerged was, “Despite African American male inmates’ ability to identify symptoms of mental health, their positive experience with previous treatment and their report of current depressive symptoms, they identify several barriers to seeking mental health treatment while incarcerated.” The core theme identified was, “Barriers to seeking mental health treatment while incarcerated,” which contributes to persistent reports and experiences of mental health symptoms (e.g., reports of persistent mental health symptoms such as depression). The story line and core theme identified in selective coding and corresponding categories/themes and subthemes are further discussed in Chapter IV.

Qualitative Assurance Processes: Trustworthiness. As with quantitative research, qualitative research must demonstrate that its procedures have validity. The concept of trustworthiness has been compared to validity, reliability, generalizability, and

objectivity found in quantitative research (Fassinger, 2005). Trustworthiness, according to Vliet (2008), is not defined by research members reaching consensus; rather, it is defined as: “(a) the data are as factually accurate and complete as possible, (b) the interpretations capture the participants’ meanings while minimizing researcher bias, (c) the categories fit with the phenomena under study and elucidate the relationships between concepts in the data, and (d) the theory is transferable (i.e., it makes sense to the reader and can be applied to persons, times, and settings other than those studied)” (p. 236). To ensure study data was trustworthy, the principal researcher reviewed all audio recordings of interviews that were transcribed by other team members and checked for accuracy. Second, the research team continually discussed members’ biases and expectations. Prior to participating in this research project, as a requirement, members had to identify their personal biases, especially given the population of the study (i.e., African American males who were incarcerated), which were discussed as a team in meetings.

Chapter IV: Results

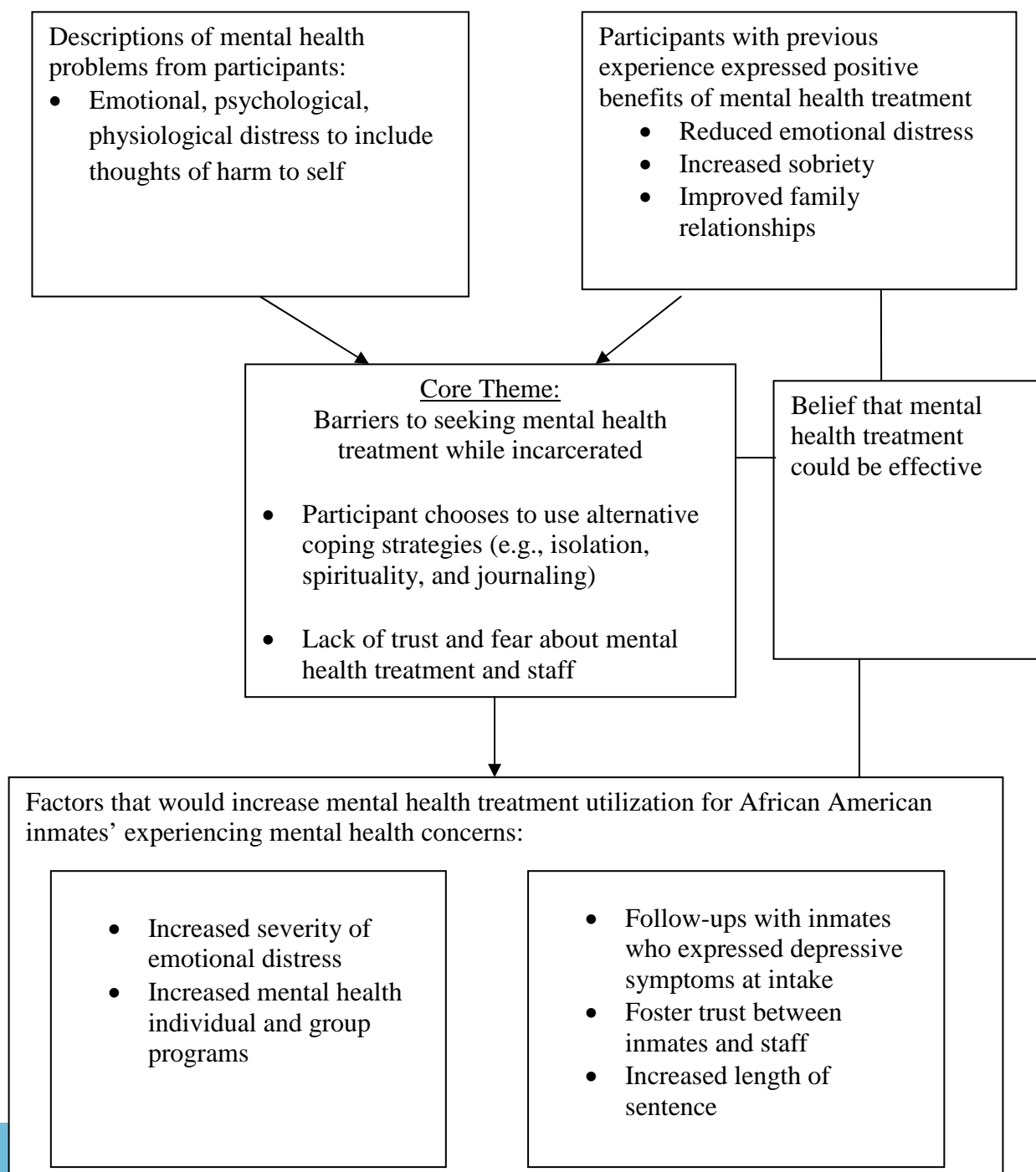
The purpose of this study was to explore factors that influence African American male inmates' decisions to seek mental health treatment while incarcerated. Topics explored included: (a) How participants defined and described symptoms of mental health problems; (b) participants' experience engaging in mental health treatment; (c) participants' awareness of mental health treatment options during current incarceration; and (d) participants' general views of mental health treatment for inmates. In order to investigate this topic, the principal researcher conducted a grounded theory study (Glaser & Strauss, 1967, see Chapter III) of 12 incarcerated African American males who reported depressive symptoms at intake, but did not request mental health services. This chapter will present and discuss the results of these 12 in-depth interviews.

The “story line” (Strauss & Corbin, 1990) that emerged from study participants was that these incarcerated African American males were able to identify symptoms of mental health problems and were currently experiencing depressive symptoms; however, they decided against utilizing mental health treatment while incarcerated for several reasons. The core theme that emerged from this grounded theory study was “barriers to seeking mental health treatment while incarcerated.” Figure 1 provides a visual representation of the story line, core theme, and major categories. The subthemes will be expanded upon and will include direct quotes from participants in order to illustrate the themes. Fake names are used for all quotes. Responses were grouped together using the following cut-offs based on how many participants endorsed each theme: a) “Majority” was used to identify themes endorsed by eight or more participants, b) “Most” was used

to identify themes endorsed by six to seven participants, and c) “Some” was used to identify themes endorsed by fewer than five participants.

Figure 1

Story Line: Incarcerated African American males were able to identify symptoms of mental health problems and were currently experiencing depressive symptoms; however, they were not utilizing mental health treatment while incarcerated for several reasons.



Participant Context/Demographics

The shared social context of the participants in this study was all participants were currently imprisoned in a state correctional facility in Milwaukee, Wisconsin. They had been incarcerated for a range of 5 to 150 days, and would likely be transferred, released, or remain at MSDF to complete their sentence. Additionally, while not discussed explicitly during the interviews, all of the participants were African American males. All of the 12 study participants reported at intake experiencing depressive symptoms, but none elected to seek or utilize mental health treatment. Finally, results revealed a subgroup of participants ($n = 6$) who had previously engaged in mental health treatment. Despite previous positive treatment experience, they shared similar views for not requesting mental health treatment services during their current incarceration experience, and thus were not separated from the larger sample for most of the analyses.

Descriptions of mental health problems from participants

Eleven of the 12 participants were able to identify and describe mental health problems in their own words. Participants in this study provided general descriptions of mental health problems as emotional, psychological, and physiological distress, including thoughts of harm to self. Specific symptoms endorsed throughout interviews by study participants were depression and anxiety. James Bond indicated how depression was a type of mental health problem, stating “[Depression] makes you depressed or something like that.” John Lee described depression as, “...you might look like you have a lot of wear and tear on your body.” James2 also described mental health problems as something that could “come in many different pictures. A person that looks sad,

depressed, lonely, lost, helpless, hurt, I believe it has many different faces.” Justin described mental health concerns by giving a personal example: “You know, [I’m] worried about my future with my fiancé. I’m starting to go through depression and having anxiety attacks throughout the day.”

Most participants discussed the difficulties of adjusting to prison and how that impacts an individual’s overall mental health. For example, John Lee stated inmates experienced “anxiety or trouble sleeping,” while James Bond noted inmates might not eat or sleep. James1 indicated, “They [inmates] physically hurt themselves or the other person” as a result of the stress, and “saying verbal abuse, physical abuse, to others, to myself, just not caring about the consequences or repercussions of how, whatever I do.” Anton described the negative effects as, “seeing things. Hearing voices that nobody don’t hear.” Finally, Benji-man’s description of mental health problems included, “it’s like crazy people. People who are not wrapped tight. Like ADHD, Bipolar, Schizophrenic”

Participants with previous experience expressed positive benefits of mental health treatment

All of the six participants who had previously participated in mental health treatment believed there were positive benefits to their experience, including reduced emotional distress, increased sobriety, and improved family relationships.

Participants reported mental health treatment reduced emotional distress.

Five of the six participants with previous mental health experience noted that they experienced reduced emotional distress as a result of the treatment. Some examples of statements from participants which supported this theme included one from John Lee, who indicated: “I was able to gain information as well as release a lot of stress that was

on me, get help about the insecurities that I had about myself and find ways to go about dealing with the situation instead of just beating myself up about it.” John, who previously was involved in family counseling mentioned, “everybody got to talk about how they felt about the loss and other situations that they were going through. So everybody got to share and spill their goods to one another and I think that was very helpful.” TJ, who also completed a drug and alcohol abuse treatment program stated, “it gave me techniques on how if I’m laying down to block out the thoughts to change my thinking patterns to think positive thoughts, and for a while they gave me some amitriptyline to take to ease me to sleep a little easier, you know. Also, going to groups and stuff like that.”

Two of these participants expressed how they either felt depressed or anxious prior to treatment and how those symptoms reduced as a result of receiving treatment. Justin, when asked how he responded to previous treatment mentioned it was “real helpful...he talked with me how to deal with my anxiety attacks and how to cope with how I deal with it. Because I was hurt about a lot of things that happened in my case between me and my then fiancé and he did tell me I had to let things go because as long as I dwell on it, it’s going to put a burden on and I’m always going to be like I guess feeling down about everything that happen.” Johnny Gardner described his experience of feeling depressed and how treatment minimized those symptoms, noting “I felt depressed my little brother is going through something that he really shouldn’t be going through. I feel like his burden is my burden and he actually helped me out and pretty much said I can’t do nothing about it.”

Participants reported mental health treatment increased sobriety. Two of the six participants of the subgroup with previous experience described increased sobriety as a result of treatment. John Lee discussed his substance abuse concerns and stated, “I had real bad alcohol problem, so going to talk to the counselor helped me, helped me get a lot of stuff off my chest... I was clean for a year and I liked the interaction of being able to talk to someone about the situation.” The second participant who had previously engaged in drug treatment was TJ. During the interview he described his treatment experience as being “mandatory, because of my case. Use of Marijuana, that’s one of my down falls. I’m back in here for smoking marijuana. It puts me in a whole different state of mind. I think I’m in peace, I’m chillin’, mellow. I’m thinking that, but in reality I’m behind on what I’m supposed to be doing.” Also, this same participant discussed being able to focus more when is not under the influence: “...when I came here, I was sober, I write like 4-5 songs a day. So right now I’m working on three mix tapes and an album at one time.”

Participants reported mental health treatment improved family relationships. Two of the six participants who reported engaging in previous mental health treatment also reported improved family relationships. John Lee, who previously mentioned a history of drug and alcohol abuse treatment, cited improvement in family relations, noting “I was able to interact with my family better.” John, who was engaged in family counseling following the death of a family member stated, “the family got together and was talking about the loss and we explained what we was going through, as a group, as a family, with the counselor. It was like, it was alright. It helped the family out a lot. It helped me out a lot too cause I got to spend time with my family and I got to see where everybody head was at and they got to see where mine was at.”

Belief that mental health treatment could be effective

The majority of participants shared a common belief that individuals with mental health problems could improve, especially with treatment. Additionally, the subgroup of six participants who had previously engaged in some form of treatment (e.g., mental health, family counseling, or substance abuse counseling) also discussed this theme. For example, John Lee stated “seeking some type of guidance...is...a way to release the problem instead of holding it in. Just by becoming more comfortable with their self, more secure with their self, because a lot of problems come from insecurity as far as other people.” Most participants believed individuals could get better, but they need to be willing to recognize they need assistance. An example of such a perspective came from TJ who stated, “You just got to be open minded and willing to learn and willing to do the best they can to become a better person.” James1 stated, “First you got to know if you got a problem. You got to want help first. Find someone you can confide in that you feel comfortable with talking to.”

Barriers to seeking mental health treatment while incarcerated

The core theme in this study was the identification of barriers that prevented participants from seeking mental health treatment while incarcerated, even though they were currently endorsing symptoms of depression or sadness and half of them had found mental health treatment in the past to be helpful. Significant barriers identified by the majority of participants were (1) alternative coping styles (e.g., isolation, spirituality, and

journaling) and (2) a lack of trust and fear about mental health treatment and staff. Two additional subthemes that emerged with some participants, though not as prominent as the previous two themes, included: participants were unfamiliar with the process of accessing mental health treatment while incarcerated, and participants decided not to request mental health treatment based on negative perceptions and experiences of others. These two subthemes were not included in the figure (see Figure 1) but will be described in this section.

Participants preferred alternative coping styles instead of utilizing mental health treatment while incarcerated. Nine of the 12 study participants opted against requesting mental health services while incarcerated, deciding instead to utilize alternative coping styles. As John Lee stated, “I just felt like being alone and I didn’t want to talk then. I just wanted to be alone and adjust myself to finishing my stay here.” Two participants’ narratives suggested attempts to self-manage their symptoms. For example, James Bond stated: “I was depressed because I was just away from home, I just had to get used to being away from home.” Similarly, John notes, “I think it’s more better... if you can deal with a situation yourself... a person might not be there when you need them. But you always gonna be there for yourself at all times. So you should be able to handle situations yourself at times... You know I can talk to her and get it off my chest but I can write it, I can also write a letter and write the words down and get it off my chest too and throw the paper away. You know, I feel like that. So you know I really been just trying to deal with stuff like on my own cause at the end you aint got nobody but yourself, that’s how I feel... If you can deal with a situation yourself rather than always having to call somebody... because I feel like I should be able to handle it on my

own.” TJ also endorsed managing emotional distress by means of alternative coping styles by noting how he uses “writing...or writing music or just go thinking to myself. Just stay by myself, keep my distance.”

Some participants shared a common belief that spirituality was an alternative coping style for symptoms of distress. For example, William stated his reason for not engaging in treatment was “because I believe in God. That’s my mental health counselor. I’ll be alright. God watching over me. It’s in his hands. I’ll get to praying personally. Ask the Lord for help; probably shed a couple of tears. I’ll be alright. I think they (referring to mental health staff) will make me just more depressed anyways.” Justin shared similar beliefs with the following statement, “I prefer religious counseling.”

Lack of trust and fear about mental health treatment and staff. Findings from eight participants revealed a common lack of trust and fear about mental health treatment as a barrier preventing them from requesting services. For example, Benjamin’s responses reflect a perceived lack of concern from staff: “... I don’t trust them... They don’t care... They can go tell their family and be cracking jokes. That shit would piss me off if it ever came back to me that I dug my heart out and gave this person all my emotions and feelings and then they go back and laugh and crack jokes about it. They really don’t care about my problems. If I talk to them, I’m going to be talking to them for nothing, wasting my breath.”

Another participant, James1 shared similar sentiments, “People feel like they can’t talk to anyone in here... They feel they don’t want their business exposed and they don’t want to talk to certain people, then they get to judging them... It’s like a friend will show more concern than what a counselor will... a counselor is gonna tell you what you

want to hear... we need counselors that can be like, 'I know where you're coming from, I know how you feel, this is not from a professional standpoint'."

Lack of familiarity with process of accessing mental health treatment while incarcerated. Five of the 12 study participants' responses indicated they were unsure exactly how to access mental health treatment services while incarcerated. As Anton said during his interview, "I really don't know how, what to do to see [a mental health practitioner]." John mentioned how others are depressed and need mental health treatment but often do not know what to do: "there are a lot of people in here who just, who is depressed and sad and they don't have nobody to talk to, nobody to give them any guidance, or just steer them in another way. I just think there's a lot of us need somebody to talk to help out with this situation."

In addition to generally being unsure of how to access services, two participants noted assumptions about mental health treatment in jail, including that it costs money and would result in seclusion. James2 was under the impression he would be charged a fee for mental health services, stating, "I would have to pay the \$7.50, I don't have the resources or family willing to consistently put money on my books and just being a man, I don't like owing nobody." Lastly, Johnny Gardner assumed that individuals who received mental health treatment services while incarcerated were housed in a separated living area, or "a special dorm."

Participants decided not to request mental health treatment based on negative perceptions and experiences of others. Three of the 12 study participants indicated how not seeking mental health treatment during current incarceration was based on other inmates' perception and experience with treatment providers. Justin stated,

“Some inmates might find it not helpful and I’d heard some of them say that it’s not.”

Williams expressed his observations in the following statement, “people go to psych and then next thing you know they be going to the pill line, like what’s going on man that’s crazy.” John’s findings revealed his negative perception regarding mental health with the following statements, “I think when people hear the word mental health they think of people hallucinating and hearing things... Or you know most people go off what they see in movies...”

Factors that would increase mental health treatment utilization for African American inmates’ experiencing mental health concerns

Results from participants varied regarding factors that would increase mental health treatment utilization for African American inmates with mental health concerns, however five main themes emerged: increased severity of emotional distress, increased mental health individual and group programs, follow-ups with inmates who expressed depressive symptoms at intake, foster trust between inmates and staff, and increased length of sentence. The majority of study participants indicated having to experience an increased severity of emotional distress as a reason to seek mental health treatment. Also, the majority of study participants suggested utilizing mental health treatment services if additional individual and group programming were available. Some participants revealed factors that included follow-ups with inmates who expressed depressive symptoms at intake, foster trust between inmates and staff, and receiving a lengthy prison sentence.

Increased severity of emotional distress. Results indicated that eight of the 12 participants stated that an increase of emotional, psychological, and physiological distress

would result in them seeking mental health treatment while incarcerated. For example, John Lee stated “if I still had trouble sleeping or anxiety or if I felt like I was getting too angry, and I couldn’t control it, then I would try and find some other type of help.” Justin stated, “When I’m consistently crying and not being able to sleep, worried, and the times that I do sleep for a couple of hours out the day I wake up worrying what’s going to happen to me I know that I’m having some issues with my mental stability...” Similarly, Young Jezzy noted, “I would have to be all the way down and out.”

Some of the participants’ results suggested they would have to experience increased thoughts of harm to self or others as a factor to seek treatment. Specifically, James1 stated, “If I felt I was going to physically hurt someone or thinking I was going to physically hurt myself, mentally hurt myself, or anything.” Similarly, Benji-man noted, “If I’m thinking about chocking somebody. Basically, when I feel like I’m threatening myself.”

Increased mental health individual and group programs. Results from eight of the 12 participants revealed a willingness to utilize mental health treatment services if additional individual and group programming were available. Specific programs described were individual talk therapy and group therapy. One of the participants, William, was unsure if the facility even conducted groups, and wondered, “Do they do classes? For all the people that think they got problems it would probably allow them to relieve their problems. Talk in a group or whatever. Get them up out that cell for a little bit.” James Bond mentioned, “Certain inmates, not everybody wants to talk their problems out. They need to provide some type of class or something that helps people who don’t want to talk their problems out.”

John Lee mentioned how he believed mental health treatment staff could provide re-entry skills for going back into the community. He revealed the following: "...getting us prepared for careers, job readiness classes, or more parenting classes, or offering... what about a class where you can get you high school diploma, or some AODA, or just, or some anger management, or if you're in for domestic violence, what about a domestic abuse class? Just something to help us transition back to our lives."

James1 suggested for a therapist just to listen to inmates and discuss their problems "...instead of just trying to give insight, or the conventional answer." Finally, Young Jezzy suggested that MSDF develop a treatment program that would satisfy probation and parole requirements with the following statement: "They should start some type of treatment for individuals like me for their probation officers."

Follow-ups with Inmates who expressed depressive symptoms at intake.

Three of the 12 participants indicated providing follow up mental health treatment services for African American male inmates who acknowledged feelings of depression at intake would increase utilization of services. Statements from John Lee depict both the need for follow-up and his reasoning for why. Examples of his responses were, "I guess just monitoring them more. Probably like once a week coming to see how a person is doing. If a person came to the mental health staff one time and said, Well, I'm having problems... depressed, can't sleep, things of that nature, come at them a week later and just to make sure things aren't going as bad. Cause it's hard to come from there and come from the outside world to just being straight locked up. I guess it's to monitor inmates, especially like first-timers." Benji-man shared a similar belief regarding follow up services while incarcerated, "They should do follow ups on their people. Like when

we first came if I was feeling depressed, can't sleep or eat. They don't do follow ups and be like so how are you, are you still depressed? They don't do none of that. That's why I say that don't give a (explicit word), so why talk to them.”

TJ mentioned that response time of mental health treatment providers was important, as well as the need to increase follow-up mental health treatment services for individuals incarcerated at MSDF for longer than 45 days, stating:

“They need to know time is everything. Time is a bullet, either you gonna use it or pull it. If an inmate put in a slip, that means, the inmate needs to be seen as soon as possible. Don't wait until you all get the time, because you all going to get paid regardless. So person's not going to put in a slip for the hell of it just to get off the unit. Know the person is putting in a slip because they really need help. Because if he didn't need help, he wouldn't put in the slip. So they need to be on time at all times and they need to check up on the inmate daily to ensure the inmate is coping and using whatever tools that they were provided with throughout the day. Otherwise, the wonder when they come, such and such is in the hole. Why, because they failed to give them the tools that he was asking for, before he reached that boiling point. Time is against us right now. If you're here over 45 days do a follow up to see how a person is feeling or doing.”

Foster trust between inmates and staff. Three of the 12 participants expressed how mental health treatment providers could change their perception of inmates seeking services in order to increase trust, and by default, service utilization. As John Lee stated, “We all just aren't bad people. Some of us make mistakes, yeah, everyone makes mistakes, it's just that we're on the borderline, with our mistakes we got to walk this straight and narrow line.” Benji-man described it as, “Listen and don't try to pre-judge them. You can't go off what the paper say, you have to listen to them. Lighten up some. Be relaxed and comfortable. Talk to them like their buddy off the stress or something, that would (make) them feel comfortable. Some people express their way different, like me, I cuss a lot I know I do. I don't want to, especially with somebody I have to explain my life to try to hurry up and think of different words to use, let me be me, myself.”

Receiving a lengthy prison sentence. Two of the participants indicated receiving a lengthy prison sentence as a factor for engaging in mental health treatment, particularly because staying in prison longer would likely increase their distress. William stated, “If these people revoke me then I’m going to want to talk to somebody ASAP. That’s too much time.” Also, Specifically, Justin noted that if he, “had to do a lot of time, I’m sure that would have an effect on [his] mental stability.”

Results Summary

The purpose of this study was to explore factors that influence African American male inmates’ decisions to seek mental health treatment while incarcerated. Results from this study revealed African American male inmates were able to identify and recognize several symptoms of mental health problems (i.e., emotional, psychological, physiological distress to include thoughts of harm). Furthermore, the majority of study participants expressed benefits of mental health treatment engagement, particularly the subgroup who had previously engaged in treatment. The core theme that emerged from this grounded theory study was “barriers to seeking mental health treatment while incarcerated.” The primary barriers were: (1) alternative coping strategies (i.e., isolation, spirituality, and journaling) and (2) a lack of trust and fear about mental health treatment staff. Finally, several suggestions were provided for ways to improve mental health engagement, including: increasing mental health individual and group programs, follow-ups with inmates who expressed depressive symptoms at intake, and fostering trust between inmates and staff, and increased length of sentence.

Chapter V: Discussion

The purpose of this study was to explore factors that influence African American male inmates' decisions to seek mental health treatment while incarcerated. Topics explored included: (a) how participants defined and described symptoms of mental health problems (b) participants' experience engaging in mental health treatment (c) participants' awareness of mental health treatment options during current incarceration, and (d) participants' general views of mental health treatment for inmates. In order to investigate this topic, the principal researcher conducted a grounded theory study (Glaser & Strauss, 1967, see Chapter III) of 12 incarcerated African American males who reported depressive symptoms at intake, but had not requested mental health services.

Overall findings revealed several major themes, including descriptions of symptoms commonly associated with mental health problems, positive benefits of mental health treatment, and barriers to seeking mental health treatment while incarcerated (e.g., participants' preference for alternative coping styles and a lack of trust and fear about mental health treatment staff). Participants' narratives and the overall themes that emerged helped to provide an understanding of the reasons why African Americans inmates may or may not choose to utilize services in prison when experiencing symptoms of depression.

Discussion of findings

This section will address the results discussed in Chapter IV as they relate to the literature in this field. After linking themes and subthemes that emerged from this

grounded theory study, the strengths and limitations of the study will be addressed.

Additionally, clinical implications and directions for future research will be provided.

Descriptions of mental health problems from participants

All twelve study participants endorsed experiencing emotional distress and were able to identify common symptoms associated with mental health. Research from previous correctional populations suggested inmates often experienced mental health problems prior to incarceration (Manderscheid et al., 2004). Diamond et al. (2008) discovered specific symptoms among a group of inmates which included insomnia, worry, depression, and racing thoughts. In a study with participants who were not incarcerated, Watkins and Neighbors, (2007) completed five focus groups (N= 46) with 18-46 year old African American males exploring what mental health meant to them, and found similar findings (e.g., schizophrenia, bipolar, depression, and low self-esteem). Consistent with previous research, in this current study participants also identified common mental health symptoms, which included isolation self from others, sadness, low mood, feelings of hopelessness, insomnia, anxiety (e.g., increased worry and irritability), suggesting they are aware that their current symptoms of depression could be markers of a mental health disorder. Nevertheless, the participants did not seek mental health services, so the subsequent findings are important for providing a context for understanding this further.

Participants with previous experience expressed positive benefits of mental health treatment

Six participants in the current study indicated having previously sought mental health treatment, though not immediately prior to or during their current incarceration.

These participants indicated three benefits of previous treatment: (a) reduced emotional distress; (b) increased sobriety; and (c) increased family relationships. Overall, these findings are similar to those of Morgan, Garland, Rozycki, Reich, and Wilson (2007) who obtained survey data from inmates with previous group therapy. Their results suggested five key components to treatment: (1) self-exploration and coping skills; (2) group relationship building and cooperation; (3) substance abuse; (4) prosocial behavior and healthy lifestyle; and (5) institutional relationships (Morgan et al., 2007, p.161).

In the current study, the majority (N = 5) of participants in this subgroup mentioned personally experiencing a reduction of symptoms due to previous therapy engagement. In a literature review of the effectiveness of group psychotherapy (e.g., interpersonal process-oriented and cognitive-behavioral group psychotherapy), Morgan, Winterowd, and Fuqua (1999) summarize evidence which supports this notion of how treatment is effective for developing rapport with inmate participants. However, this study only explored how effective group therapy was in comparison to levels of defensiveness, empathy, or disciplinary actions while incarcerated. Study participants endorsed being willing to engage mental health treatment in the future if needed. Morgan et al.'s, (1999) research highlighted three key components that were positively affected by group treatment: inmates' attitudes, feelings, and behaviors. In the current study of inmates at MSDF, participants revealed how reducing emotional distress (e.g., "stress, anger, depression") impacts their overall behavior. Possibly having inmates engage in therapeutic activities (i.e., group or individual therapy) could eliminate and/or reduce emotional distress.

A large meta-analysis (N=9995), though not conducted within a correctional population, explored treatment outcomes of participants receiving Cognitive Behavioral Therapy (Butler, Chapman, Forman, & Beck, 2005) vs. individuals receiving placebos and placed on waiting list. Those individuals who participate in the CBT aspect of therapy had “superior” outcomes compared to those in the placebos or placed on the waiting list (Butler et al., 2006). Despite not being conducted within a correctional population, the results are indicative of the effectiveness of treatment and its correlations with positive outcomes. Finally, participants expressed how treatment allowed them to work on personal issues, which improved the overall quality of relationships with family members. In summary, it appears that the African American inmates in this dissertation project were aware of what mental illness might look like, and a subgroup of them had positive previous mental health treatment. Thus, they reported less distress, increased sobriety, and improved family relationships.

Belief that mental health treatment could be effective

Overall, the majority of the study participants believed engaging in mental health treatment could lead to symptom reduction. Findings from a study that explored the perceptions of mental health treatment effectiveness from a sample of 665 multi-ethnic individuals found that African Americans (N=82) reported mental health treatment as effective, which would lead to symptom reduction (Anglin et al., 2008). However, the Anglin et al. (2008) involved participants from the general population recruited primarily through telephone surveys, not incarcerated individuals. In a help-seeking study among New Zealand inmates, Skogstad et al., (2005) discovered that participants reported a willingness to engage mental health treatment for emotional distress or personal issues,

however, would need seek mental health treatment if experiencing suicidal ideations. Watkins and Neighbors (2007) discovered in a general population setting that African American males were able to recognize symptoms of depression, though were unwillingly to seek services as a result of individual discomfort and discussing mental health problems. Taken together, this research suggests that individuals are able to recognize symptoms associated with mental health problems, however, are not willing to engage in treatment. These findings are very similar to the current study.

Barriers to seeking mental health treatment while incarcerated

Participants identified primary barriers preventing them from engaging mental health treatment engagement: (1) participants preferred alternative coping styles (e.g., isolation, spirituality, and journaling) instead of utilizing mental health treatment while incarcerated, and (2) a lack of trust and fear about mental health treatment and staff.

Participants preferred alternative coping styles instead of utilizing mental health treatment while incarcerated. A preference to pursue alternative coping strategies has been found in a study with the general population. For example, Snowdon (2001) found that 87% of participants reported preferring to deal with the problems on their own (e.g., ignore symptoms due to self-reliance or increase religious activities). In a study of inmates, Morgan, Steggan, Shaw, and Wilson, (2007) found barriers preventing participants from seeking treatment such as self-preservation/self-reliance, and professional service provider concerns (e.g., participants did not want therapy from an unlicensed professional). Taken together, these studies suggest that self-reliance is an important construct in the lives of adults in the general population and adult male inmates. In a general study of young African American men, Watkins and Neighbors

(2007), also found that participants wanted to handle problems on their own. In other words, self-reliance might be an effective strategy that helps African American inmates endure adversity. Alternatively, this self-reliance could become problematic if they are unable to manage the distress and if self-reliance prevents them from seeking help. Given that this self-reliance might be a prominent characteristic in the lives of African American inmates, it warrants further attention in empirical research as well as within the mental health treatment in prison and jails.

In addition to self-reliance, the role of spirituality in coping deserves further investigation. Studies have shown that spirituality and religion are related to coping and positive health (Ano & Vasconcellas, 2004), and these inmates report that spirituality served as an alternative strategy for helping them deal with distress. Among African Americans, spirituality has been noted to be prominent (Ano & Vasconcellas, 2004) suggesting it maybe a valuable construct for further study.

Lack of trust and fear about mental health treatment and staff. Mistrust of professional mental health treatment staff was a common theme voiced by participants in this study. African American men in the United States historically have had negative perceptions toward medical and mental health as noted by several studies with the general population (Duncan, 2003; Griffith et al., 2011; Morgan et al., 2004; Morgan et al., 2007; Skogstad et al., 2005; Snowden, 2001; Thompson et al., 2004; & Woodward et al., 2011). In fact, Watkins and Neighbors (2007) reference the challenges faced by African Americans regarding research in the U.S. beginning with the infamous Tuskegee Syphilis experiment. In the Skogstad et al. (2005) study, incarcerated individuals believed they were not able to trust mental health treatment staff if they were having

significant mental health problems. Results from the current study also revealed participants often experienced a difficult time connecting or trusting mental health treatment staff.

Lack of familiarity with process of accessing mental health treatment while incarcerated. Participants in the current study noted being unfamiliar with the process of accessing mental health treatment while incarcerated. These findings are similar to Ward et al.'s (2009) results that consisted of a community sample of African American women in major metropolitan city. Similarly, Thompson et al. (2004) conducted focus groups with (N= 201) African Americans in a community setting and found that participants were unaware of the resources available to them for mental health treatment. These findings have not appeared in published literature regarding incarcerated African Americans, however, so it is possible they are only relevant to MSDF. Further research in this area would be helpful to better understand this finding.

Participants decided not to request mental health treatment based on negative perceptions and experiences of others. Participants noted that one barrier to engaging in mental health treatment was others' negative perceptions and experiences of treatment. Previous research with African American adults in the general population has found both negative (Ward et al., 2009) and positive (Anglin, Alberti, Link, and Phelan, 2008) perceptions towards treatment. Unfortunately, limited research exists on the relationship between others' perceptions and mental health treatment engagement. However, Griffith et al. (2011) discuss the strong social norm within certain populations of African Americans regarding negative perceptions of help-seeking behaviors. This norm might be accentuated by others' perceptions of mental health treatment, such that

individuals who hear about unsuccessful experiences might be even less likely to pursue treatment. Similarly, the overall stigma surrounding mental illness, if perpetuated by others close to an individual, may heighten their reluctance to engage in treatment. Additional research should investigate how negative perceptions and the influence of others impacts inmates' participation in mental health treatment.

Factors that would increase mental health treatment utilization for African American inmates' experiencing mental health concerns

In addition to beliefs about mental health and barriers regarding engagement, this study found several factors that participants indicated would lead to mental health treatment engagement. These five factors included: increased severity of emotional distress, increased availability of mental health individual and group programs, follow-ups with inmates who expressed depressive symptoms at intake, fostering trust between inmates and staff, and increased length of sentence. These five factors will be reviewed further in the next section.

Increased severity of emotional distress. Historically, African American men have prolonged medical or mental health care until symptoms become extremely severe, often resulting in inpatient hospitalization (U.S. Department of Health and Human Services, 1999). In this study, participants' willingness to engage mental health treatment only if the severity of emotional distress (e.g., thoughts of harm to self or others) increased suggests a similar reluctance to engage in treatment.

In contrast, a recent study that explored barriers to help-seeking in 52 men in a New Zealand correctional facility, Skogstad, Deane, and Spicer (2005) found opposite results. Inmates were incarcerated in either a medium or maximum security prison and

reported being less likely to seek mental health treatment if having thoughts of harm to self (Skogstad et al., 2005). Study participants indicated an unwillingness to notify mental health staff due to possible placement in a single cell isolation, which could impact future movement (e.g., early release or transfer to a less restrictive facility). The discrepancy in these findings could be a result of the demographics and context of participants. In the current study African Americans were studied, a population whose lack of mental health treatment engagement could be attributed to frequent psychosocial stressors within the United States (e.g., community violence, frequent interaction within the criminal justice, and perceived discrimination) (Watkins & Neighbors, 2007). Additionally, as mentioned above, African Americans may be more likely to rely on alternative coping strategies such as self-reliance and spirituality, and thus may wait until symptoms become very severe before seeking help.

Increased mental health individual and group programs. Study participants reported that they would be more likely to seek mental health treatment if MSDF provided additional treatment options. Research conducted by the state of Washington Department of Corrections found that providing additional mental health treatment options correlated with an increase in inmate participation (Butler et al., 2006). Furthermore, in a review of research over the last 40 years, Butler et al. (2006) evaluated 291 programs that were associated with individuals with mental health problems and correctional experience and found that recidivism decreased with treatment engagement. Specifically, evidence-based treatment programs utilizing Cognitive Behavioral Therapies were the most effective at preventing recidivism. Therefore, it seems as though participants' beliefs that increased mental health treatment options will lead to more

involvement is supported by research. Clearly issues of resources are likely to influence the ability of institutions to provide mental health services, however, but the fact that both participants and previous research are highlighting its importance is worth noting.

Follow-ups with inmates who expressed depressive symptoms at intake.

Participants in the current study indicated that following up with inmates who expressed depression symptoms at intake would increase participants' engagement with mental health treatment. Research exploring the potential benefits of following-up with inmates who expressed depressive symptoms at intake is currently unavailable. Clearly, in the medical system, providing monitoring services for patients with chronic conditions (e.g., hypertension, high cholesterol, and diabetes) is considered normal (Goodman, McKay, & DePhillippis, 2013). It's therefore likely that follow-up could potentially lead to increased mental health treatment utilization while reducing the stigma of mental health treatment. This would be a fruitful area for future research.

Foster trust between inmates and staff. One of the most important skills a therapist must master is the art of developing adequate rapport with clients, and participants acknowledged that increased trust between inmates and staff would improve mental health treatment engagement. In a qualitative exploration examining the factors associated with effectively reaching African American males in a medical outreach study, Plowden and colleagues (2006) found three related barriers: (a) trust of the medical provider conducting medical outreach; (b) perceived safe and caring environment (e.g., "non-judgmental, non-racist, or culturally insensitive"); and (c) being informed of the cost benefit to them (e.g., informing participants of positive stories from patients who received treatment and a reduction of medical symptoms). Although the Plowden et al.

study was conducted with older African American males in a community sample, incarcerated males in the current study also reported they did not want to be “pre-judged.”

Additionally, establishing a trusting relationship with inmates could reduce the underreporting of mental health symptoms or the reluctance of participants to seek care until symptoms become severe. Kendrick, Andersons, and Moore (2007) interviewed 28 African American males between the ages of 18-25 and discovered that the majority of participants reported denying experiencing common mental health symptoms (e.g., depression, sadness, or anxiety) due to a lack of trust of providers. Therefore, when individuals fail to report current symptoms they are not able to receive treatment that has been proven effective. This can be even more complex in a correctional facility due to inmates perceiving the therapist as a correctional official (e.g., being able to communicate with security personnel regarding inmates) rather than a traditional psychotherapist. For example, inmates discussed how they would prefer if a correctional therapist could “make them feel comfortable.”

In a study about help-seeking with inmates, Skogstad, Deane, and Spicer (2006) identified strategies that might help to improve relationships between staff and inmates. These authors suggested communicating clear guidelines regarding roles in the therapeutic relationship (e.g., volunteered or mandated by correctional officials), which would reduce the negative perception inmates have of mental health treatment. Overall, the goal of any therapist or mental health professional would be decrease barriers preventing participants from utilizing their services.

Limitations of the Study

As with any study, there are limitations that must be acknowledged. The first limitation of this study was the limited generalizability of findings due to the type of facility from which participants were sampled. Given that MSDF is designed comparable to a city or county jail, participants' responses cannot be compared to inmates incarcerated at other state correctional facilities, which typically consist of a longer prison sentence.

Also, it is important to note that study participants were not officially diagnosed with a mental disorder; rather, they were recruited based on their responses to a single item (e.g., feelings of depression and/or sadness) on the mental health screening interview form conducted at intake. Conclusions about coping strategies and reasons for not seeking mental health treatment, therefore, must be tempered by the reality that perhaps the participants did not have a mental disorder and were rather experiencing temporary feelings of sadness or depression that did not necessitate treatment. Future studies which investigate participants with more long-standing symptoms of depression or a diagnosis of depression obtained through a structured clinical interview (e.g., Rogers, 2003), are definitely warranted.

Additionally, some of the recommended procedures for grounded theory studies (Glaser & Strauss, 1967) were not followed, such as sampling until saturation, or conducting follow-up interviews to allow participants to verify study findings (Seal et al., 2004 & Vliet, 2008). Unfortunately given the average length of incarceration among this study's target population, some of these practices would not have been feasible, however, this limits the trustworthiness (Corbin & Strauss, 1990) of the findings.

Clinical Implications

While it is not guaranteed that implementing suggestions from study participants will guarantee an increase in mental health treatment engagement, it is possible that addressing some of the identified issues may lead to increased engagement. Specifically, increasing group therapy (e.g., psycho-educational or processing groups) could provide benefits for a number of reasons. First, group therapy provides treatment opportunities for multiple participants with fewer treatment providers, thus conserving resources. Second, depending on the structure of the group and facilitator, groups are relatively less formal than traditional individual psychotherapy. Also, group facilitators are able to structure the group format based on the needs of participants. For some, individual therapy can be seen as more threatening to someone unfamiliar with the process. Ongoing group therapy might appear more accessible to inmates and also appear less threatening.

The results also suggest that clinical interventions, whether in individual or group modalities, might focus on discussing inmates' alternative coping strategies such as self-reliance and spirituality. Since it is unknown if the alternate coping strategies are effective at dealing with distress, clinicians must be careful not to judge these approaches as less or more valuable than traditional treatment. Nonetheless, interventions related to coping, how to identify when personal coping strategies are not working, and how to seek additional help could be warranted.

Another possible clinical implication would be for mental health treatment staff to develop a protocol for following-up with inmates who expressed experiencing depression or sadness at intake, but did not request services. Literature indicates that the best

opportunity to identify inmates needing mental health symptoms is at intake (Adams & Ferrandino, 2008). Although MSDF mental health treatment staff currently follow-up with inmates suspected of experiencing significant distress, possibly developing a psycho-educational group for identified individuals who expressed depression or sadness at intake could be a possibility.

Directions for Future Research

Findings from this study provide several directions for future research. First, future studies should continue to explore how inmates decide to seek mental health treatment in a variety of settings and correctional facilities to see if perspectives are similar or different from those in the current study.

A valuable next step would also be to investigate inmates who do decide to seek mental health treatment to better understand the factors that encouraged them to do so. Future research should explore correlations of increased group therapy at a correctional facility with mental health treatment engagement. One of the factors participants indicated as a reason to engage in mental health treatment was through group therapy. Therefore, future research could investigate the effectiveness of group therapy and mental health treatment engagement. Lastly, researchers should explore if and how follow-ups with inmate' who reported experiencing depressed or sadness actually has an effect on treatment engagement. Many of the study participants expressed concern regarding trust, fear, and feeling misunderstood by treatment staff. A possible suggestion could include reviewing yearly training of PSU staff members, especially those who routinely interact with inmates to explore what factors could reduce the concerns of trust among inmates. These might include efforts to bridge cultural differences, decrease perceived stigma, or

increase communication about mental health treatment options. As a result of this training, PSU staff might develop creative ideas to increase the chances of inmates of seeking mental health treatment while incarcerated.

Overall Summary

In conclusion, the purpose of this study was to explore factors that influence African American inmates' decisions to seek mental health treatment while incarcerated. Twelve African American males who reported depressive symptoms at intake but who had not sought mental health services were interviewed. Data was analyzed using grounded theory methodology (Straus & Corbin, 1990). Results revealed several major themes, including: descriptions of symptoms commonly associated with mental health problems, positive benefits of mental health treatment, and barriers to seeking mental health treatment while incarcerated (e.g., participants' preference for alternative copings styles, a lack of trust and fear about mental health treatment staff). Participants' narratives and the overall themes that emerged helped to provide an understanding of the reasons why African American inmates may or may not choose to utilize services in prison when experiencing symptoms of depression. Lastly, limitations, clinical implications, and directions for future research were reviewed.

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APPENDIX A: Informed Consent

MARQUETTE UNIVERSITY
 AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS
 Understanding African American Male Inmates' Decisions
 To Seek Mental Health Treatment While Incarcerated
 Principal Investigator: Darnell A. Durrah Jr.
 Department of Counselor Education and Counseling Psychology

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate. Please know that your participation (or non-participation) will not impact your offender status, such release date, or institutional privileges with the Milwaukee Secure Detention Facility (MSDF), where you are currently being recruited.

PURPOSE: The purpose of this research study is to learn how African American male inmates' decide to seek mental health treatment while incarcerated. The researcher want to learn about this topic from African American men who indicated feeling really depressed or sad while incarcerated. People who participate in the study will be asked questions about experiences or lack of experiences with mental health services while incarcerated or in the community. As a participant, you will be one of 14 participants in this research study.

PROCEDURES: As a participant in this study, you will be interacting with 1 student researcher for about 2 hours. First, you will be asked to fill out a brief survey about your background, which will take about 5-10 minutes. You will then be interviewed about how you decide or decided to seek mental health treatment while incarcerated. This interview will be audio taped/recorded so that it can be transcribed later and your comments can be recorded accurately. The audio recordings will be destroyed after they are transcribed, and transcripts will be destroyed 7 years after the study is finished. To protect your privacy, your name will not be used on the surveys, tapes, or transcripts. In fact, for confidentiality purposes, you will be asked to use a fake name during the interview.

DURATION: Your participation will involve 1 face-to-face meeting with the researcher. This meeting will take about 2 hours. If the interview is interrupted for some reason and you still want to continue participation in the study, a second face-to-face meeting can be scheduled to finish the interview.

RISKS: There are some minor risks related to participation in this study. The risks are probably no more than you would experience in everyday life. However, it is possible that the questions asked during the interview may cause you to become upset. If the interview becomes too upsetting for you, it can be stopped at any time, and you can be referred to an on-site Psychological Service Unit (PSU) staff member (licensed psychologist) who can assist you. Meanwhile, you should not tell me any information

about past or future crimes that are unknown to the authorities, as I cannot guarantee confidentiality of that information.

BENEFITS: There are no direct benefits to you for participating in this study. Meanwhile, the benefits associated with participation in the study include contributing to scientific research and particularly to the field of psychology. Your participation in the study may help people understand the research topic better, especially those who work with incarcerated individuals.

CONFIDENTIALITY: All information you reveal in this study will be kept confidential (with the exception of intent to harm yourself or others and abuse/neglect of child/disabled adult/older adult-see the “Risks” section of this sheet). All your data will be given a code number or fake name rather than using your name or other information that could identify you as an individual. When the results of the study are published, you will not be identified by name, but the researcher may use direct quotations of what you say during the interview. All de-identified data will be kept indefinitely for potential future research. All electronic audio data will be destroyed after completion of transcription. In the meantime, de-identified study data will be kept in a locked file on Marquette University property. Only study personnel will have access to it, though research records may be inspected by Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies. It is possible that information from your interview or background information survey will be used for future research purposes.

COMPENSATION: You will be compensated for your participation with a \$10 deposit to your institution account, even if your participation in the study ends early or you do not want to finish the interview. Your account will be credited at the conclusion of your meeting with the researcher.

INJURY OR ILLNESS: Marquette University will not provide medical treatment or financial compensation if you are injured or become ill as a result of participating in this research project. This does not waive any of your legal rights nor release any claim you might have based on negligence.

VOLUNTARY NATURE OF PARTICIPATION: Participating in this study is completely voluntary and you may withdraw from the study and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled. Should you wish to skip any questions or end your participation at any time, simply tell the researcher. If you withdraw from the study, information you already shared about yourself will not be used in the study. However, the researcher will keep a record on the number of participants who withdraw from the study, if any.

CONTACT INFORMATION: If you have any questions about this research project, you can contact Darnell Durrah, the Principal Investigator, by submitting an institution request to PSU and it will be forwarded. If you have questions or concerns about your

rights as a research participant, you can contact Marquette University's Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

Participant's Signature

Date

Participant's Name

Researcher's Signature

Date

APPENDIX B: Brief Demographic Form

Interview Number: _____

Date: _____

Fake Name: _____

Age: _____

Ethnicity/Race: _____

Marital Status: _____

Level of Education:

What was the last grade you completed? _____

Did you complete your HSED/GED? ____

If yes, did you complete it while incarcerated? _____

Incarceration:

How times have you been incarcerated either at MSDF or another state facility? _____

How many times have you been at MSDF? _____

How long have you been at MSDF? _____

Were you offered psychological services at MSDF? _____

Psychological Services:

Have you ever received mental health treatment at MSDF? _____

Have you ever received mental health treatment in the community before coming to MSDF this most recent time? _____

APPENDEIX C: Protocol Questions
(10/25/2011 Flesch-Kincaid grade level 6.0)

Introduction:

Thank you again for agreeing to be a part of this study. As you know, I am interested in better understanding African American male inmates' decisions to seek mental health treatment while incarcerated. During this interview I will be asking you questions about how you define mental health and mental illness, as well as why you might or might not request to get mental health services while you are in prison. Remember there are no right or wrong answers—I just want to get your views. Please talk as much as you can for each question.

Definitions of Mental Health:

1. How do you define or describe *mental health*?
2. What would you say mental health problems might look like? (Prompt: how would you know you were having some type of mental health problem?)
3. Do you think people who are having mental health problems can get better?
 - a. If yes, ask, "How can they get better? What helps people get better?"

Mental Health Service Experience

Sometimes people who are having troubles or mental health problems choose to see a provider like a counselor, substance abuse counselor, psychologist, social worker, or even a psychiatrist. The next questions are going to ask about your experiences with mental health services.

4. Have you ever seen a professional mental health provider (like a counselor, psychologist, etc...)?
 - a. If yes, Ask participant,
 - i. "Tell me a little about your experience(s). Who did you see?"
 - ii. What was it like?
 - iii. For how long did you work with them?
 - iv. How did you end up seeing that professional (referral, voluntary, etc.)?
 - v. Was it helpful?
 1. If yes, ask, "Can you tell me how it was helpful for you?"
 - vi. Would you ever go see that person or someone like them again?
 1. If yes, ask, "Why or why not?"
 - vii. Is there anything else you would like add (pause for a moment)
 - b. If "No" ask: "Why haven't you ever seen a mental health professional?"

Mental Health Services in Prison

Now I have a couple of questions I want to ask you about mental health services in prison specifically.

5. Are you aware of mental health treatment options at MSDF?
 - b. If yes, ask, "Have you ever used those services before?"
 - i. If yes, what type of services have you used?
 1. How did you hear about these services?
 - ii. How helpful were these services in the past?
 - c. If no, proceed to question #6.
6. Have you ever been incarcerated at another state facility?
 - a. If yes ask, "Were you aware of mental health treatment options there?"
 - i. If yes, ask, "Have you ever used those services before?"
 - ii. If yes, what type of services have you used?
 1. How did you hear about these services?
 - iii. How helpful were these services in the past?
 - b. If no, go to next question #7
7. At intake here at MSDF, you reported you were feeling really sad/depressed, but you did not request any mental health services at this time.
 - i. What made you not want to see a mental health provider while you were here at MSDF?
8. Under what circumstances, if any, would you seek help from a mental health professional while in prison?

Participants' general views of mental health treatment for inmates

I just have a few more questions to ask you. So now I would like to ask you some general questions about your personal views about mental health treatment for inmates that are incarcerated.

9. What do you think is important for prison staff (psychologists, etc.) to know about what inmates think about mental health treatment?
10. How do you think mental health treatment in prison settings can be improved?
 - a. What exactly would you change if you could?
 - i. (After the participant has finished with his answer, ask "Is there anything else you would want to change?")
11. Is there anything else you want to say about this topic of mental health treatment in prisons?

APPENDIX D

Consent/Refusal for Recording

Name of Participant (real name): _____ Fake Name: _____

Date: _____

Information for participant:

In order to complete this interview the researcher would like to record what you say. The information will help the research improve the quality of this study.

Type of recording (please provide initials)

___ Audiotaping (The researcher will use an audio recorder that only records what you say.

Purpose of recording (please provide initials)

___ IRB approved research

Privacy protection and retention of audio recording

The research will keep all recordings of you in a locked safe place.

Right to withdraw consent to audio recording

You have the right to withdraw your consent anytime during the audio recording of the interview.

Verification by the principal researcher

By signing below, I certify that I have provided the above information to the participant

Signature of Principal researcher: _____ Date Signed: _____

To be completed by the participant:

___ I refuse to consent to the audio recording as described above.

___ I voluntarily consent to the recording as described above.

Signature of Participant: _____

Date Signed: _____

APPENDIX E

Mental Health Screening Interview Question #8

8. ____ Yes ____ No Have you been feeling really depressed or sad? Reasons? _____
- ____ Yes ____ No Have you been crying? How often? _____