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MENTAL HEALTH STIGMA AND INDIGENT DEFENSE

by

RUTH F. RICHARDSON

Under the Direction of Eric R. Wright, PhD

ABSTRACT

This study aimed to facilitate a greater understanding of the attitudes, and experiences of stigma among indigent clients of two urban Atlanta public defender offices. In order to gain insight into the experiences of this hard to reach population and the factors associated with mental health self-reporting. By examining the general views of self stigma, public stigma and structural repercussions this study will contribute to the understanding regarding stigma concerns, experiences and coping strategies. Findings can inform efforts to effectively increase understanding of how indigent clients viewed themselves and others identified formally or informally as mentally ill.

INDEX WORDS: Indigent, Stigma, Mental Health

MENTAL HEALTH STIGMA AND INDIGENT DEFENSE

by

RUTH F. RICHARDSON

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctorate of Philosophy

in the College of Arts and Sciences

Georgia State University

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MENTAL HEALTH STIGMA AND INDIGENT DEFENSE

by

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August 2018

DEDICATION

For every client I've ever had the privilege to work for, from each of them, I have learned

so much. I could not have written a single page without the unwavering support, love, and

unfailing sense of humor of my husband, David—I bow.

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1   INTRODUCTION

This research explores how mental illness stigma, poverty, and involvement with the criminal justice system intersect to materially affect the life outcomes of those affected by multiple intersecting labels. The high numbers of mentally ill men and women incarcerated today are indisputable. One of the unintended consequences of deinstitutionalization is that mental health increasingly has become the purview of the legal profession (Fagan 2003; Gainsborough 2002; Webb 2017). The relentless rhetoric and punitive political policy directed toward the country's most disadvantaged and vulnerable have created a situation where the justice system functions as a surrogate mental health provider, stepping into a breach that ought to be occupied by health care service providers (Bronson and Berzofsky 2017; McConville 1995; Roth 2018).

The various means by which people have been stigmatized are in part the result of ongoing political policies that have impacted the field of medicine in all areas, specifically for the purposes of this research the area of mental health. Parallel with the results of defunding of the public-school system and the decimation of social programs to assist and support the less fortunate members of society, the consequences have been severe for the disadvantaged and discriminated against. This research is part of a larger study, the "Assessment of the Civil Legal Needs of Indigent Criminal Defendants," (ACLNID). This study focuses on the area of mental health stigma and the impact of multiple stigmatized identities. Further analysis of the data collected has led to the realization that the civil legal needs of the indigent clients of the public defender exemplify the material manifestation and operationalization of stigma in its various forms.

The result is increasing marginalization on many fronts for people involved with the criminal justice system today in the United States, especially those deemed to be in such extreme

poverty as to meet standards for indigency. These individuals face ongoing state-sanctioned stigmatization through practices of routine disenfranchisement, the origins of which can be identified in a lack of equality and social justice (Alexander 2010; Chung 2016; Mauer and Chesney 2002; Uggen, Larson, and Shannon 2016). This history must be taken into account to form a meaningful understanding of contemporary circumstances in the areas of mental health, indigent defense, and incarceration.

Central to the construct of identity in the United States is the commitment to the ideal of equality. Although the distance between this mythical ideal and reality seems insurmountable, it is still cherished and presented as a social reality. Germane to the equality narrative is the supposition that everyone in this country is equal before the law. The political rhetoric, however, far exceeds the legal reality faced by many of this country's most vulnerable citizens who do not enjoy the same treatment as those insulated by wealth and status. Minorities and the poor have been marginalized, disenfranchised, increasingly vilified, and omitted from any working reality where they are treated fairly and equally.

Most of the indigent are constrained by the intersection of multiple overlapping labels, such as criminal record, negative racialization, poverty, and mental illness (Alexander 2010; Hartwell 2004; Roth 2018). If we understand how perceptions of stigma impair clients from actively seeking help, we can develop clearer pathways for clients to access help quickly when facing criminal charges.

Moving forward, it is imperative to understand that the offices of the public defender exist to meet that the standards of the constitutional right of counsel for the indigent. It does not automatically follow that providing mental health intervention and treatment aligns with this primary directive (Uphoff 1988). According to legal standards, clients must be competent

enough to stand trial and to assist in their own defense. If a client's ability to meet competency requirements is called into question or compromised, the attorney's responsibility is to investigate the various recourse options available (Minor and Noffsinger 2017).

Many barriers prevent the effective treatment of mental illness inside and outside of the criminal justice system, including but not limited to poverty, lack of adequate treatment options, and the impaired ability of people with mental illness to navigate complicated medical service systems (Link 2003; Link et al. 1989; Link, Mirotznik, and Cullen 1991; Markowitz 1998; Pescosolido 2013; Tetlow and Phillips 2016; Wright et al. 2007; Wright, Gronfein, and Owens 2000). Therefore, initial (early) identification (ideally first 72 hours) of those suffering from mental illness is critical to improving outcomes of indigent clients so that the processes can begin for alternatives to mainstream incarceration and treatments (Tetlow and Phillips 2016; Link 2016). Failure to identify defendants with mental illness often results in a longer period of incarceration, as well as missed opportunities for treatment and the development of a re-entry plan that will assist with housing, benefits, and employment opportunities. The latter are considered protective factors against re-offending.

Conducting research with the offices of the public defender provides a unique opportunity to explore the complex realities of stigma in the real world. Access to their clients has provided the opportunity to gain insight into the lived experiences of this hard-to-reach population. Additionally, the perspectives of the attorneys and social workers provide critical supplemental information regarding their clients' lived experiences and the structural and institutional barriers that impact them all.

1.1 Specific Aims

This exploratory study seeks to ascertain how issues of stigma around mental health inhibit clients from being forthright about their mental health status. This research utilizes data generated during the Assessment of the Civil Legal Needs of Indigent Criminal Defendants (ACLNID). ACLNID research explores the life circumstances of indigent criminal defendants to determine problems they experience prior to and while interacting with the criminal legal system. The first study to focus on the civil legal needs of indigent defendants, ACLNID identifies areas of civil legal needs that could benefit from intervention before and during the adjudication of criminal cases, specifically:

> Collect data by conducting semi-structured interviews with indigent defendants of the Fulton County Circuit Public Defender and the Stone Mountain Circuit Public Defender (hereafter referred to as the Fulton Co Public Defender and the DeKalb Co Public Defender) to assess the civil legal needs.

The data collected during the ACLNID study provides information that facilitates a more in-depth analysis to uncover insights into the issue of mental illness labeling and stigma.

1. Identify attitudes of indigent clients to seeking help for mental health issues, their own or of people close to them.

2. Gain understanding of the experiences indigent clients may be having or have had in the past concerning mental illness, their own or family members.

The ACLNID study fills a gap in current legal research by providing information about the civil legal needs of indigent clients facing criminal charges, and as such adds to the body of knowledge concerning holistic defense practices. Analysis of the information from the overall study has illuminated the difficulties some people experience in gaining access to legal help pertaining to civil issues, including but not limited to housing, education, and health insurance.

To avoid potential confusion, any reference to the larger ACLNID study will be identified specifically as such.

Although the data that has been assessed is derivative from ACLNID, this analysis specifically addresses how client attitudes toward mental health issues are indicative of the ways in which stigma impacts client decisions to seek assistance through self-reporting to the attorneys and social workers concerned with their defense. Plus, legal representation can be enhanced by understanding how mental illness is acknowledged and processed by individuals, as well as recognizing the existence of multiple perspectives. This process offers greater insight into this underserved and under-resourced population.

Civil legal needs and stigmatization are closely related, and many of the most pressing areas of civil legal needs arise from ongoing predatory and discriminatory practices. Such practices are built upon and maintained through the deployment of the negative stereotypical constructs of poverty, race, and mental illness. The sociological analysis of mental health stigma and the various mechanisms that support and oppose it can contribute not only to existing sociological literature but also to studies involving civil legal needs and holistic defense practices.

1.2 Dissertation Organization

The subsequent chapters of this dissertation are organized in the following way. Chapter 2, "Background," includes a brief history of the development of the indigent defense system in Georgia. An overview of the theory and study of stigma is addressed through the review of existing literature and the theoretical conceptualizations pertaining to stigma, mental illness, racialization, and criminality.

The methods section, Chapter 3, includes the research design used for this project, descriptions of sample selection, data collection, and the basis for this study's analytical premises. Coding decisions are outlined both generally and with specificity as they pertain to mental health and mental illness stigma. Finally, a brief reflexivity statement acknowledges the researcher's interest, experience, and suitability for undertaking this work pertaining to indigent defense and mental health issues.

Chapter 4 provides historical, political, and cultural contexts that have contributed to the contemporary disparities and vulnerabilities inherent among the indigent. This section goes on to highlight how political policy at both the federal and state levels support inequitable practices and contribute to the negative rhetoric that consequently shapes social forces. For example, the influence of pharmaceutical interests and the development of the *Diagnostic and Statistical Manual of Mental Disorders* are presented to trace the evolution of treatment and diagnostic protocols in the area of mental health.

Next, chapter 5 presents the data, providing a broad overview of the insights and lived experiences of the participants in this study. Findings are organized according to age cohorts and comparative experiences of mental health diagnosis, educational attainment, and homelessness. Observations are not made from a deficit perspective (Yosso 2005). They are provided as a framework to further facilitate a foundational understanding that participants contend with multiple stigmas.

For overall coherence, the findings have been divided into three separate chapters. Chapter 6 provides the perspectives of attorneys, social workers, and clients around diagnosis. Who is diagnosing? What are the most salient existing mental health issues, and what do these

mean in terms of how labels are received, or the means by which existing labels are activated and new labels applied.

Chapter 7 looks at the ways that people with mental illness labels attempt to manage stigma, including how stigma is anticipated and experienced, deflected, or avoided. When can stigma resistance be effective? How does stigma perception relate to how people seek out and/or stick with appropriate treatment.

Chapter 8 examines the motivational forces that support the application and acceptance of potentially limiting labels in terms of accessing services. How does accessing services factor into a perceived shift in the paradigm of how labels are viewed by those who receive them? How has labeling contributed to the relentless pathologizing of the recipients? How does labeling support beliefs, prejudice, and discriminatory treatment toward people with mental illness? Lastly, what are the possible repercussions of labeling on individual life chances and trajectories.

In Chapter 9 "Discussion and Conclusions", the overall findings are reviewed in a wider context. The limitations of this study are discussed and directions for future research explored. Lastly, the conclusion will examine the main points that have emerged and what these mean overall sociologically.

2   BACKGROUND

This exploratory study is concerned with the attitudes of Dekalb and Fulton County Public Defender clients, and therefore by extension is investigating an aspect of incarceration in the south. The context for the information gathered includes not only interaction with the criminal legal system, but also an overwhelmingly disproportionate representation of race and poverty. Therefore, critical race scholarship—as well as stigma-based research around issues of

mental illness, possessing a criminal record, and how multiple stigmas intersect—must be examined to avoid the misrepresentation of attitudes and perceptions arising in a vacuum.

This is a sociologically significant site that provides the opportunity to investigate stigma from the multiple perspectives of attorneys, social workers, and clients in the criminal justice system. This site also allows for the expansion of the stigma construct to include the analysis of structural influences that have disadvantaged the stigmatized (Corrigan, Markowitz, and Watson 2004; Corrigan et al. 2005; Link and Phelan 2001).

The study of the structural stigma permits us to illustrate how contemporary issues have been influenced or created by historical, economic, and political forces. Although structural forces actively shape individual and group level processes, they are themselves shaped and influenced by individual and interpersonal factors. Pertaining specifically to this study is the examination of the ways in which individuals respond to and attempt to cope with structural stigma. Often the study of structural and individual stigma is done in isolation, our research site allows us to investigate interrelationships between the two.

Because the study is concerned with the indigent clients of two urban public defender offices in the state of Georgia, I include a section on the development of the Public Defender system of delivery in Georgia in the context of the Supreme Court rulings that brought about the legal reality of indigent defense. Lastly, the methodology section and study overview will be supplemented by copies of the semi-structured interview guides and other documents required by the Georgia State Internal Review Board.

2.1 Indigent Defense Overview

The American legal system has a long history of acknowledging an individual's right to legal representation to ensure a fair trial, and one would be hard pressed to locate anyone who

disagrees with this right. The problem has always been to transform this aspect of the equality myth into a reality. The attempt to eliminate the marked difference between rhetoric and reality can be seen in the development of indigent defense. An indigent defender system is defined as "a method of providing indigent defense services where an attorney or group of attorneys, through a contractual arrangement or as public employees, provides legal representation for indigent criminal defendants on a regular basis" (Benner 1975:669).

Through a series of decisions, the Supreme Court has guaranteed the right to counsel to the indigent (Appendix A), however, the court has not provided guidelines for the way in which the states should provide this constitutional right. Therefore, the states have been left with the significant obligation of providing defense services for the poor that they must implement, fund, and administer. Indigent defense is a product of federal mandates through the courts and legislative action by the states. As such, it reflects political will. In Georgia, defending the poor has been subject to partisan politics, and thus a system that initially held great promise has been weakened and attacked from within (Appendix B).

Both the Fulton County Public Defender and the DeKalb County Public Defender came into being when The Georgia Public Defender Standards Council was established in 2003 as an independent agency within the executive branch of the state government responsible for overseeing indigent defense in Georgia. The General Appropriations Act, passed by the state general assembly, funds the circuit court public defenders, but additional funds may be supplemented by counties and cities. Counties in the judicial circuits provide the funding to cover office costs of public defenders (Appendix B).

The court also provided no guidance for determining indigence. In many jurisdictions, Georgia for instance, felony defendants are presumed to be entitled to appointment of counsel

only if they earn less than 150 percent of the federal poverty guidelines (Gershowitz 2005).

Countrywide, various systems of representation emerged, of which the main three are the

contract system, the panel system, and the public defender system.

The call for empirically driven data and evaluation of indigent defense systems has been

increasing steadily as the reality of representation for the poor in this country falls far below the

idealized rhetoric. Empirical evaluations have increased to assess the effective delivery of

defense to the poor in this country (Frederique, Joseph, and Hild 2015). The Public Defender

systems in North Carolina, Texas, and New York, have moved toward an evidence-based

practice model, with the intention being to "tether decision-making to empirical, rather than

intuitive or experiential evaluations of practice policy options" (Laurin 2014).

2.2   Literature Review

The exclusion from society of stigmatized people has devastating outcomes for those

affected. To be an indigent criminal defendant in contemporary society is to be marginalized and

discriminated against. Couple indigency or poverty, as it is most commonly known outside of

legal policy circles, with mental illness, and you will have identified an inherently vulnerable

population. A review of the literature concerning research of mental illness stigma provides a

greater understanding of the ways in which stigma affects people at multiple levels and the

various means that have been adopted to evaluate and decrease deleterious effects.

Goffman's concept of social identity introduces the term "spoiled collective identity"

(Overton and Medina 2009:143). This is thought to occur when the behavior of people is judged

to be outside of societal norms, and this failure to act in a socially acceptable way is viewed as a

moral failing or flaw. People can internalize the negative judgement of others, leading to reduced

self-esteem and self-efficacy. Corrigan, Watson, and Barr (2006), describe self-stigma as

negatively affecting life outcomes and creating self-doubt as to the ability to live independently, hold a job, and/or find a partner. The process of stigma, according to Corrigan (2014), involves recognition of cues, activation of stereotypes, and prejudice or discrimination toward that person.

Arthur Kleinman and Rachel Hall-Clifford (2009) suggest that the concept of stigma has altered since articulated by Erving Goffman in the 1960s. Goffman asserted that people became associated with the stigmatized condition if they passed from a "normal" condition to a "discredited" or "discreditable" social status (Goffman 1963; Kleinman and Hall-Clifford 2009:419). Link and Phelan introduced structural discrimination into their model, identifying the role that institutional disadvantage plays in stigmatizing individuals (Link and Phelan 2001; Kleinman and Hall-Clifford 2009).

Modified labeling theory was introduced by Link and colleagues in response to labeling theory put forth by Scheff (1966). Their response dismissed Scheff's assertion that labeling caused mental illness and shifted focus to those people to whom the label was being attached (Link 1987; Link et al. 1987, 1989; Link and Phelan 2001, 2013). Through their examination of existing literature and subsequent formation of modified labeling theory, Link determined that negative societal reactions were exacerbated by psychiatric labeling of individuals (Corrigan 2007). People could choose to reject a label on the basis that they feared rejection, but the expectation of rejection by others could create a cycle whereby individuals would be rejected (Cockerham 2014).

A common point of agreement among Scheff and scholars in the modified label tradition was that stigma is relevant because it impacts people's lives. Wright, Gronfein, and Owens (2000) referred to "spoiled identities" (70) because the outcomes of a formal label of mental illness usually are not positive to the individual. The negative impacts were seen in a myriad of

areas including housing, education and economic prospects, social functioning, and of course general esteem (Link et al. 1989, 1997, 1999; Link and Phelan 2001; Markowitz 1998; Martin, Pescosolido, and Tuch 2000; Pescosolido 1992; Pescosolido et al. 1999; Pescosolido and Martin 2015; Wright et al. 2000).

The basic premise for the modified labeling theory of Link et al. (1987, 1989) was that people are socialized in such a way that creates beliefs and these beliefs lead them to treat those with mental illness in a certain manner. The more people believed that they will be devalued or discriminated against, the greater their reluctance to interact with others and develop coping skills that in turn will improve their chances for developing social support networks, jobs, and self-esteem (Scambler 2011). In conceptualizing stigma, Link and Phelan emphasized the convergence of various elements, such as stereotyping and creating "us" and "them" labels that facilitate a loss of status when coupled with discrimination in a power situation (Link and Phelan 2001; Scambler 2011; Wright et al. 2000).

Conceptually and methodologically, researchers considered a plethora of stigma-related issues. For the purposes of our work, however, helpful topics included incarceration, concepts of multiple stigmas, and the three components of public stigma—prejudice, stereotype, and discrimination (Link and Phelan 2001).

The negative effects of stigma-related issues was widely researched among various groups including veterans and active military personal, police officers and other first responders, medical professionals, and mental health care providers (Greene-Shortridge et al., 2007; Royle Keenan, and Farrell 2009; Wrigley et al. 2005). Goals of much mental illness stigma research focused on finding ways to mitigate and eradicate stigma but revealed little success.

According to Corrigan (2015), as of 2014, over 100 peer-reviewed empirical articles were published indicating that stigma is a significant barrier to seeking treatment (Clement et al. 2015; Graham et al. 2003; Vogel, Wade, and Hackler 2007). Research found that issues of gender and ethnicity affected help-seeking (Levant et al. 2013; Pederson and Vogel 2007; Cheng, Kwan, and Sevig 2013; Conner, Koeske, and Brown 2009).

The negative consequences of psychiatric labeling were the means by which the aggregate stereotypes and discriminatory practices toward the mentally ill become personally relevant (Link 1987; Link et al. 1989). Negative attributes such as dangerous, lazy, and untrustworthy were some of the beliefs found to be culturally held about the mentally ill (Corrigan 2007; Kroska and Harkness 2006, 2008; Link 1987; Rosenfield 1997).

According to Corrigan (2007), psychiatric diagnosis, created by medical professionals to better understand mental illness, was an example of structural stigma, an unintended consequence which has exacerbated mental illness stigma. By this means, the general public formulated the idea that those with mental illness categorized by diagnosis are in fact a homogeneous group and are not likely to change significantly. Through the use of this lens, people with mental illness became defined solely as their diagnosis (Corrigan 2007; Hill 1988).

Gronholm et al. (2017) systematically reviewed and assessed 40 studies comprised of qualitative, quantitative, and mixed methods research on the topic of relationships between stigma and help-seeking resulting from initial psychotic episodes. Their meta-synthesis identified six themes in relation to stigma and accessing care: "'sense of difference,' 'characterizing difference negatively,' 'negative reactions (anticipated and experienced),' 'strategies,' 'lack of knowledge and understanding,' and 'service related factors'" (Gronholm et al. 2017:1867). In the

context of this research, these themes will be considered when assessing how readily public defender clients disclose mental health issues.

According to the authors, their review not only identified future areas for research but also provided information regarding the positive effects of early intervention. This research will address concerns about stigma that can impact the willingness to recognize early mental health episodes and seek beneficial interventions (Clement et al. 2015; Gronholm et al. 2017). Overall the studies reviewed by the authors were qualitative, and findings revealed that no matter how much experience or knowledge was possessed by families of people facing first-time psychosis, stigma influenced everyone's decisions around seeking help (Boydell et al. 2003; Gronholm et al. 2017).

The U.S. and Canada conducted the majority of the studies in the meta-synthesis by Clement et al. Others were done in Europe, Australia and New Zealand. Five were conducted across multiple continents (2015:14). In Britain, Canada, and the United States, studies of attitudes towards individuals with mental illness indicated similar tendencies toward negative beliefs, fear, and the willingness to support forcibly confining people exhibiting dangerous behaviors. People also indicated a lack of willingness to have personal relationships with those suffering from mental illness (Martin et al. 2007, 2000; Pescosolido et al. 2008).

Attribution Theory purported that understanding causality of mental illness as something outside of an individual's control will decrease stigma because it reduces blame and results in increased sympathy, less emphasis on punishment, and more help and acceptance. This approach focused on the genetic component of mental illness and its effect on the overall acceptance of people with these issues. While the results have pointed to genetic explanations being helpful

initially, soon they moved into genetic essentialism and ideas of biological determinism (Corrigan et al. 2003; Phelan 2005).

In stigma and labeling research, prevalent questions around the genetic component and attribution theory revealed that relying on a genetic basis for mental illness is not helpful for the overall acceptance of those suffering (Corrigan et al. 2003). However, consistent with a danger appraisal hypothesis, the effects of perceptions of "dangerousness" on helping and rejecting responses were unmediated by responsibility beliefs. Many of these effects operated by increasing fear, a particularly strong predictor of support for coercive treatment. The results from this study also suggested that familiarity with mental illness reduces discriminatory response (Markowitz 1998; Markowitz, Angell, and Greenberg 2011).

Extensive studies have been conducted in mental health stigma. Qualitative, quantitative, and mixed methods have been applied, and findings have reinforced the necessity of ongoing research in this area (Pescosolido and Martin 2015). For example, using a random sample of 5555 students across 13 universities, Eisenberg et al. (2009) found that an individual's self-perception of stigma was higher than the actual personal stigma; that students who were male, younger, and Asian tended to have higher levels of personal stigma; and that personal stigma was significantly and negatively associated with help-seeking. Studies examining people's own stigmatizing attitudes found generally that higher personal stigma is associated with lower help-seeking among both adults and adolescents (Corrigan et al. 2003; Gove 2004; Watson, Kelly, and Vidalon 2009).

A community-based qualitative study by Mathews et al. (2006) centered on the attitudes among African Americans toward mental illness and seeking treatment. The study used focus groups to examine cultural factors, community norms, and attitudes towards stigma. Five

thematic categories were examined: "descriptive terms and causes of mental illness," "cultural norms regarding mental health," "attitudes toward mental health service use," and the "presence and determent of mental illness stigma," plus "strategies for reducing mental illness stigma and increasing access and use of mental health services" (Mathews et al. 2006:253).

Many stigma-related factors impact African Americans seeking mental health services, including dealing with health care services where workers lack cultural competence and the outright physical unavailability of health care services (Corrigan et al. 2014). Studies also found different reactions to mental health stigma and different understandings of mental illness in the African American community (Abdullah and Brown 2011). Studies conducted in community settings found that people were reluctant to seek help even if they perceived a need; as high as one in four did not seek help because of concerns around what others would think (Angermeyer and Matschinger 2003; Corrigan et al. 2003). And furthermore, for individuals, these self-concepts of stigma developed sequentially over time (Corrigan et al. 2003, 2006).

Interacting mechanisms between structural stigma (Link and Phelan 2001) and individual stigma also were found to impact immigrant mental health negatively, due to the internalization of discrimination (Yang et al. 2007). This suggests that individual forms of self stigma may mediate the relationship between structural stigma and poor health. Cultural interaction with structural forms of stigma was studied to identify the ways in which this facilitated the production of adverse mental health outcomes (Yang et al. 2014).

Pescosolido, Martin, Lang, and Olafsdottir (2008) drew upon stigma theories and studies from various social science disciplines at micro, meso, and macro levels to create what they call a Framework Integrating Normative Influences on Stigma (FINIS). Pescosolido et al. defined stigma "as a mark separating individuals from one another based on a socially conferred

judgment that some persons or groups are tainted and 'less than.''' (Pescosolido et al. 2008:

431). Furthermore, as stigma is a social construction brought about through and in social

relationships, it was subject to contextual normative influences and could therefore be analyzed

using a normative framework (Pescosolido et al. 2008).

At the meso level using FINIS, where the units of analysis were social networks and

treatment, the results suggested a combination of factors influencing people's attitudes toward

others with mental illness. The real-life experience of people without and with mental illness

could, if the interaction was positive, serve to counter negative media images. However, a

negative portrayal could be reinforced significantly by only a very limited exposure if it was

subsequently accompanied by media messages (Pescosolido 1991; Pescosolido 2013;

Pescosolido et al. 2008; Pescosolido and Martin 2015). In their integration of the "results of

theoretical work, methodological discussions, and empirical findings," Pescosolido and Martin

(2015: 88) also extrapolated new directions for stigma research (Pescosolido 2013; Pescosolido

et al. 2008; Pescosolido and Martin 2015).

Link and Phelan's stigma model was based upon asking people about their emotional

responses using descriptive vignettes. From this process, Link and Phelan determined that

negative emotional reactions toward those with mental illness were seen as precedents of

intended distancing, discrimination, and diminishing status (Link and Phelan 2001; Link et al.

2004). According to Schomerus and Angermeyer (2017), a German study following Link and

Phelan's approach found that perception toward some mental illnesses was improving and more

tolerant; for example, more people thought those with depression should be shown more

patience. Conversely, the study found that during the same period of 1990 to 2011 (Gaebel,

Rossler, and Sartorius 2017:164*),* the perception of fear toward people with schizophrenia

increased, and a tangible trend was seen that separates schizophrenia from other mental illness perceptions (Angermeyer et al. 2013). This finding specifically is relevant to the public defender clients interviewed for this study. Schizophrenia and schizoid affective disorder comprise a significant number of the diagnoses found in this population.

According to Pescosolido et al. (2010), the General Social Surveys of 1996 and 2006 in the United States revealed no change in blame and dangerousness perceptions around schizophrenia and a small decrease in blame directed toward those with depression. However, the survey was indicative of an increase in blame toward alcohol dependency (Gaebel et al. 2017).

In England, the Royal College of Psychiatrists conducted a study between 1998 and 2005 that found slightly decreasing ideas of dangerousness and unpredictability around schizophrenia, but depression and opinions around blame showed no changes (Crisp et al. 2005). Similar studies conducted in New Zealand (1999-2002) and Australia (2003, 2004-2011) noted increased beliefs of unpredictability and dangerousness (Vaughan and Hansen 2004; Reavley and Jorm 2012, 2014). Again, these findings are germane to our study due to the prevalence of schizophrenia and schizoid affective spectrum disorder among the incarcerated generally and the participants of this study specifically.

People view those with schizophrenia as unpredictable and dangerous but not responsible for their condition. This perception is in contrast to an eating disorder; people do not think that morbidly obese people are dangerous or unpredictable, but they do think that such people are responsible for their disorder. The harshest stigmas are reserved for dual diagnoses of schizophrenia and substance abuse disorders; these individuals are viewed as dangerous and unpredictable, as well as guilty for their condition (Crisp et al. 2005; Schomerus et al. 2011).

Thornicroft et al. (2009) conducted a worldwide study in which they observed a high prevalence in actual and anticipated discrimination both toward and by people suffering from mental illness (Gaebal et. al. 2017). This idea of behavior based on anticipated discrimination is directly reflected in this research project, as is actual discrimination experienced by indigent clients of the public defenders.

Negative opinions and stigma towards people with a schizophrenia diagnosis are intense. Despite the belief by some that understanding biological models for mental illness would decrease stigma, the opposite has in fact occurred (Angermeyer et al. 2011; Kvaale, Gottdiener, and Haslam 2013; Schomerus et al. 2012). The increasing stigmatization has led to suggestions by some in the health care profession to change the name of this constellation of symptoms, to combat not only prejudicial beliefs of dangerousness and unpredictability but also entrenched beliefs that recovery is not available to people with this array of symptoms (Maruta and Matsumoto 2017).

By 2013, Link and Phelan believed sociologists should be drawing on the advances in other disciplines to further sociological study of stigma and acknowledge that multidisciplinary approaches to theoretical frameworks for the study of stigma are needed. On the other hand, certain research has moved away from stigma. Representatives from both the Substance Abuse and Mental Health Services Administration (SAMSHA) and National Institute of Mental Health (NIMH) rejected the term "stigma," claiming that it does not communicate the true harshness of its impact and substituting the term "discrimination" (Pescosolido and Martin 2015). Still, despite disagreements amongst researchers, stigma study has continued to grow not only in its original domain of mental health but also to study many more health-related topics and other

social arenas such as financial issues, bankruptcy, accessing social benefits, and public housing (Pescosolido and Martin 2015).

Schnittker and John (2007) specifically looked at the impact of incarceration on stigma and health, noting the very real stigma associated with released felons who, for example, are routinely disenfranchised. The work on felon disenfranchisement and analysis of racial disparity indicated ways in which prison and jails have developed into mechanisms for stratifying people, similar to other stratifying institutions that reflect and ultimately generate disparity (Wakefield and Uggen 2010).

Devah Pager's article (2003), "Mark of a Criminal Record," illustrated the significance of incarceration to limiting future life chances. Also, this article found that for potential job seekers, it was more advantageous to be white with a criminal record, than black without one; the study specifically found that a white person with a record was more likely to be hired over a black person without one. Triple stigma, a term put forth by Stefanie Hartwell, described those dually diagnosed with mental illness and substance abuse who are also involved with the criminal justice system (Hartwell 2004). Policy intended to help the mentally ill through deinstitutionalization had not been successful, and community tolerance for mental illness was limited (Hartwell 2004; Link et al. 1999; Martin et al. 2000).

People with mental illness make up a significant percentage of the population in jails and prisons and are more likely than their non-mentally ill counterparts to serve out the entirety of their sentences. Plus, without re-entry support, they are likely to add to the recidivist percentages. No doubt Hartwell (2004) sought to support policy for assisting dually diagnosed mentally ill persons, but for me, her approach further stigmatized the mentally ill. Everything she presented

about violence, likelihood of recidivism etc., should have also been contextualized with non-mentally ill substance abusers.

Another repeated criticism of the "stigma" concept has been that different researchers have utilized different definitions. For our purposes, we will rely partly upon the building blocks set out by Pescosolido and Martin (2015:92). Additionally, people with mental illness and their families reported negative experiences with stigma and discrimination such as rejection from families, schools, and churches, and if they were lucky enough to be employed, their coworkers (Martin et al. 2007; Pescosolido et al. 2008; Wright et al. 2000).

Studies have examined how fundamentally different approaches to mental illness impact society. For example, in the United States, an emphasis on fear and potential for violence resulted in the removal of mentally ill people from the mainstream. In other countries like Iceland and Germany, where the emphasis was on inclusion (Olafsdottir 2007), that was not the case. Thus, the effects of labeling and the stigma of mentally ill were connected with an unintended consequence of skyrocketing incarceration rates in the United States.

Another observation noted the coupling of stigma around co-morbidity for drug and alcohol addiction in young males. According to the MacArthur Violence Risk Assessment Study, these are only two of 12 possible factors and even these represent a poor predictor of violence (Pescosolido et al. 2008; Monahan et al. 2001).

No studies have been done specifically with indigent clients of public defender offices and their personal and public perceptions of stigma towards individuals with mental illness. This study's questions, however, are congruent with the research regarding deflection efforts of individuals to avoid mental illness labeling and their effect on an individual's likelihood of

seeking and receiving helpful services (Clement et al., 2015; Gronholm et al., 2017; Thoits 2011, 2016; Thoits and Link 2015).

Also pertinent was the process-focused framework that Watson et al. (2009) employed in their study of justice system-involved youth and their parents' approach to the meaning attached to mental health and mental health services. The central role of interaction in the decision-making process also laid a helpful foundation to this research (Pescosolido 1992; Pescosolido et al. 1999). And Eisenberg et al. (2009) completed a relevant study among college students that framed questions around perceptions of public and private stigma and identifying factors which are most likely to increase a person's propensity to seek help.

The stigma-based effects of incarceration on long-term health were examined by Schnittker et al. in their longitudinal study (2007). The evidence of a strong causal relationship presented in their findings was representative of how risk factors around incarceration and its impact upon mental illness are complicated, multifaceted, and process-driven. The theoretical model for self-stigma was used to assess how incarcerated individuals internalize the stigma of being a criminal offender (Moore, Tangney, and Stuewig 2016).

This research will build on and contribute to the body of knowledge around individual perceptions of private and public stigma of mental illness in two ways. The first is general in the context of legal institutions and organizations. Through learning from those most closely involved, we will explore, for example, how the choice to include social workers and partner with community organizations and other state agencies has facilitated better outcomes for those with mental illness.

The second is specific. We will be looking at the ways in which indigent defendants facing criminal charges in Georgia both resist and acquiesce to a system that attempts to assist

them through greater access to mental health treatment. This study will contribute to the extant

literature by working with this hard-to-reach population. Not enough actual information exists

from people engaged with the criminal justice system about their experience of structural and

individual stigma. Their opinions and experience have been overlooked and under-accounted for

in large scale survey data, which also excludes most of the indigent, whether involved with the

criminal justice system peripherally, directly, or incarcerated.

Although the sample size for this study is limited, the information covers multiple

domains. Through the facilitation of increased direct engagement with a severely marginalized

population as well as the public defender offices, more projects of this type can be designed. The

most salient characteristic of stigmatization is the creation of "us and them." if this successful

othering can be interrupted and subverted, the mechanisms that support discriminatory practices

can be challenged. Equally important is the need to demonstrate how these practices have

contributed to the ongoing pathologizing of the most disadvantaged. These overlapping stigma,

prejudice, and discriminatory practices are the foundation of the deficit perspective.

The effects of labeling are complicated. Discrimination is a common experience for those

who have been labeled. One study found that mental illness, race, sexual orientation, and

physical disability were the most likely categories for discrimination (Corrigan et al. 2003).

Although labels are often immediately helpful, they can lead to unintended deleterious

consequences over time. This study identifies areas for potential intervention, where protective

measures could be put in place for indigent clients. For policy development purposes, the

professional experiences of attorneys and social workers can increase understanding of the

realities of the structural limitations and barriers their clients encounter. With this in mind, the

actual needs of their clients can be identified and efforts directed to improve legal and social outcomes.

In sum, this study fills a gap by providing descriptive data about the lived experiences of this hard-to-reach, routinely excluded population, and as such findings will add supplemental insights to the existing literature. Analysis through coding information from semi-structured interviews can provide indications of how people attempt to manage and resist stigmatized identities. This data can be useful for determining the directions for support that will be most helpful for those who are most negatively affected by mental health labeling. This work also provides insight into practical, effective ways to address undue influence and negative stereotyping.

Two previous studies have been done directly with the DeKalb County Public Defender's indigent clients. The first in 2012 was conducted by Phillips and Tetlow, who, using descriptive statistics, looked at the higher costs of incarcerating mentally ill misdemeanor offenders. Significantly, the majority of people in jail who are mentally ill have committed minor crimes. However, they are much more likely to serve their entire sentence than non-mentally ill inmates. The significance of mental health treatment and its effects on recidivism are known, so this study will focus on how the barriers to people getting treatment are based on lower economic status, cost, lack of health insurance, and inability to navigate the confusing health care system (Tetlow and Phillips 2016).

The second, an exploratory needs-assessment study, was done by Tanja C. Link in conjunction with the Dekalb County Public Defender (unpublished info provided by Link from her presentation). Her research involved individuals who were arrested on a felony probation warrant between June and August 2015. This assessment examined probation revocation and the

barriers to successful probation completion. Although not specific to mental illness stigma, a noted factor was the increased costs of mental health evaluation and treatment. Link's research contributed a growing understanding of how attitudes and reactions to mental illness, as well as other stigma, can intervene and create difficulties for successful legal outcomes.

Research has also examined whether the likelihood of Dekalb County Drug Court Graduation can be predicted based upon demographic data and the Level of Service Inventory-Revised (LSL-R). The project was conducted to fulfil partial requirements for a Master of Public Health degree, and findings were positive generally. The author suggests a need for further qualitative study among the drug court participants (Holiday 2018).

2.3   Theory

The following theoretical premises are discussed to illustrate their contribution to the formation of key analytic frames. Having a theoretical understanding of the development of labeling theory can aid us in understanding the relevance of Modified Labeling Theory to our analysis. The significance of the negative forces of racialization across various areas, such as psychiatry and the criminal justice system, are also crucial to understanding the importance of mental health stigma. To recognize significant connections between cultural, structural, and negative outcomes for those with mental illness in the criminal justice system, there must be acknowledgement of how historical, contemporary, and procedural context informs and impacts upon people's diminished status and exclusion.

2.3.1 Mental Illness Labeling

The majority of theoretical scholarship pertaining to the stigma construct identifies the work of Erving Goffman as the originating point. He codified his ideas and concepts in articles, such as "The Moral Career of a Mental Patient," (1959), and books, *Asylums: Essays on the*

Social Situation of Mental Patients and Other Inmates, (1961) and *Stigma,* (1963). Goffman (1961) detailed how an individual progresses from the status of "civilian" to that of a mental patient. Various discrediting marks or attributes could be stigmatized such as physical deformities or blemished characters, for reasons which include mental illness, sexual deviance, criminality, and addiction. The stigma of race or religion was designated by Goffman as "tribal stigma." These various physical, moral, and status differences devalued and discredited individuals. The result, according to Goffman, was that "we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (Goffman 1963:5).

Theories specific to mental illness stigma include Labeling Theory and Classic Labeling, introduced by Scheff in (1966), which focused on the negative consequences of labeling, asserting that labeling actually caused mental illness. This work led to the development of Modified Labeling Theory, the basic premise of which was that individuals are socialized in culturally specific ways that include value systems around mental illness. These systems specifically devalue individuals who suffer from what society considers outside of the norms of acceptable behavior and are therefore mentally ill. In conceptualizing stigma, Link and Phelan emphasized that stigma is a complex construct where various elements, such as labeling, stereotyping, and discrimination converge to create notions of "us" and "them," so economic and political power is also being exercised (Link et al. 1989, 1997, 1999; Link and Phelan 2001, 2013; Scambler 2011).

Another theoretical development in the conceptualization of stigma was attribution theory, which purported that the etiology of mental illness was outside of an individual's control. This premise would lead to increased sympathy toward the mentally ill and therefore diminish society's coercive tendency towards those suffering from mental illness. However, this theory

did not prove helpful and soon gave way to essentialism and biological determinism (Corrigan et al. 2003; Phelan 2005)

Pescosolido and Martin reiterated that "stigma is conferred through labels, 'mentally ill' by medicine, 'criminal' by justice system, these produce negative stereotypes, of varying consequence." And thus "stigma represents the intersection of cultural differentiation, identity formation through social interaction, and social inequality" (Pescosolido and Martin 2015:93).

One barrier to seeking help for mental illness was the wish to avoid the negative consequences of being labeled and the subsequent devaluation and discrimination (Link 1987; Link et al. 1989: Kroska and Harkness 2006; Perry 2011; Pescosolido 2013). This fear was very real, with cultural ideas about the mentally ill ranging from increasing incompetence to dangerousness (Stout, Villegas, and Jennings 2004; Wahl 1992; Wahl, Wood, and Richards 2002).

Link and Phelan (2010, 2013) identified three goals of stigmatization as exploitation, enforcement of social norms, and avoidance. They also introduced the conception of stigma power, incorporating Bourdieu's theory of symbolic power and his ideas of "misrecognition, hidden taken for granted aspects of culture" (Link and Phelan 2014:25).

Also, those faced with stigmatization acted in various ways to resist labeling and to deflect the resultant stigma (Thoits 2011, 2015, 2016). The empirical work in Modified Labeling theory developed ideas relevant to active stigma, avoidance, and resistance (Link et al. 1989, 2002; Link, Mirotznik, and Cullen 1991; Thoits and Link 2015). This was identified as "secrecy," concealing labeling information, providing information to dispel stereotypes, "education" or "withdrawal," the avoidance of potentially rejecting situations (Thoits 2011; Link

et al. 1989, 1991). Subsequently the outright "challenging" and "distancing" was also included by Link et al. (2002).

Challenging amounted to the active and direct confrontation of deployed stigmatization, which can be identifying such behavior immediately and objecting to statements as they are expressed (Thoits 2011, 2015, 2016; Thoits and Link 2015). Distancing was the cognitive separating a person does from the stigmatized group (Thoits 2011). The outcome of the latter amounts to the individual person saying, "I'm not like them…your stereotypes of them are misapplied to me" (Link and Phelan 2013:537).

Both Classic Labeling Theory and Modified Labeling Theory had taken positions that were partially correct, and thus labeling brought both positive and negative consequences, resulting in new treatments and services on one hand, but further stigma and discrimination on the other (Link and Phelan 2013; Perry 2011; Rosenfield 1997). Both noted the paradox of labeling providing the means by which the most disadvantaged secure services and benefits, as well as how people seek to avoid and resist the resultant stigmatization (Link et al. 1989, 2002; Thoits 2011).

Goffman's scholarship (1961) on asylums suggested that stigma is more a product of the way in which mental institutions are organized and less a result of the behaviors of people who suffer from actual mental illness (Link and Stuart 2017). Goffman was not alone in this belief, and according to Link and Stuart (2017), other scholars also attributed the stigma suffered by those with mental illness to the organization of psychiatry and mental health institutions. These scholars heralded a period of distrust towards mental illness institutions and the medical field of psychiatry (Scheff 1966; Foucault 1975; Szasz 1974). Corrigan's work also indicated that an

actual clinical diagnosis could exacerbate negative stigma toward the mentally ill, by further implying group cohesion of the mentally ill to the general public (2007).

Through the use of grounded theory methodology and the employment of various theoretical lenses for analytic purposes, stigma can be identified, not only of mental illness but also of overall client-based perceptions around incarceration. As noted previously, Link and Phelan emphasized the convergence of various elements, such as stereotyping and creating "us" and "them" labels that facilitated a loss of status when coupled with discrimination in a power situation (Link and Phelan 2001; Scambler 2011; Wright et al. 2000).

2.3.2 Racial stigma stereotypes/ racialization

Racial stigma is widely evidenced and ongoing. The consistent negative political rhetoric toward African Americans has created and reinforced negative stereotypes in ways which can be easily traced through political administrations and agendas in the United States. The negative racialization of African Americans has been a dominant principle used to structure social, cultural, and political relations in the United States. Race continues to act as a marker of inclusion and exclusion, equality and inequality. Institutional racism, contrary to popular belief and despite attempts to weaken and eradicate, is becoming more entrenched and not only entrenched but intentionally entrenched (Bell 1995; Bonilla-Silva 2001, 2010; Feagin 2013).

Racial stereotyping can be both explicit and implicit. Widely accepted research using the implicit association test (IAT) has confirmed that computer-generated positive or negative attributes overwhelmingly indicate implicit bias, the preference for Whites compared with Blacks (Greenwald, McGhee, and Schwartz 1998).

The general acceptance of racist attitudes and outcomes in the justice system is unacceptable. The processes of stigmatization do not occur in a vacuum, and we are,

contextually speaking, in the era of the prison-industrial complex and mass incarceration (Alexander 2010; Blackmon 2009; Wacquant 2010).

The history of the racialization of psychiatry was also critical to this research and must be understood to gain an understanding of the perceptions of mental health, both in self and others. As Metzl states, "incarceration, misinterpretation, and stigmatization are connected by the variable of history" (2009:190). Reflecting his belief, which he attributes to Lacan's theory of crisis, racialization occurred in response to the threat posed to the United States by the changing status quo brought on by the civil rights movement (Metzl 2009).

Metzl's observations of disproportionate schizophrenic diagnosis among African American men have been corroborated by multiple empirical investigations. The relationship between race and schizophrenia was assessed with a logistic regression analysis, using data collected from a random sample of 313 severely mentally ill individuals, from four Chicago state mental hospitals. This study, according to the authors, suggests "that significant problems may exist with regard to the treatment and diagnosis of minority groups within the mental health system and the need for culturally appropriate services for minorities especially within large urban areas" (Pavkov, Lewis, and Lyons 1989).

There have also been multiple empirical investigations that point to the disproportionate diagnostic tendency to label African Americans with childhood and adolescent Conduct and Oppositional disorders (Atkins-Loria, MacDonald, and Mitterling 2015; Delbello et al. 2001; Kilgus, Pumariega, and Cuffe 1995). The effects of structural discrimination have been shown to disadvantage stigmatized groups cumulatively through laws, social policy, and institutional practices (Hatzenbeuhler et al. 2014).

In 1990, a study conducted by Cohen et al. found that African American and White adolescents received different treatment outcomes. For African Americans, they were placed in the juvenile justice system while their Caucasian counterparts were treated in the hospital system. This discrepancy occurred despite White teenagers often scoring lower on the *Child Behavior Checklist*, a standardized tool used to measure symptoms and behaviors, including lawbreaking behaviors (Cohen et al. 1990).

The creation of racial hierarchies is facilitated by the historical and ongoing assignment of racial meaning to differences at the individual and group level. These differences could be real, imagined, or simply ascribed, but resulted in the formation of power hierarchies that provided the foundation for racism and discrimination (Burton et al. 2010). These racial stratification systems were driven by both overt and covert underlying processes and mechanisms (Burton et al. 2010; Massey 2007).

The legal institutions in the South always reflected harsh discriminatory practices. Pre-Civil War, the southern states passed laws that solely applied to free men of color and slaves, punishing these groups with harsher penalties than white perpetrators of these same crimes (Haney 2005; Garland 2010; Steiker and Steiker 2015). After the war, African Americans continued to be sentenced to stricter punishments than White Americans under a new form of legal discrimination, the Black Codes (Bullock and Rozell 2007; Haney 2005; Garland 2010; Steiker and Steiker 2015).

The overrepresentation of African American men in jails and prisons in this country has become indisputable. Literature has examined the development of the public defender system in the United States and speaks to both its weaknesses and strengths (Bright 2003, 2010; Bright and Sanneh 2013; Frederique et al. 2015; Primus 2016; Spangenberg and Beeman 1995). In addition,

due to the contraction of public support for facilities to address mental illness, people with mental illness have become disproportionally represented in jail and prison populations (Bronson and Berzofsky 2017; Herman 2014; Roth 2018).

Because of the impact that race and ethnicity have upon criminal justice outcomes, the importance of state context on the indigent defense policy also needs to be understood. Research has indicated that the Southern states have greater minority populations and greater perceived racial tension, as well as a penchant towards more punitive policies toward minorities (Bullock and Rozell 2007). In Georgia, the legacy of white supremacy has long been felt in the justice system from the black codes of Jim Crow to automatic sentencing and what appears to be its most recent incarnation—the relentless criminalization of poverty (Haney 2005; Garland 2010; Steiker and Steiker 2015).

Both the Dekalb County Public Defender and the Fulton County Public Defender are reflective of the disproportionate representation of African American men. As such, these institutions need to be contextualized and understood as the culmination of intentional law and policy implementation before and after the Civil War. This study's findings are interpreted from the perspective that African Americans in the United States generally, and in southern states specifically, face systemic structural, race-based barriers to equal opportunity across all domains (Bell 1995; Delgado 2012; Curry 2015). Thus, any analysis must consider the intersectionality of multiple issues that result in deleterious consequences, both criminal and civil (Collins 1990; Crenshaw 1989,1991; Gotanda 1995).

That all citizens are equal in the eyes of the law is a powerful and pervasive myth in the United States, equally powerful although perhaps not quite as pervasive as the racial equality myth. This myth of racial neutrality in law is one that the Supreme Court has persisted in

perpetuating despite overwhelming evidence to the contrary. This pattern can be seen as a way of protecting the power dynamic and discouraging challenges to the hegemonic understanding of law (Bell 1995; Bonilla-Silva 2001, 2010; Feagin 2013).

2.3.3 Problems of Procedural Justice

Theories of procedural justice note the impact of individuals' perceptions of their treatment by the legal system, regardless of legal outcomes, as just or unjust (Blackwell and Cunningham 2004; Sandefur 2008). If people feel they have been treated fairly, they are more likely to accept legal process and its outcome as legitimate and to comply with the rules (Blackwell and Cunningham 2004; Clark and Savner 2010; Greene-Sternberg 2016; Gressens and Atkinson 2009; Sandefur 2008; Tyler 1988).

Procedural justice is critical for addressing racial inequality in indigent defense. Research also must be done to understand the systemic and embedded stereotypes that have contributed to the incarceration of a disproportionate number of minorities (Alexander 2010; Farrell and Holmes 1991; Gressens and Atkinson 2009; Tyler 1988).

Canada and Watson (2013) noted a sense of procedural justice in the study of mental illness stigma as well. They found that those who believed they had been treated fairly and with respect by mental health providers not only had better mental health outcomes but also criminal justice system outcomes (Corrigan et al. 2014; Watson and Angell 2013).

Erving Goffman (1976) studied public face and backstage reality as a way of minimizing discordant signals and detaching the reality of the shortcomings of everyday work from larger organizational myths. That work also can be applied to any analysis of legal institutions and its organizations. Interaction rituals are connected to the larger normative processes of social order, "while standards and rules 'are impressed upon individuals from without,' the rules an individual

follows are derived 'from requirements established in the ritual organization of social encounters'" (Powell and Colyvas 2008; [Goffman 1976:45]).

3   METHODS

3.1 Methodological Approaches

Prior methodological approaches in stigma research have included the use of vignettes, longitudinal studies, large population surveys and comparative analysis studies predicated upon the data from the large population studies. Some of the earliest and most influential research was conducted by social and clinical psychologist Dr. Shirley Star, who collected and coded significant amounts of data from open-ended questions, resulting in a qualitative study with 3,500 respondents (Link and Stuart 2017). Other methodological approaches used to study stigma, included the participant observation fieldwork on which Goffman based his *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961).

Three major contributions have been attributed to the Star study. First, she used vignettes constructed about mentally ill people and deployed these to gauge public response to and opinions about mental illness. These vignettes also were utilized by subsequent researchers, and over time not only did a pattern of "increased recognition" of mental illness emerge, but new theories were developed (Gaebel et al. 2017:8). For example, sociologist Derek Phillips' early social distance scale indicated the likelihood of rejection for a person who sought help for mental illness (Gaebel et al. 2017). One of the shortcomings of the vignette method of investigating opinions about mental illness is that it did not present references to treatments and potential for positive outcomes.

The second and third contributions by Star resulted from her use of multiple methods, using open and close ended questions, thus triangulating the data. Star captured the response and

the reason for the response. She found that people understood and stigmatized mental illness in different ways, involving three features: loss of cognitive function, a brief loss of reason that led to a loss of self-control, and this loss of control resulting in actions that were viewed by others as inappropriate and incomprehensible (Gaebel et al. 2017: Link and Stuart 2017).

Using vignettes, Link and Phelan investigated the likelihood of social distancing, discrimination, and diminishing status (2001, 2004). Likewise, Pescosolido et al. captured American's views of mental health and illness with data from the General Social Survey (1996, 2006) (Pescosolido 2013). According to Pescosolido (2013), however, the limitations of using vignettes led to the development of the criteria in the Diagnostic and Statistical Manual, Fourth Edition, which was introduced to the General Social Survey modules about mental illness (2013).

Other methodological approaches include longitudinal studies, which have been carried out in the United States (Pescosolido and Martin 2015; Schnitter et al. 2007), the United Kingdom (Crisp et al. 2005), Australia and New Zealand (Vaughan and Hansen 2004; Reavley and Jorm 2012, 2014), and Germany (Angermeyer et al. 2013; Gaebel et al. 2017; Schomerus and Angermeyer 2017). Thornicroft et al. (2009) conducted a worldwide study that detected a high prevalence of actual and anticipated discrimination toward and by people suffering from mental illness (Gaebel et al. 2017).

Researchers have also conducted systematic analysis and reviews of existing studies of stigma in the attempt to address broad research questions, involving both quantitative and qualitative evidence. One such study by Clement et al. describes the main methodological weakness of qualitative research as the failure to provide the "reflexive account of the researcher's influence" (2015:19).

The lived experience of those who deal with being stigmatized has also been studied both qualitatively and quantitatively (Lysaker et al. 2007; Ritsher and Phelan 2004; Schulze and Angermeyer 2003). Pescosolido and Martin identified seven dimensions of public stigma by coding data using an exploratory methodological approach—Social Distance, Traditional Prejudice, Exclusionary Sentiments, Negative Affect, Treatment Carryover, Disclosure Carryover, Perceptions of Dangerousness (2015:97).

These various methodological approaches have strengths and limitations. One limitation has been the introduction of diagnostic terminology from manuals written by the American Psychiatric Association, and heavily influenced by the pharmaceutical industry, into large populations surveys. This process has essentially provided the vernacular for the domination of an overwhelmingly biologically based causation paradigm of mental illness. It also provided the foundation for astronomical increases in the sales of antidepressants and psychotropic medications. The introduction of diagnostic criteria also increased the stigmatization that pharmaceutical-based funding ostensibly was provided to remedy.

Many of the studies using survey-based methods entirely missed those who were incarcerated, many of whom experienced the negative effects of stigma across many domains and multi-levels. This research includes many of the voices that larger studies exclude, also providing a forum for the insights and experiences of those who work within the framework of stigma--poverty, prejudice and discrimination.

Furthermore, Thornicroft et al., pointed out that surveys provide information on attitudes toward imaginary situations or what participants thought people would do in imaginary situations, and do not assess actual behavior comparatively with what people say. This weakness has led to the promotion of a more qualitative approach that could provide evidence of how those

with mental illness subjectively experience and cope with stigma (2009). Other methodological approaches have been developed or integrated into the study of stigma, notably mixed methods and intersectionality (Hartwell 2004; Pescosolido and Martin 2015). Process-focused framework has also been utilized to study this issue (Watson et al. 2009).

According to Pescosolido and Martin, stigma researchers would benefit from a greater understanding of the lived experiences of those who are stigmatized (2015). Also, qualitative studies have been suggested as a way to augment the findings of studying structural stigma (Corrigan et al. 2005). Furthermore, it has been suggested that smaller samples and the exploration of lived experiences in specific settings may assist in gaining a more nuanced understanding of the consequences of stigma (Cook and Wright 1995; Pescosolido and Martin 2015).

The unique opportunity that this research provides is the ability to find out about how people with mental illness subjectively experience their world and the ways in which stigma is operationalized, as well as how multiple stigmatized identities impact people. The larger assessment of civil legal needs provides additional real-world insight into how multiple stigmas operationalize beyond the hypothetical. Through the concrete linkage to civil legal needs as consequences of stigmatization, support is provided for the study of stigma in areas other than mental health such as housing, education, and employment. All of these have been seen to be impacted by the reduction of life choices experienced by those who are labeled with mental illness**.**

3.2 A Qualitative Study

The research conducted here is unique in that we were able to access the clients of the public defender while they were involved in active adjudication of their cases. Furthermore, the

research sites included local jails, where, due to the support of the public defender leadership, we were granted access to interview and digitally record the interviews. Thus, we are in a position to investigate potential linkages between the mechanisms of micro-macro stigma.

This hard-to-reach mostly marginal population has been consistently excluded from larger survey studies around mental health attitudes and experiences. The current mental health crisis within incarcerated populations makes this research highly relevant. It has the potential to make a real impact on the ways in which mental health issues are viewed and managed. In particular, the data gathered can expand the analysis of the relationship between how people with mental illness labels are stigmatized and the impact on disclosure and attitudes toward help-seeking.

The research sites also provided the opportunity to observe how structural and institutional organizations inform and reproduce stigmatizing identities. This process was achieved through label application and the reality of tethering social benefits, educational services, and legal processes to diagnostic criteria and labeling.

Qualitative research was utilized to enable the capturing of subjective experiences and complexity. In the actual lived experience of people, they are often spoken about or spoken at, but rarely spoken with. This premise has been the driving force for both my study and the larger ACLNID study. In my opinion, underestimating the value of contextualized lived experiences would be a significant oversight and disservice to social science research. After all, it is the basis upon which we build our variables that we wish to quantify.

For the purposes of this study, I have chosen to use aspects of the grounded theory methodological process (GTM). I also consider how larger structural phenomena shape the data. This study seeks to contribute unique empirical knowledge and to advance existing theory. This

combination allows for new perspectives on existing theoretical ideas, while maintaining leeway for the emergence of original, contemporary theoretical implications. Grounded theory methods prescribe that data be both collected and analyzed simultaneously.

Due to the exploratory nature of the research questions that have been addressed and the fact that the data for analysis has been generated by the larger ACLNID study, a qualitative approach to this research also makes practical sense. The choice of in-depth interviews is seen as the best way to gather rich contextual data about the way in which individuals have experienced and regarded the various impacts of civil legal needs on both them and their families—and by extension, their lived experiences with and attitudes toward mental illness, disclosure, and help-seeking.

Best practice mandates that qualitative studies involving in-depth interviews identify the point at which saturation is achieved (Charmez 2005). According to LaRossa (2005), theoretical saturation has occurred when no new information or insights are generated; this is the point at which you have a "well-grounded concept" (LaRossa 2005:841). For Creswell and Miller (2000), reaching saturation for use in grounded theory research typically requires 20 to 30 in-depth interviews. Kuzel (1992) tied his suggested numbers to heterogeneity and ultimate research objectives. When taken into consideration, these parameters suggest six to eight interviews for a homogeneous sample and 12 to 20 data sources (Guest, Bunce, and Johnson 2006). The number of completed interviews for this project is 46, which includes 30 public defender clients, eight attorneys and eight social workers. We are confident that a sufficient degree of saturation has been achieved, while at the same time, divergent opinions were present indicating diverse perspectives were included.

3.3   IRB Requirements

From the initial stages of study formulation, the ACLNID researchers were cognizant that this study included prisoners who are protected under the vulnerable population guidelines for IRB review purposes. To adhere to these guidelines, the study was designed in such a way that potential subjects can make truly voluntary and uncoerced decisions whether or not to participate. Participants were reminded throughout the interview that they could decline to answer any or all of the questions, and at the end of the interview they were asked if they still wished to be included in the study.

On advice from the Georgia State University Institutional Review Board (IRB), the project was submitted in two separate study applications. One was made for research involving only the indigent clients of the public defenders which ultimately became H17462, and a separate application was made for research involving attorneys and social workers, H17266. The logic in support of two separate application submissions was that one of the applications involved clients who required full IRB consent, and by removing the attorneys and social workers to a separate application, the client application would be less complicated. This division made sense for a few reasons, but the most significant was the fact that without permission to interview indigent clients, we would be unlikely to proceed with the attorney and social worker interviews.

Per IRB instructions, all participants understood that choosing to participate or not in the study would not serve as an advantage or disadvantage to them in any way. In other words, "there will be no changes to the general living conditions, medical care, quality of food amenities, or opportunity for earnings. Also, the risks involved in participating in research are

commensurate with the risks that would be accepted by non-prisoner volunteers" (GSU IRB manual).

3.4 Overview of Study Design

This study has been organized around semi-structured anonymous client, attorney, and social worker interviews designed to assess the civil legal needs of indigent criminal defendants represented by the Fulton County and DeKalb County public defender offices. The ACLNID study is a qualitative analysis, presented as the first part of an exploratory sequential mixed methods design.

Interviews with the attorneys and social workers took place at the offices of the FCPD and the DCPD, which also served as key locations for gathering organization-related materials pertaining to structure, caseload, adjudication, and budgets. Indigent clients who were incarcerated were interviewed at both the Fulton County and DeKalb County jails. Clients who were out on bond were interviewed in a public and safe environment of their choosing.

Sampling plan

A non-probabilistic and purposive sampling frame was adopted, with the focus on the indigent clients of two urban public defender offices, and as such involves several special considerations. In this section, I outline the specific strategies used to mitigate any risks and ensure compliance with the relevant federal guidelines governing research involving vulnerable populations so that procedures for the selection of subjects were fair and immune from arbitrary intervention. Subjects were selected randomly from an available group who met the characteristics needed for the research.

The client sample from the Fulton Co. Public Defender was comprised of people facing felony criminal charges. The client sample from the DeKalb Co. Public Defender comprises

those facing misdemeanor and felony criminal charges. The decision to break down the defendants this way is due to the fact that the Fulton Co. Public Defender represents only those facing criminal felony charges. There were no exclusions based on gender, race, or age (18-80).

The heads of the respective offices sent an office-wide email asking attorneys to give their clients the opportunity to participate in the research by reading a prepared written description of the study (Appendix C). They were provided with a card and envelope (Appendix D) that gave the client the opportunity to indicate willingness to learn more about the study. At the same time, the client was provided with a card containing contact information for researchers (Appendix D). The attorneys may have been aware that the clients had expressed interest in learning more about the study, but they would not know if their clients ultimately participated, unless the clients chose to tell them.

The original plan was for sampling to continue until 25-30 people in each felony and misdemeanor category were willing to have follow-up discussions. At that point, I would set up a visit, go over the research thoroughly with the respondent, and answer any questions the potential participant may have. What ultimately became necessary was for me to set up appointments at the respective jails as we went. The reason for this adaptation was that we ultimately received client cards a few at a time, so we did not know how long participants would be available. Thus, waiting for a higher number did not make sense from a scheduling perspective.

If the determination was made that people would like to proceed, I then went over the consent form (Appendix E) with the participant and answered any questions or concerns regarding that document. If at this point, clients agreed to participate, I asked them to select a pseudonym. I then turned on a digital recorder and obtained a verbal consent using the

pseudonym, therefore eliminating any written documentation of the client participating in the study. This procedure contrasted with that for the attorney and social worker participants, who were given two copies of an informed consent document, and if they agreed to participate, they signed both, giving me a copy and retaining a copy for their own records.

Client semi-structured interview guide

The client interview guide developed for this project was highly structured and specific, more than it would normally be for this type of research (Appendix F). The reason for this was practical; having the support and permission of the public defenders to speak to their clients without attorneys is rare. To be able to record interviews was also a break from normal practices. On top of this, being granted access to the jails to conduct the interviews in a contact visit setting (meaning no glass between interviewer and participant) was something that is unprecedented. For these reasons, it became critical to the process to collect as much information as possible during the one-two interviews being allowed. If something was missed, limited access to participants and jail regulations made it unlikely there would be another chance. Plus, because we were not privy to their criminal charges and judicial process, we had no way of knowing if a person would remain incarcerated in the same location.

Based upon general civil legal service checklists, the client interview guide consisted of 70 questions (Appendix F) which were designed to gather background characteristics and to elicit individual experiences regarding housing, safety and security, financial, benefits and subsidies, health, mental health, military, education, employment, driver's license, voting, and general questions regarding people's experiences with civil legal needs agencies. Following the suggestion of Kvale (2007) and Patton (2002), all the interview guides (Appendices F, G, H) were designed according to methodological principles, as were the follow-up questions and

probes used to clarify and expand responses. Participants were also repeatedly reminded

throughout the interview that they were not required to answer any of my questions per IRB

requirements.

Although questions contained no specific wording regarding stigma and labelling, some

tapped into these issues enough to identify where issues of stigma could be impacting a client's

willingness to self-disclose. Found in multiple sections of the client interview guide, these

questions included specific inquiries Q57, Q58, and Q59. For example, Q57 "Have you ever

been diagnosed with a mental illness? If yes, where? When?" Or question Q59, "have you ever

been hospitalized for mental illness? If yes, When? Where?" Also included are general questions

such as Q62 "Is there any reason you have not or would not seek help for a mental health issue,

either your own or a family member?" (Appendix F).

Attorney and social worker semi-structure interview guide

The attorney and social worker interview guide (Appendices G and H), consisting of 55

and 60 questions respectively, were the means by which the researcher gained insight into how

these professionals comprehend the various civil legal needs of their clients. Also, the responses

would allow for the expression of how they perceived mental illness, both in their clients and in

general, as well as the different ways in which they perceived their clients looking at mental

illness, in themselves, their families, and others in general. Their insights and professional

experience with clients' willingness to disclose mental health issues will also prove valuable to

assessing the role of stigma and barriers to seeking help.

3.5 Data Collection

Prior to drafting semi-structured interviews and meeting with IRB, the researchers met

with the respective heads of the public defender offices, as well as attorneys and social workers,

to get permission and input into the most effective and least disruptive way to conduct interviews. It was important that the attorneys and social workers supported what we were proposing, and we were very clear that the information we were seeking from their clients was not in any way associated with their present criminal legal situation.

There was also a meeting at the Fulton County Jail, attended by the head of the Fulton County Public Defender, the head social worker and an attorney from that office. Present from the jail administration was the Sheriff and two of his administrative officers. This meeting led to the decision by the Sheriff to agree to inmates being interviewed and that I should be subject to a comprehensive background check, as well as schedule and attend a separate informational session at the end of which there would be a test. The purpose of the latter was to give me sub-contractor clearance status that would allow me to move about the jail. I was provided with identification that confirmed my clearance until December 30, 2017, and access codes to the library.

In order to expand my contextual knowledge of the public defender offices, I researched the evolution of the public defender system in Georgia, as well as systematically familiarizing myself with various court procedures in the two counties. My preparation included becoming familiar with alternatives in sentencing and mental health court procedures in order to learn more about how those with mental illness are represented by both the Fulton County and DeKalb County Public Defender offices.

The interviews conducted with clients adhered to the timetable and scheduling preferences of the Fulton and DeKalb County Jails. Despite my subcontractor status and access codes, I was still required to alert the Jail when I was going to conduct interviews, and a guard was provided to accompany me to the library. The same guard located the potential participant

in the jail by the identification number provided on the client cards and brought the potential

participants to the library and returned them to their cell blocks afterwards. For interviews with

non-incarcerated clients out on bond, I acquiesced to their preference for location.

Interviews at the Dekalb County Jail (DCJ) proceeded somewhat differently. After

speaking with the Sheriff, I ascertained that they would be less likely to see me as a disruption to

their schedule if I came on the weekend, which I offered to do. This adjustment was not a part of

the formal agreement between the jail and the Dekalb Public Defender but came up in

conversation between myself and the officer in charge of organizing my access.

I would schedule with the jail to go on an upcoming Saturday or Sunday, bring the

potential participant names with me, and sign in at the main desk. An officer was then located to

take me to what I soon learned was the admitting area for female inmates. Once there I would set

up in one of the two attorney booths. The officer at the intake desk was the person who would

call for participants to be brought from their cells or other areas in the jail. I would see multiple

people while there.

At both jails, I had to specifically request each time I went for the potential participants to

be brought individually. I was caught off-guard when a participant who had been waiting, just

around a corner in the hallway at FCJ, stated during his interview "yeah, like what he said…" At

the DCJ, it was slightly different. The guard had kept people in a holding cell, close to the

admitting area which was cold and very uncomfortable. I had no way of noticing this until one of

the men refused to hear anything about the study because he was fed up with waiting and sure he

was coming down with a cold. After these incidents, I repeatedly stressed the need to bring

people to interview areas one at a time, which they did from then on. This change often resulted

in my spending a long time between interviews. I used this time to write notes about the previous interview, as well as site contact information for that day.

The interviews ranged in time from 40 minutes to 3 hours. No references were made to any of the criminal charges facing the client, nor were the names of the client or their family members associated in any way with the results. To this end, as noted previously, a fictitious name/pseudonym was used during the recorded interview. This practice extended to social worker and attorney interviews as well.

Interviews with attorneys and social workers were conducted at their respective offices, and all interviews also were 100 percent voluntary and anonymous. They signed consent forms, retained a copy for their records, and like the client participants, they too chose a pseudonym that was used for the verbal agreement to record digitally. The recordings were password-protected and transcribed by a transcriptionist who had signed a confidentiality agreement as a condition of employment. The recordings will be deleted within six months of the original interview.

Ultimately, 46 interviews were conducted using semi-structured interview guides including 30 client interviews, eight attorneys, and eight social workers. From the total number of client cards received (60), two potential participants had been released and one had a disciplinary charge and therefore was not permitted to speak to me. Three people declined when they heard more about the study; two younger men did not see how the study would benefit them, and an older gentleman only wanted to discuss getting land back that his brother had stolen from him while he was in jail. One woman who was out on bond did not have time to complete an interview. Another person out on bond did not turn up at the designated time and place. One person declined due to being kept waiting too long in the holding cell at DCJ. Only one person refused to be part of the study after completing an entire interview. He did not give a reason, nor

was he upset, but he simply changed his mind and his interview was deleted immediately. The remainder of potential participants indicated on the client card that they did not wish to participate.

3.6 General Coding

The digital audio recording was password-protected and encrypted, per IRB instruction, and the transcriber was required to sign a confidentiality agreement. After the interview transcription was verified by the interviewer, the recordings were destroyed within six months. As the principal student investigator, I have been responsible for data-cleaning and preparing the final datasets for analysis. I developed a respondent matrix and utilized the software package NVivo in conjunction with manual coding. NVivo is a computer-assisted qualitative data analysis software (CAQDAS). Grounded theory methodology in this instance will allow for the incorporation of the perceptions and perspectives of those most affected by the intersection of multiple collateral consequences and stigmas in relation to the criminal justice system.

Analysis began early in data collection, along with a continuing review of the literature, researcher experience, and the interviews which all informed the analytic process. For the purposes of this study, the terms, "concept," "category," and "theme" are not interchangeable. Category was descriptive, and a priori categories were deployed as well as new ones developed. The use of semi-structured interview guides provided the initial descriptive framework for analysis. Therefore, the themes identified were strongly linked to the data, however, themes did not necessarily directly reflect questions used in interviews (Braun and Clarke 2006; Creswell 2014; Patton 2015). Through this identification of categories and subcategories, I began to identify candidate themes (Bazeley 2009; Braun and Clarke 2006).

Due to the process of ongoing analysis coupled with simultaneous data collection, findings have been refined, challenging generalizations through a more in-depth analysis of the data. In some instances, I discovered that initial findings continued to be supported, or if support weakened, new themes were developed, combining existing ones or creating subthemes. I have not restricted analysis to individual cases, but have been accessing information from across all data, interview transcripts, field notes, and basic institutional numbers, such as number of attorneys/social workers per office and number of cases per office and per social worker (Miles and Huberman 1994; Henderson and Balfour 2015).

As noted, the client interview guide for the ACLNID is based upon general civil legal service checklists. Additionally, the client interview guide consisted of 70 questions (Appendix F) which were designed to gather background characteristics and to elicit individual experiences regarding housing, safety and security, financial, benefits and subsidies, health, mental health, military, education, employment, driver's license, voting, and general questions regarding people's experiences with civil legal needs agencies. Following the suggestion of Steinar (1996) and Patton (2002), all the interview guides (Appendices F, G, H) were designed according to methodological principles, as were the follow-up questions and probes used to clarify and expand responses. Participants were also repeatedly reminded throughout the interview that they were not required to answer any of my questions per IRB requirements.

A participant matrix was created concurrently during the ongoing data collection. Along with basic demographic information such as age, race, and sex, additional categories were also identified and tracked. One example was whether or not a person had graduated from high school or obtained a GED. Another asked whether the participants were homeless at the time of their arrest, or if not, if they had experienced homelessness previously. Also included were questions

about health insurance, mental health issues, driving license status, type of state identification, and ability to vote.

The words "stigma," "stigmatizing," or "labelling" were not included in the semi-structured interview guides. These questions sought to identify how issues of stigma could be impacting a client's willingness to self-disclose. I included the entirety of the transcripts for coding about stigma and mental health diagnosis because although highly structured, interviewees introduced issues of mental health throughout the interview and did not necessarily remain specific to the mental health section. Participants were not restricted to respondents who met any psychiatric diagnostic criteria for mental illness.

These questions included specific inquiries Q57, Q58, and Q59. For example, Q57 "Have you ever been diagnosed with a mental illness? If yes, where? When?" Or question 59, "have you ever been hospitalized for mental illness? If yes, When? Where?" Also included are general questions such as 62 "Is there any reason you have not or would not seek help for a mental health issue, either your own or a family member?" (Appendix F).

Each interview was recorded using a digital recorder, and these were subsequently transcribed by a professional transcriptionist. I listened to the recordings and verified the transcripts, as did a graduate research assistant from the College of Law. The data was cleaned, missing words identified, and each version saved in a separate password-protected file. When the interview was formatted and verified, I entered it into NVivo. Client, attorney, and social worker interviews were identified as subjects and cases, and interview questions were treated as a priori codes and entered as nodes. After entering the transcribed interviews into NVivo, I and a law school graduate assistant provided additional coding to identify civil legal needs, as well as expand mental health coding.

Initial coding indicated expectations of prejudice and discriminatory treatment among those who disclosed that they have been diagnosed with a mental illness. From these, I then went on to code for perceived and anticipated experiences of stigma. Literature points to confusion and vagueness of terms in stigma research (Pescosolido and Martin 2015). Therefore, so that this research could be situated within the existing literature, I sought to use accepted terms described by previous researchers.

Participants employed a variety of stigma-resisting strategies, and I coded these according to the deflection strategies conceptualized by Thoits (2011, 2016; Thoits and Link 2015). The strategies themselves will be explained in greater detail in subsequent sections. I also developed new conceptualizations as information emerged from the data.

Similarities and differences within and between client, attorney, and social worker interviews emerged around areas of consensus and diverging views related to the identification of barriers to help-seeking and disclosure of mental health issues. Differences and similarities between varying demographics also became apparent; most notably, differences in education attainment correlated with different perceptions of mental illness stigma pertaining to multiple areas of diagnosis and etiology. The interaction of text, codes, and themes in this study involved several iterations before analysis proceeded to the interpretative phase. At this point, connections were drawn with existing or newly developed theoretical constructs.

3.7 Mental Health Specific Coding Information

The semi-structured interview guide, essentially the a priori template, was based on the research question assessing the civil legal needs of indigent clients of the public defender. During and subsequent to the data collection from 46 interviews, 30 client, eight attorney, and eight social work interview transcripts were entered into NVivo. This process was iterative and

reflexive. The data collection and analysis stages in this project were undertaken concurrently, and I reread the previous stages of the process before undertaking further analysis to ensure that emerging or developing themes were well grounded in the original data.

The codes developed for the interview guide were the initial nodes entered, and client, attorney, and social worker interview transcripts were entered as cases. The text was coded by selecting segments of text that were representative of the code. The segments of text were then sorted, and a process of data retrieval was organized across the 46 interviews.

Analysis of the interview responses was guided but not confined by preliminary codes. During the coding process, inductive codes were assigned to segments of the data that described a new theme observed in the text.

These additional codes were either separate from the predetermined codes or they expanded the existing code. For example, the concepts of public stigma and stigma resistance were initially coded as "attitudes toward telling others about mental health issues." However, other comments from different sources in relation to resisting or avoiding disclosure resulted in the development of multiple separate data-driven codes.

The initial levels of codes were based on questions 57 through 61 from the semi-structured interviews guide, presented below in Table 1. During the course of analysis, an expanded list of more detailed codes also were identified. Table 2 presents mental health specific coding around anticipated and actual stigma experiences and identification of how media influenced stereotypes were acknowledged by clients. The last table in this section includes the coding categories that captured the various methods of stigma management that were deployed to resist and minimize potential stigmatizing efforts of others (Table 3).

Table 1 Mental Health A Priori and Expanded Coding

A Priori Template Codes	Expanded Coding
Q57 Have you ever been diagnosed with MI? If yes Where? When	Attitude toward telling others re: MH Issues Childhood MH issues Diagnosis yes – w/ or w/o medication? Family Member w/ diagnosis, w/informal diagnosis, i.e. anecdotal Impressions of African American help-seeking and MH issues
Q58 Have you ever been prescribed medication? If yes, Where? When? By Whom?	Attitude toward medication Consistency of medication
Q59. Have you ever hospitalized for mental illness? If yes, Where? When?	Confusion around inpatient mental health treatment
Q60 Have you ever sought help with regard to a mental health issue? From whom?	Attitude toward help-seeking for self and/ or others - Negative / Positive/ Unsuccessful Attempt
Q61 Do you have any issues around addiction? If yes, would you mind telling me about that?	Attitudes toward substance abuse and mental illness
Q62 Is there any reason you have not or would not seek help for a mental health issue, either your own or a family member?	Attitude toward seeking help for self and /or others Negative /Positive/ Unsuccessful Attempt

Table 2 Mental Health Specific Coding

Stigma Experience	Actual	Anticipated
Media Influence	Equates anger/violence with MI	Equates unpredictability with MI

Table 3 Stigma Resistance Strategies

Deflection	Define in less discrediting terms	"emotionally overwhelmed"
	Not me	"I hope you can tell…"
	Not who I am	"I am not my MI"
	Renames diagnosis	"brain disorder"
	Yes, no, sort of	
Challenging	Education- educating	
	Just No - Does not accept diagnosis full stop	
No Resistance	Completely open to discussing MH issue	
No Fly Zone	Does not go beyond "no" answer to MH questions	

3.8 Reflexivity

In their meta-analysis of existing quantitative and qualitative studies of mental health-related stigma and help-seeking, Clement et al. indicated that a main methodological limitation in qualitative research was the failure to provide the "reflexive account of the researcher's influence" (2014:19).

Within the context of the current study, and as the main interviewer for this project, I am aware that my personal professional experiences shape my interpretation of the data, and I rely upon reflexivity to identify the ways in which this informs outcomes. As Charmaz states, "No qualitative method rests on pure induction—the questions we ask of the empirical world frame what we know of it" (Denzin and Lincoln 2005:509).

I did not have any previous contact with any of the clients that I interviewed for this project. I do have experience in capital indigent defense as a mitigation specialist and therefore was comfortable in my interactions with the respective clients of the public defenders and being in the jails where the majority of the interviews took place. I also believe that my former experience was helpful to the public defender offices. They could trust that I would be comfortable with their clients and understand the importance of not discussing any issues pertaining to their current legal situation.

It was very important to me, not just because of the IRB requirements but also personally, that the participants in this study understood that it was completely voluntary and that they were not obligated in any way to share any information with me. Every person who took part in this study did so willingly, knowing it would not benefit them personally in any way. This participation was incredibly generous. They were generous with both their time and their

personal narratives. I was very aware that the topics I was asking participants to discuss are ones we all can find difficult to speak about for many reasons. I tried to be sensitive to any anxiousness people may have had and quickly sought to dispel any when detected. Structurally, the interview guide incorporated multiple reminders throughout the process that participants were not obligated to answer any questions.

I moved to the United States from Canada as an adult with my husband. I currently hold dual citizenship, American and Canadian. As a naturalized American citizen, I do view certain behaviors and values in the United States as perhaps, foreign. I believe that due to my Canadian experience and perspective, I am somewhat predisposed to what in the United States is likely considered a liberal view or value system (not neo liberal). This tendency runs especially in areas of law, for example, opposition to the death penalty, support of health care and public education for all, and disfavor of privatization of various legal services including prisons, jails, and probation services.

An example of the way in which this difference can manifest is how I view the civil legal needs that were assessed by the main study. The Canadian government handles rules, regulation, and oversight of the major institutions. Whereas here in the United States, for example, stopping predatory behavior in the area of finance, such as car loans, student loans, and mortgages, is assigned to the courts. And there are significant barriers of process to obtaining benefits, getting a decent education, and having a reasonable expectation of equity.

Another significant area of difference in my outlook to normative attitudes here is my skepticism towards the evolution of the Diagnostic Manual and the American Medical Association. I believe that the impact and scope of corporate pharmaceutical involvement in the area of mental health and illness have yet to be adequately accounted for across all domains.

The initial shock that directed me to investigate areas of legal and social justice was the legality of the death penalty. Of course, I knew theoretically that the death penalty was legal in parts of the United States, but I only understood that in the abstract from American popular culture, television, and movies. I discovered that since my government had made the death penalty illegal, it truly had become a non-issue for me personally. To actually see an execution reported on local news and read about it in daily newspapers, albeit buried way in the back, was surreal. I began to comprehend the difference in cultural and political reality of the area in which I was now living in a way I had not before.

This discovery facilitated my exposure to the complexities of indigent defense at both the capital and non-capital level, which began in 2005 when I became a volunteer with the Southern Center for Human Rights. This experience led me to actively seek the means by which I could acquire the appropriate skill set that would allow me to make a contribution to this field. I have witnessed firsthand the need for intervention to aid the urban community through both social and economic justice frameworks. I acquired a Master's in Social Work from Georgia State University and worked in the area of Capital Defense as a mitigation specialist, at the pretrial, trial, and habeas/postconviction legal stages.

My views are shaped by my experience in the world of indigent defense. I have been described, as "defense orientated." This assessment can be complimentary or pejorative, depending on the role of person using the term. One of the lessons I have learned and for which I am very grateful is to value the lived experience of other people, whoever and wherever they may be. I strive to go beyond cultural competency to practice cultural humility.

My intention has been to develop a concrete skillset that will allow me to contribute in a tangible way to the improvement and equalization of justice and human rights. My real-world

experience has provided a solid foundation for this research project. The result of building

concrete training in qualitative research has enabled me to systematically gain a deeper

understanding of my clients and the contextual realities that have come together to shape their

lives.

The examination of social stratification and its ramifications will further increase my

ability to create a theoretical and applicable framework to facilitate the likelihood of more

positive outcomes. These methods will also allow me the means by which to comprehend the

ways in which societal stratification and multiple forms of stigma have negatively impacted the

lives of so many public defender clients. This hope is what motivated my participation in this

project, and it is what motivates me in my professional life as well.

4   CONTEXT

The interaction between micro and macro political policy changes affects relationships

between social structures and individuals; economic and political conditions produce and

racialize inequality and stigma. These interactions are complex, their impact far-reaching, and so

the mechanisms of misrecognition, discussed by Link and Phelan (2014), that serve the interests

of the stigmatizers must be disrupted and exposed. In order to gain meaningful insight into the

normative beliefs around the policies that impact mental health stigma, education disparity,

homelessness and poverty.

Therefore, the focus of any meaningful study must include the organization of institutions

and policies. The goal of this project is to gain greater insight into how participants' experiences,

actual or anticipatory, relating to mental illness stigma may impact their willingness to disclose

relevant information early in the criminal justice process. This issue is part of a broader pattern

of marginalization and stigma and cannot be reductively examined in isolation. In order to

comprehend the overall situation, it needs to be situated within the context of a more nuanced, multifaceted, and complex understanding.

The context for the information gathered includes not only interaction with the criminal legal system, but also an overwhelmingly disproportionate representation of race and poverty. Therefore, analysis cannot ignore how historical practices and social inequalities have shaped the lives of the participants in this study. If these factors are ignored, a false assumption of equality can distort findings and promote the myth that all have had access to equal opportunities. Such omission would facilitate further discrimination and pathologizing. This is not to say that personal agency has no part in people's decisions. It does, but personal agency is being operationalized in a landscape that has been greatly restricted by significant outside forces. Ultimately individuals either act or they do not, and in doing so they weigh beliefs and perceptions about the consequences of their actions.

First, the means by which participants are considered to have a mental illness needs to be discussed. For the purposes of this research, we relied upon the diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V 2013). This decision was in keeping with the contemporary application of forensic psychiatric mental health practices by Georgia Regional Hospital and both the Fulton County and Dekalb County Jails' medical providers.

Forty-six semi-structured interviews were conducted and coded for analysis. These included interviews with eight attorneys, eight social workers, and 30 clients from two separate county public defender offices. This project sought to identify the attitudes and experiences of indigent men and women toward mental health and illness, disclosure, and help-seeking. Because these people are currently involved in the criminal justice system, specifically with the

offices of the public defender in Fulton and Dekalb Counties, by extension, this research is investigating an aspect of incarceration in the southeast United States.

No claim is made here that a complete understanding of all the historical contexts can be provided. We can, however, include historical information pertaining to poverty and incarceration, as well as to the development of the Diagnostic and Statistical Manual of Mental Disorders (APA) and the subsequent widespread deployment of diagnoses and disorders that have disproportionally affected racial minorities and the poor. Also, we can better assess the impact of the rhetoric that informs policy and public opinion regarding mental illness, race, and dangerousness and how it has been deployed using delivery methods that are both systematic and haphazard.

In their conceptualization of stigma as being multi-level, Campbell and Deacon frame stigma as "how social effects become sedimented in the individual psyche in ways that often make it difficult for stigmatized group members to resist their devalued status" (Campbell and Deacon 2006:411).

4.1 Indigency

All of the clients interviewed for this study met the criteria of indigence as defined by the state of Georgia (Pursuant to OCGA §17-12-80(c) in order to qualify for representation by a public defender. Their income must be less than 125% of the Federal Poverty Guidelines (hhs.gov/poverty-guidelines). To calculate this amount, annual income is multiplied by 1.25 or (125%), rounded up to nearest dollar and divided by 12 to ascertain monthly income. In order to qualify for representation, a person must have a monthly income less than $1,256.

Studies indicate that the majority of the poor in this country are not poor because they lack the individual will to get themselves out of their poverty. They are constrained greatly by

larger legislative policy including minimum wage and anti-union legislation that has exacerbated the problem in urban areas such as the areas where our study participants live (Ullucci and Howard 2015). Most of the families that meet indigency requirements are headed by working adults, so at issue is not unemployment per se but issues of being inadequately paid or working part time. Anyon argues that the "main determinant of whether one is poor or not is whether or not one has a decently paying job" (2014:21).

At the time of their arrest, 13 out of the 30 people interviewed were homeless. If we include those who have been homeless at some point in their life, the number increases to 20 people out of 30, or two thirds. Poverty overall has been reduced to a stigmatized condition. Homelessness carries with it a great potential for stigmatization and is found to be on par with the level of stigmatization directed at those who have been hospitalized for psychiatric issues and treatment (Phelan et al. 1997). In part, the stratification processes to maintain hierarchies of dominance depend upon operationalization of fundamental cognitive belief systems (Link et al. 1997; Phelan et al. 1997). Therefore, addressing multiple issues of stigmatization is critical to understand the various ways that categories of "us and them" are produced (Link 2003).

The negative stigmatization of the poor has a strong historical precedent and has been well documented since the Middle Ages and before. Varying amounts of blame have been ascribed to the individual for the condition. Phelan et al. support that The English Poor Laws, from the 14th to 18th century, attested to this phenomenon and separated the poor into two groups. The "deserving poor" were widows and orphans, army and war veterans. The "non-deserving poor" included anyone who was not part of the narrowly defined deserving categories (1997).

In recent decades, the attitudes of Americans toward the poor have become increasingly harsher and blame-focused, with many people viewing all poverty as a moral failing without exception. This judgement, in turn, has been accompanied by marginalization and punitive policy implementation. The origin of this posture towards the poor is usually attributed to the Reagan administration of the 1980s. From the perspective of this research, however, the backlash actually began earlier as a reaction to the Johnson administration's civil rights and "War on Poverty" legislation. The results of the ongoing battle between the deserving and undeserving poor can be seen most recently in the political drive to defund Medicaid and promote work for benefits quid pro quo.

This shift, from the overt to the more circumspect or covert, has in part provided the impetus behind the growth in rhetoric attributing specific values, such as welfare dependency, to violence. Such constructs now are embedded firmly into public consciousness and deployed when necessary not only for political gain but also for acceptance of discriminatory practices within the criminal justice system. Although it didn't start with his administration, Ronald Reagan's mythical "black welfare queen" is perhaps indicative of how labeling has directed the process of pathologizing the African American population in particular.

A profound policy shift occurred in 1996 with President Clinton's signing of the Personal Responsibility and Work Opportunity Act (PRWORA). This legislation changed the culture of welfare from being simply needs-based to conditioned upon evidence of personal responsibility and self-sufficiency for young single mothers. The results exacerbated the economic living challenges of already marginalized populations of women and children living in poverty (Hansen, Bourgois, and Drucker 2014).

Race is a construct; it has no biological validity. It does, however, have a real impact on perceptions toward African Americans and other non-whites**.** The relentless political rhetoric vilifying and dehumanizing the poor, usually minority populations in this country, has fueled the mechanisms for the incarceration of Black, and to a lesser extent Hispanic men. Part of this rhetoric is the fear-mongering around the notion of the violent mentally ill, who are routinely scapegoated and further stigmatized in association with public incidences of violence, especially involving an unsuspecting public, i.e. mass shootings.

Stigma is a useful concept from a criminal justice perspective, on two levels. The first is the fact that it can punish the perpetrator for his crime, plus it can alert the community through notifications, such as sex offender registries. "Every minor offence, every act of disorderly conduct—particularly if committed by poor people in public spaces—is now regarded as detrimental to the quality of life…. tiny crimes are viewed cumulatively" (Garland 2001).

Tough on crime laws and policies contributed to the incarceration tsunami that swept over the country devastating the communities of people of color. Parallel to the larger federal policy, the state of Georgia has systematically been defunding the public-school system for roughly the past 16 years (GBPI Report). The impact of this policy on the children who had the misfortune to attend affected schools must be considered when looking at the negative trajectories and outcomes of individuals in these age groups.

Identifying the structural framework that produces inequality is key in understanding how negative structural influences impact people and create pathology, as well as possible solutions via policy and law. The goal is to reorganize these factors, while at the same time, not further demoralizing the people who have been the most impacted. I advocate the creation of a new lens

that will both allow for and promote personal agency, as well as develop a greater understanding of the legal, political, and social forces that diminish access to resources and opportunity.

The criminal justice system has become a means by which people are further marginalized, not only by overt practices of disenfranchisement but also by multiple areas of collateral consequences. Harsh welfare policies have melded with intense marketing strategies by the pharmaceutical companies and the buy-in by federal and government state agencies, i.e. FDA. Simultaneous defunding of public schools has profoundly affected the life trajectories and potential outcomes of the population we are studying. Furthermore, the collective experiences of age cohorts seem to reflect this overall shift in policy.

The categorization of people and assigning labels impacts how children are perceived and educated in the U.S. The stereotypes and ideologies associated with being African Americans are mostly negative and have been framed as inferior to European Americans. This perceptual dichotomy has materially reduced the former's educational and other opportunities. African American boys from working class and families living below the poverty line experience the greatest inequity and exhibit low academic performance (Murrell 2008).

In March 2018, the Government Accountability Office (GAO) produced a report for Congress that outlined the disparities in discipline for Black students (male and female) and students with disabilities. These findings are significant to one of the themes that emerged during this research--the decreased likelihood that students removed from the classroom for disciplinary reasons can regain, or catch up, on lost educational ground. The GAO report found that although approximately 17.4 million more white than black students attended K-12 public schools in 2013-14, nearly 176,000 more black than white students were suspended from school that year (2018:19).

In Georgia high poverty high schools, the main reported reason for disciplinary actions is attendance issues (28), i.e. students who were late to class or did not get to the next class in the allotted time. Elementary schools were less punitive because of a recognition that tardiness was usually due to circumstances beyond the child's control, such as the instability of homelessness (29). Officials in Georgia also provided examples of trauma common to students, including homelessness, being taken from their parents, or having been through violent situations (31). Nevertheless, the accrual of these types of minor infractions led to suspensions and expulsions.

The 2011 CDC Health Disparities Report noted that "The age-standardized prevalence of poverty was 15-20 percentage points higher among persons who had not completed high school than it was among those with more education than high school" (17). Poverty status diminishes access to a myriad of health care services and contributes directly to health disparities (CDC Health Disparities Report 2011). Also, people with severe mental illness live approximately 15-30 years less than non-mentally ill counterparts (Khuller 2018).

The acknowledged long-term negative effects of homelessness and limited education opportunities are pertinent to our study. Although we examine mental illness stigma, it cannot be entirely disassociated from the overall social reality and structural disadvantage throughout the participants' lives. According to the Modified Labeling Theory, pathologizing and deficit-based perspectives are routinely deployed to reproduce stereotypical and discriminatory beliefs that form the basis for an "us" and "them" delineation.

4.2 Medicalization

According to Conrad (2007), studies of medicalization have focused primarily on professionals and patient groups, while corporate influences were viewed as secondary. In the 1980s, a buyer-driven system of health care began to emerge (Conrad 2007:18). That shift

marked the beginning when small changes in wording about diagnostic criteria would have significant impact for market growth (Horwitz 2002).

Patients were now viewed as "consumers" or potential markets, a model first used by cosmetic surgeons. Today pharmaceutical companies comprise America's most profitable industry with revolutionary new drugs having greatly expanded their influence (Conrad 2007).

4.2.1 Evolution of the DSM, from DSM-I in 1952 through DSM-V 2013

According to Moncrieff, the "modern state has been seeking a solution to the problem of madness since at least the end of the 18th century" (2009:51). Major changes in the structure of mental health diagnosis started to be felt both within and outside the medical field in the 1980s. The American Psychiatric Association Diagnostic and Statistical Manual or the DSM was first published in 1952. Ironically, one of the rationalizations motivating the psychiatric community's production of the manual was to counter their diminishing status and perceived stigma toward them from the public and the medical profession (Conrad 2007; Moncrieff 2009; Peterson 2008). Revised editions were introduced in 1968 (DSM-II) and 1980 (DSM III). This last publication marks a distinct shift in the medical paradigm from psychoanalytic to biomedical and was revised in 1987 becoming the (DSM-III-R). More revisions occurred in 1994 (DSM-IV), 2000 (DSM-IV Revision), and 2013 (DSM-V).

The DSM III has been described as the means by which mental health professionals legitimized their professional authority to manage mental health issues. Researchers cite the shift from the DSM II's focus on the psycho-dynamic model of mental illness to a diagnostic model in DSM III (Kirk and Kutchins 1992; Lane 2007). The change originated not because of an increase in knowledge from medical research or studies, but rather from social dynamics, including the necessity of measurable criteria for insurance reimbursement (Horwitz 2002).

This diagnosis-based approach was linked with identifying clusters of symptoms indicating a specific underlying disease such as schizophrenia (Conrad 2007; Frances 2013; Horwitz 2002). The DSM III was revised and became the DSM-III R in 1987, which some practitioners consider "a mistake and a distraction" (Frances 2013:69). At this point, the diagnostic system had evolved into what Allen Frances, M.D., former chair of the DSM-IV (1994) task force, described as the "unwitting tool of drug company marketing" (2013:69).

The DSM-IV was published in 1994 and critiqued by Horwitz and Wakefield for conflation of normal (for example, the sadness of grief which will over time dissipate) with "true depressive disorders that are not proportionately grounded in social contexts" (2007: 107). They supported further that this medicalization of "normal" emotions prevented legitimate research from discovering real causes and effective treatment for true disorders and legitimate psychological dysfunction.

The 1990s were significant in mental health treatment not only because of this development, but also for the 1997 Food and Drug Administration Act (FDAMA), which loosened constraints for off-label prescribing. This federal law opened the door for pharmaceutical companies and their sales representatives to give doctors off-label uses as long as they provided adequate scientific documentation or were engaged in clinical trials for the new uses (Conrad 2007). At the same time, the regulation reduced requirements for the amount of information shared in direct-to-consumer advertising (DTCA) (Corrigan, Kosyluk, Fkuo, and Park 2014; Payton and Thoits 2011). The only countries that permit DTCA today are the United States and New Zealand.

During the 1990s, pharmaceutical companies began to lobby the federal government to include attention deficit disorder (ADHD) under the protection of the Individuals with

Disabilities and Education Act. Lawmakers also cleared the way for families to collect social security supplemental income (SSI) in instances where children were diagnosed with the disorder (Peterson 2008).

Between 1990 and 2000, prescription drug spending tripled in the United States, from $50 billion to $150 billion or more (Szegely-Marzak 2001). In the same timeframe spending on anti-depressant drugs rose 800% (Tanouye 2001). The new 'atypical' antipsychotic drug created a 600% rise in the sale of neuroleptics to $4 billion dollars in 2001 (Moukheiber 2001). The success of "atypicals" can be measured in the increased use of antipsychotic drugs in youth in 1992 with 50,000 young outpatients using them; by 2002 the number had increased to 530,000 (Thomas 2002).

Eli Lilly funneled money through the World Psychiatry Association (Rosen et al. 2000) and NAMI (Oaks 2000:14; Silverstein 1999) to mount an anti-stigma campaign. The thrust of the campaign was to advocate "for the elimination of discrimination against people diagnosed with schizophrenia, so long as they are taking medication—by force if necessary" (Mosher, Gosden, and Beder 2013:132).

In what has been suggested was a coordinated tactic, The Treatment Advocacy Center (TAC), originally a branch of NAMI, began feeding the media with stories about the dangerousness of untreated schizophrenia. This campaign involved disseminating stories about untreated schizophrenia and violent behavior (Torrey and Zdanowicz 1999:27), as well as promoting stories about episodic violence perpetrated by individuals with schizophrenia and bipolar disorder, claiming this accounted for 1000 homicides per year in the U.S. (TAC 2001). The intention was to facilitate legally mandated involuntary treatment of people in their own homes.

It has been well documented that ADHD drugs, such as Ritalin, are often the jumping off point for what becomes a long history of medications for children. Within 10 years, children who had been diagnosed with ADHD also were being diagnosed with comorbid depression, obsessive compulsive disorder, conduct disorder, generalized anxiety disorder, or intermittent explosive disorder, when children express (allegedly) disproportionate or extreme anger during what observers classify as minor incidents (Peterson 2008).

Large pharma has been a part of every major decision and policy direction since the 1980s. The study of stigma has begun to look at the ways in which medicalization has impacted views of mental illness by the general public, those with mental illness, and close friends and family. For example, research has assessed direct-to-consumer marketing by pharmaceutical companies and its effect on stigmatizing attitudes (Corrigan et al. 2014; Payton and Thoits 2011). The insidious and sometimes obvious influence of large pharma further can be identified through the shifting and expanding use of "diagnostic" language within large community studies and surveys.

The difference in approach to disseminating information about psychiatric disorders and medications began to show up in discrepancies among large social surveys, notably the number of participants who would advise against or for taking psychotropic medication (Mojtabai 2009). It began with the General Social Survey, which in contrast to other countries, did not distinguish between different psychiatric medications or conditions. Also the prevalence of direct-to-consumer advertising increased significantly. The nature of the benefits that these advertisements promote are somewhat vague, as are the side effects (Mojtabai 2009).

Mojtabai concluded it was necessary to develop more targeted and selective public information campaigns so that they could identify the conditions that "merit the use of

psychiatric medications and to distinguish these conditions from self-limited stresses of daily life that not require medication treatment" (2009:1022). Mojtabai had received considerable research funding from Bristol-Myers Squibb Pharmaceuticals. The financial support of medical and academic study by pharmaceutical companies has been viewed as increasingly problematic in terms of study validity and motivation.

The National Institute of Mental Health (NIMH) developed a fully structured interview that could be administered by interviewers. This diagnostic interview schedule was based upon the DSM-III and designed for the Epidemiologic Catchment Area (ECA) studies conducted at five sites in US cities and translated into many other languages (Regier and Robins 1991). Ultimately, it was altered for use in special populations including children (Shaffer et al. 2000).

Other DSM specific interviews and diagnostic instruments are available for community-based research, including the Structured Clinical Interview for DSM-IV (SCID), the World Health Organization-Composite International Diagnostic Interview (WHO-CIDI), and the Mini International Neuropsychiatric Interview (MINI). Various research has relied upon large community studies to determine population views on mental health issues both in themselves and others, for example, the US General Social Survey (GSS) 1996, 2006 (Pescosolido et al 2008, 2010; Thoits 2016).

According to Conrad, the incorporation of diagnostic language into surveys has the potential to "medicalize more of life's problems and overstate the existence of untreated psychiatric 'pathology.' Findings like this could spur an actual increase in medical treatments for minor life difficulties and serve as a rationale for extending psychotropic treatments to larger portions of the population" (2007:132). Using results from the Epidemiologic Catchment Area Study, Corrigan (2007) found low levels of participant treatment of people with schizophrenia,

and that those with more serious mental illnesses were no more likely to participate than those with less severe mental illness symptoms (Regier, Narrow, Rae, and Manderscheid 1993).

Corrigan also determined that Kessler et al. (2005) had found similar results in The Nation Comorbidity Survey (2001). It should be noted here that Kessler has long been considered to have significant conflict of interest issues due to his longstanding relationship with major pharmaceutical companies. He has received considerable research funding from the latter on a scale that has meant by extension, he has been working for pharmaceutical companies for most of his career. Therefore, his findings should be viewed from this perspective.

As noted previously, most mental health assessment instruments fall into one of two categories, diagnostic or dimensional. The DSM series initially supported the idea the mental health is characterized by qualitative differences that can be converted to categories or diagnosis—although the DSM-III and DSM-IV and DSM-IV-TR (APA Text Revision 2000) stated specifically "that no definition of a mental disorder adequately specifies precise boundaries between normality and abnormality" (Stein et al. 2010). In contrast the DSM-5 (APA 2013) presented a shift towards dimensional or continuous aspects of mental health. The DSM-5 also introduced a standardized method for assessing severity for all diagnoses with an emphasis on simplicity and clinical utility (121).

Several studies have been concerned with whether the public can correctly identify psychiatric disorders. These studies point to partial and often incorrect understandings. The public may recognize certain types of symptoms over others, and these symptoms may expand public conceptions of what comprises mental illness (Phelan, Link, Stueve, and Pescosolido 2000). The public's broader definition of mental illness closely parallels another development in psychiatry: the first version of the DSM, published in 1952, contained 106 diagnoses (80), while

the fourth version DSM-IV published in 1994 contained 297 (Mayes and Horwitz 2005; Schnittker 2013:80).

For example, conduct Disorder is a DSM-IV and DSM-5 diagnosis and the criteria include "a disturbance in behavior that causes clinically significant impairment in social, academic, or occupational functioning" (2013:472). This disorder is associated with Oppositional Disorder (ODD) in younger children and Antisocial Personality Disorder in adults (APA, DSM-5, 2013). These disorders are considered treatment-resistant or intractable and thus associated with greater stigma.

The over-diagnosis of mental illness in African Americans in childhood, adolescence, and adulthood contributes greatly to the multidimensional stigmatization of this population and further compromises life chances and outcomes. Therefore, to study individual stigma neglects the identification of the ways in which multiple stigmas and their social categories mutually construct and reinforce each other (Cole 2009).

Contextually speaking the alliance between large pharmaceuticals, the American Medical Association, and the formulation of the DSM-III has led to the increase in prescribed psychotropics from 13 percent of the U.S. population in 1997 to 19 percent in 2007 (Hansen et al. 2014). Prescribed antidepressants increased 400 percent between 2005 and 2008 alone (Hansen et al 2014; Pratt, Brody, and Gu 2011).

4.2.2 Schizophrenia and Schizo-Affective Disorder Spectrum

A 1939 study by Faris and Durham illustrates the macro to micro link that sociologists perceive to impact mental health stigma (Corrigan et al. 2004). The team reviewed the medical records of Illinois State Mental Hospital, focusing specifically on schizophrenia. They found that people with a schizophrenia diagnosis most often came from intercity areas with high population

density and less affluence. This method of community study was a departure from prior individual-based assessments which focused on the unique aspects of a person's history and not on commonalities of groups with similar exposure to environmental conditions (Aneshensel 2005; Aneshensel, Phelan, and Bierman 2013:118).

Jumping ahead to the present, according to Schomerus and Angermeyer (2017), a German study, following Link and Phelan's approach, found that public perception toward some mental illnesses were improving; for example, more people thought those with depression should be shown more patience. Conversely, the study found that during the same period (1990 to 2011) (Gaebel et al 2017:164*),* the perception of fear toward people with schizophrenia increased, and a tangible trend separated schizophrenia from other mental illness perceptions (Angermeyer et al. 2013). This finding specifically is relevant to the public defender clients interviewed for this study. Schizophrenia and schizoid affective disorder comprise a significant number of the diagnoses found in this population.

People view those with schizophrenia as unpredictable and dangerous, but not responsible for their condition. This perception contrasts with an eating disorder; people do not think that morbidly obese people are dangerous or unpredictable, but they do tend to think that such people are responsible for their disorder. The harshest stigmas are reserved for dual diagnoses of schizophrenia and substance abuse disorders; these individuals are viewed as dangerous and unpredictable, as well as guilty for their condition (Crisp et al. 2005; Schomerus et al. 2011).

Negative opinions and stigma towards people with a schizophrenia diagnosis are intense. Despite the belief by some researchers that understanding biological models for mental illness would decrease stigma, the opposite has in fact occurred (Angermeyer et al. 2011; Kvaale et al.

2013; Schomerus et al. 2012). This increasing stigmatization has led to suggestions by some in the health care profession to change the name of this constellation of symptoms. The intent is to combat not only prejudicial beliefs of dangerousness and unpredictability but also entrenched feelings that recovery is not available to people with a schizophrenia diagnosis (Maruta and Matsumoto 2017).

The racial disparity in schizophrenia diagnosis has not diminished. The meta-analysis of Schwartz and Blankenship (2014) confirmed a disproportionate over-diagnosis of African Americans. However, all of the disparity could not be attributed to diagnostic protocols, a finding also supported by Metzl's 2009 historical analysis and Veling and Susser's 2011 study that connected "racial diagnostic disparities in schizophrenia to structural, institutional, and social factors before the diagnostic encounter" (Olbert, Nagendra, and Buck 2017).

4.2.3 Impact of the perception of the etiology of mental illness

Attribution theory purports that understanding the causality of mental illness outside of an individual's control somewhat mitigates stigma. However, the resultant essentialism regarding mental illness and the genetic, biological explanation has allowed for a different level of stigma associated with diseases. This ranking, if you will, places schizophrenia as being dangerous, violent, and more likely to be African American, and it has been curated by the media most successfully (Metzl 2009). The combination of pharmaceutical influences and media portrayal has contributed to the overt racialization of diagnostic criteria and consequences include linking mental illness with non-recovery (Wahl 1992; Stout et al. 2004)

Important to this discussion is the impact of social factors on mental health. Increasingly the biology-alone model is proving inadequate, as is the slightly modified, genetic predisposition to effects of stressors like poverty and violence. Phelan (2010) looks at the increased role played

by social conditions in health inequalities (Phelan, Link, and Tehranifar 2010). Read takes the issue further and is unequivocal in directing us to look away from the biology factor that has been heavily promoted by pharmaceutical industry (Read 2004b, 2007, 2011; Read et al 2007).

Much confusion also occurs around diagnostic protocols and uniformity. An example in Georgia is the diagnosis "Bipolar Schizophrenia," which has been used by the prison system. According to Social Worker Minerva:

> Georgia State Prisons have this thing where they diagnose people as schizophrenia bipolar, so just diagnose them with both… I don't like that, but they do that, and they diagnose them – and a client will tell you, "I'm bipolar schizophrenic." They love saying that. "Bipolar schizophrenic." I've never heard that before. So I think that the prison system in Georgia is so used to people come through with one of the two, they just diagnosed them with bipolar schizophrenic

However, this diagnosis is not legitimate and as such is not recognized by other medical agencies. Incorrect diagnosis decreases the likelihood exponentially that those who suffer from mental illness will be prescribed the correct medication:

> People aren't given the correct medication. Their needs aren't addressed, even when they're released. Because I have a provider saying, "Well, what's the real diagnosis? I can't really do anything if you're telling me bipolar schizophrenia. What's their history of medication?" The jail's not giving them anything because they were just recently diagnosed.

Diagnostic labels do have purpose for treatment and research, but the negative outcomes and implications must also be understood and addressed. "Through socio-cognitive processes of groupness, homogeneity, and stability, stigmatizing diagnostic labels may impact housing, and job opportunities as well as individuals' self-esteem, self-efficacy, and treatment utilization" (Ben-Zeev, Young, and Corrigan 2010:325).

The criminal justice system has become a means by which people are further marginalized, not only by overt practices of state-sponsored stigma disenfranchisement but also by multiple areas of collateral consequences impacting people ensnared by it. The confluence of

harsh welfare policies, the intense marketing strategies by the pharmaceutical companies, and the buy-in by federal and government state agencies, i.e. FDA, and simultaneous defunding of public schools has profoundly affected the life trajectories and potential outcomes of the population we are studying. Furthermore, the collective experiences of age cohorts do seem to reflect the overall shift in policy and the social changes that this convergence has produced.

The pathologizing of people who are negatively impacted by multiple overlapping stigmas has meant that when discussing or studying any aspects of these processes, situating them in a broader structural context is the only responsible option. Stigma that result in a myriad of negative consequences across multiple domains and various settings needs to be understood as the squellae of a host of financial, legal, governmental, and ultimately ethical decisions with which academics specifically, and society generally, must engage with politically in order to change and improve the life circumstances of society's most disadvantaged.

5   OVERVIEW OF THE DATA

In this chapter, the participant characteristics are explained and the circumstances of the indigent clients are presented generally to formulate a basis for later analysis pertaining to mental illness stigma. Naturally the greatest focus is upon the public defender clients. All of the participants in this project—attorneys, social workers, and clients—were asked to choose a pseudonym, by which they are referred throughout the interviews to maintain anonymity. To avoid any transgressions related to anonymity, particularly amongst the attorneys and social workers, I do not reference specific offices, unless unavoidable. For the same reason, I also have chosen not to provide demographic information beyond years of experience working in the area of indigent defense. I do this in part to demonstrate the significant amount of institutional

knowledge possessed by these people and to underline the great value that their contribution and insights have provided to this study.

5.1 Attorneys & Social Workers

For the eight attorneys interviewed, years of experience ranged from 2.5 to 17. All had worked in the area of criminal defense throughout their careers. The interviews demonstrated that these professionals are very committed to their work with their clients, have a significant amount of knowledge about the mental health issues faced by their clients, and regularly consult with social workers regarding their clients. The views and descriptions provided by attorneys in response to interview questions are used throughout the analysis to demonstrate knowledge, triangulate reports, and gain understanding of the ways in which stigma around mental illness impacts working with their clients.

Social workers contribute significantly to increase the chances of positive outcomes for clients. Their extensive institutional knowledge, both academic and forensic, materially impacts how clients with mental illness can best be helped and connected to services that can support and reinforce mental health treatment. We interviewed a total of eight social workers, whose experience ranged from two-and-a-half to 25 years. Although categorized as social workers working in the area of indigent defense, or technically forensic social work, they displayed variations in educational background. One young woman had a degree in forensic psychology. Others graduated from Masters of Social Work programs that focused on community involvement, while the rest received their training from clinically-focused and counseling programs. All had the equivalent of a master's degree.

Excerpts from interviews with social workers are used to demonstrate their strong connection and commitment to their clients, as well as their extensive knowledge of the realities

faced by their clients, who are marginally situated and coping with multiple stigmatized identities. The accounts of social workers not only reflect their clients' civil legal needs but also the existence of multiple barriers and the ways in which these functioned in the lives of this group that are not necessarily experienced by others.

5.2 Clients

The participants in this study experience multiple forms of disadvantage and disempowerment. Therefore, addressing issues of mental health stigma in the context of inequality is compelling. The following section creates a more nuanced picture of those interviewed before looking at the thematic development and analysis specific to mental health stigma.

Thirty clients have been interviewed for this study, ranging in age from 18 to 71. Twenty-five of the 30 self-identify as African American; of those, 23 are male, two are female. The remaining five are Caucasian males, who self-identify as white, ranging in age from 22 to 51. The researchers acknowledge that the study contains gaps. No study participants are between the ages of 61 and 70, and only two races are represented. The limited number of women also precludes us from making any claims specific to gender.

The youngest interviewee, 18-year-old Allen, has a ninth-grade education, has been diagnosed with ADHD, was homeless at the time of his arrest, and has previously experienced homelessness. Following Allen, there are five interviewees under the age of 25—Bobby 20, Beastmode 21, Dwayne J. 22, Teddy 22, and Chris Smalls 23. All are African American, with the exception of Teddy who is white.

Beastmode, Teddy, and Chris Smalls have all been formally diagnosed with mental illness that resulted in their hospitalization: Teddy and Chris Smalls with schizophrenia,

Beastmode for bipolar depression. Like Allen, Beastmode, and Dwayne J., Teddy has experienced homelessness and was homeless at the time of his arrest. However, he is the only member of this group to have graduated from high school.

African Americans Dwayne J. and Teddy, both age 22, were in the Fulton County Jail at the time of their interviews. We learn that Teddy has been hospitalized multiple times since he was first diagnosed with schizophrenia at the age of 16, signed in by his mother to Ridgeview. A subsequent psychotic episode resulted in his being tasered by police and taken first to Grady Hospital, where he was stabilized from the tasering, and then to Anchor Hospital, both in Atlanta. The young men have another difference—although Teddy was expelled from high school, he was ultimately able to graduate. Dwayne J. has never progressed beyond grade 10 despite repeated attempts to enroll at an open campus school. Teddy was homeless at the time of his arrest, unlike Dwayne J., who lives with his older sister.

Six men are in the next age group of 25 to 30. Morgan and Ninety-Three are both 25 years old, followed by Constantine and Abel, both 26 years old. Next up is 28-year-old Jonathan and 30-year-old Reggie. All are African American with the exception of Abel, who is white. Like Teddy in the younger cohort, Abel is the only high school graduate in this age group, although Jonathan has completed his GED. Ninety-Three and Constantine have been hospitalized for mental illness. Morgan and Reggie both report severe depression. All six have experienced homelessness. Ninety-Three and Constantine were both homeless at the time of their arrest.

Looking at the experiences of 26-year-old African American Constantine and 26-year-old Abel who is white, again we note the difference between a high school diploma and no high school diploma. Both men experienced trouble in high school. Both were suspended at some point for fighting. Ultimately though, Constantine dropped out around grade 10. He went through

the trauma of his biological father being murdered, and he himself was hospitalized within a few years for mental health-related issues because his mother worried he was suicidal.

Constantine and Abel both have had significant drug addiction issues that would fulfill the substance abuse disorder found in the DSM-5. Constantine used marijuana, cocaine, and MDMA (ecstasy). Abel struggles with long-term heroin addiction. Constantine has not been to a residential drug rehabilitation program. Abel has received care at numerous residential rehabilitation centers over the years, the longest for 90 days.

Thirty-one-year-old Teresa is the first female interviewee. With her in the 30-35 age range are Jon and Mr. J., who are both 32 years old. All three are African American. Jon has not graduated from high school, Mr. J. has, and Teresa has a GED. Teresa was not homeless at the time of her arrest, but she has experienced homelessness on multiple occasions throughout her life, as a child with her mother, as an adult on her own, and with her children. Most recently before her incarceration, she was living in her car with her children and in various shelters. Mr. J. and Jon were both homeless at the time of their arrest. Mr. J has not been diagnosed with a mental health issue, but both Teresa and Jon have. Teresa, although she did not seek help herself, expressed her gratitude for the intervention, that included diagnosis, medication, and counseling.

Teresa's mother was very involved in Teresa's treatment. Teresa found both the counseling sessions she attended on her own, and the ones with her mother very beneficial. However, Jon found his involvement with psychiatric in-patient facilities unhelpful. Jon, who has been homeless since 2010, reported being taken to Dekalb Crisis for the first time when he was 20, although neither he nor his mother know exactly why. He has been hospitalized multiple times since his initial visit. While hospitalized, he has met with doctors and been diagnosed,

although he reports he has no faith or trust in either his caregivers or diagnosis. While having been medicated while hospitalized, Jon discontinues all medication immediately upon release.

There are three men in the next age group of 36 to 40. One of these is Week, a 36-year-old white male who has significant mental health and developmental issues. Week's experience diverges from the other white clients interviewed. He did not graduate from high school, and he is unable to read or write. Cee Pressure, 38, has completed his GED, and Albert Einstein, 40, is a high school graduate. Both of these men are African American.

Albert Einstein also completed two years of college and joined the Navy, although ultimately he was dishonorably discharged for marijuana possession. Cee Pressure and Week were both homeless at the time of their arrest, but Albert Einstein was not.

Week has been hospitalized frequently throughout the years and has been diagnosed with various developmental disorders, as well as bipolar schizophrenia. Albert Einstein has been diagnosed with paranoid schizophrenia and suffers from seizures. Cee Pressure has taken ADHD medication. At the time of the interview, he was involved with his son's school and concerned that his son has also received an ADHD diagnosis. Cee Pressure is not supportive of this, nor is he supportive of medicating his son.

Of the next 41 to 45 age cohort, Kim K is a 42-year-old female, Fred Jones is 43 years old, and Tommy Moore and Five-Percent are both 45. All are African American. In addition, Draco is a 44-year-old white male who has served in the military, and although he did not see active duty, he was honorably discharged. Draco relies on VA health coverage for his HIV medication. Of this group, the only one without a high school diploma or equivalency is Five-Percent. Both Draco and Kim K have experienced long-term homelessness and were homeless at the time of their arrests. Kim K and Five-Percent have been hospitalized for mental illness

issues, and Draco also feels he has persistent long term mental health issues. No study participants were between the ages of 46 and 50.

Danny and Elliot were both 51 years of age at the time of the interviews and are African American and Caucasian respectively. Danny, the youngest of eight children, attended school until the third grade and has lived with his mother his entire life. Elliot has a high school diploma and has been homeless for the past five years. Elliot lost both his parents when he was very young and was raised by a sister. Elliot reported that he has been jailed in Dekalb County 20 or 30 times, mostly for county ordinance violations such as pedestrian solicitation in the roadway, basically standing on roadway ramps with a sign asking for money. David, it seems, will not stop shoplifting.

Next, we have 57-year-old Two-Two, as well as Michael Wright and Tony, who are both 58 years of age, and 60-year-old John Brown. All of these men are African American. Michael Wright and John Brown have graduated from high school, and both men were homeless at the time of their arrest. Michael Wright described his situation as "Well, I was borderline homeless. My sister allowed me to use her mailing address."

John Brown did not state openly that he has been homeless, but after looking back at the interview, contact notes, and field notes, it became clear he was homeless at the time of arrest. John Brown served in the military and was honorably discharged but was not currently receiving benefits. Two-Two and Tony did not graduate from high school, and neither man was homeless at the time of their arrest, although Two-Two has been homeless multiple times on previous occasions.

Two of these men have had mental health issues, and a third has spent a significant amount of time in hospital for a head injury. The oldest person interviewed for the project was

71-year-old David, an African American male who did not graduate from high school and was homeless at the time of his arrest. David reported a longstanding substance abuse disorder, alcoholism, for which he has spent time at Georgia Regional Hospital. He described the experience as "being treated like an animal in a zoo."

5.3 Summary Participant Data

This study is not generalizable, but this observation does not negate the fact that the 30 clients interviewed are reflective of the disproportionate demographic predominance of African Americans involved with the criminal justice system in the United States today. African Americans made up 92 percent and 76 percent of the project's participants who are represented by the Fulton County Public Defender's office and the Dekalb County Public Defender's office respectively. According to the United States Census Bureau, the total population of Fulton County is 996,757, of which 44.1 percent are African American and 45.2 percent are Caucasian. Dekalb County has a population of 723, 902, 56 percent African American and 34 percent Caucasian (Census.Gov).

(https://factfinder.census.gov).

Table 4 Distribution by County

	African Americans	
County	**In This Study**	**Total Population**
Fulton	92%	44.1%
Dekalb	76%	45.2%
Total	83%	44.6%

Those involved with the criminal justice system are facing multiple, intersecting constellations of stigma around poverty, homelessness, race, and mental illness. There is not a single person among our client participants who is not dealing with a minimum of two, and many three and four stigmas. We interviewed 30 clients overall, including 25 African Americans, two of which were women. Out of the 30, five were Caucasian men. The ages ranged from 18 to 71, with an arithmetic mean age of 37.

Of the 30, 37 percent graduated from high school. However, if we break the percentages down by race, then 80 percent of the Caucasian group have graduated from high school, indicative of a significant difference when compared with 28 percent of the African American group who graduated from high school. I do not include GEDs in this group, not because I do not think they are representative of an equivalency, rather to demonstrate how many of those interviewed were able to graduate from the public system of education. Of those aged 18 to 30, 17 percent graduated high school. However, if we remove the two Caucasians, 22-year-old Teddy and 26-year-old Abel, the percentage of the remaining African Americans who graduated from high school is 0 percent.

Among ages 31 to 40, 33 percent have a high school diploma. If the single white male is removed from this calculation, the percentage of those with a high school diploma increases to 40 percent. However, 80 percent of those in the age range 41 to 50 have a high school diploma. Remove Draco, who is white, and that percentage decreases to 75 percent, but of all the age cohorts this one has the highest proportion of high school graduates. In the 51 to 71 cohort, the percentage of those with a high school diploma is 43 percent. Once again if we remove Elliot, the single white male, the number of those having graduated from high school drops to 33 percent.

The addition of the Caucasian interviewees had the opposite effect on the percentages when it came to homelessness at the time of arrest. Of the 30, 40 percent were homeless at the time of their arrest. Of the 25 African Americans, 32 percent were homeless at the time of their arrest, and for the Caucasian group, 80 percent were homeless at the time of their arrest. Of the total 30, 67 percent have experienced homelessness previously. Remove the Caucasians and of the remaining 25 African Americans, 60 percent have been homeless. Among only the Caucasian group, 100 percent have previously experienced homelessness. (See Tables Below)

Table 5 Summary of Education and Homelessness of Age Cohorts and Race

	Age 18 to 30		
	African American	**Caucasian**	**Total**
Number of Participants	10	2	12
High School Graduate	0%	100%	17%
Homeless at time of Arrest	20%	50%	25%
Homeless Previously	70%	100%	75%

	Age 31 to 40		
	African American	**Caucasian**	**Total**
Number of Participants	5	1	6
High School Graduate	40%	0%	33%
Homeless at time of Arrest	60%	100%	67%
Homeless Previously	80%	100%	83%

	Age 41 to 50		
	African American	**Caucasian**	**Total**
Number of Participants	4	1	5
High School Graduate	75%	100%	80%
Homeless at time of Arrest	25%	100%	40%
Homeless Previously	25%	100%	40%

	Age 51 to 71		
	African American	**Caucasian**	**Total**
Number of Participants	6	1	7
High School Graduate	33%	100%	43%
Homeless at time of Arrest	33%	100%	43%
Homeless Previously	50%	100%	57%

	Total Study Population		
	African American	**Caucasian**	**Total**
Number of Participants	25	5	30
High School Graduate	28%	80%	37%
Homeless at time of Arrest	32%	80%	40%
Homeless Previously	60%	100%	67%

Homelessness is a barrier to successful mental health treatment as Tequila, a social

worker with many years of experience succinctly puts it, **"**you can't maintain your health if you

have nowhere to lie down, so it starts with housing. It starts with the ability to care for

themselves. You can't take mental health medication if you don't have a place to lie down, no

place to keep it."

Tequila describes the following scenario, which all of the social workers interviewed

discussed as a barrier that is produced and maintained by complicated bureaucratic processes:

> A majority of my clients qualify for benefits. But it's the cycle of—like I said, you
> have to go to someone to fill out all the paperwork. You have to go to this
> appointment and that appointment, then this hearing and then that hearing. This
> can take two years. They already have been hospitalized, incarcerated. They can't
> make it. Or they finally get a hearing, and then they're in jail.

If a client does qualify and manages to receive SSI, with assistance in finding housing, the

process is still difficult and options are limited. So, in reality the struggle to subsist will be an

ongoing daily stressor for most of these individuals:

> And then I don't know if this is relevant to the question, but I know that my
> clients on Social Security, I think the max they get is, like $755, I just think that
> that's—not much at all, and it's insane. And when we place them—most of the
> places that we put them for housing that charge rent to clients with Social Security
> is around $600 a month, so that leaves them hardly anything. Even if you get food
> stamps, the most I've seen my clients get is, like, $195, plus the balance of their
> check is—already accounted for—this may come in another section, but I know
> they can take from your Social Security if you're behind on child support.
> (Jessica)

Homelessness is regarded as highly stigmatizing, as reflected in the various euphemisms

that participants used to minimize the experience. For example, Michael Wright considered

himself "borderline homeless" because his sister let him use her address to receive mail. Teddy

described "staying in a few shelters." Bobby noted that his "family moved a good bit."

Constantine recalled being evicted with his family when he was younger. Allen, the youngest

participant, was homeless at the time of his arrest because he could not live with his mother or she would face eviction because he had gotten into trouble. Other times homelessness was referred to as "the nights I stayed out" (Jonathan) or "thugging it out." (Morgan). The majority of Caucasian participants were homeless at the time of their arrest, and if not at the time of their arrest for long periods of time throughout their lives.

Stigma involves stereotyping and devaluing individuals according to the groups they belong to. Our participants experienced multiple sources of stigmatization. The general overview has been presented to reinforce the complexity of multiple intersecting stigma. We will move now to the chapters that discuss the specific findings from our research pertaining to mental health stigma.

6   MENTAL ILLNESS AND LABEL APPLICATION

Multiple labeling issues have impacted the participant group from this study, and how they are acted upon and act to construct one another is not easily delineated. The following chapters discuss the emergent themes and findings of this research specifically in terms of mental illness stigma. However, we do not see the viability of the reduction of any stigma in isolation, and so do not suggest isolation could form the basis of remedy.

Previous research has examined the types of mechanisms through which stereotyping results in discrimination against labeled individuals. Three general mechanisms of exclusion have been described by Link and Phelan (2001). Structural institutional mechanisms impact through reduced employment and educational opportunities. Interpersonal interactions refer to explicit as well as implicit discrimination. The final mechanism that impacts individuals is their own beliefs and behaviors (Link and Phelan 2001).

Emergent themes were identified from the data and discussed throughout the Findings chapters. Chapter 6 examines how the legal institution has attempted to adapt to the increasing influx of mentally ill clients. Attorneys have increasingly become De Facto Mental Health Service Facilitators, while still having to fulfil their primary responsibility of providing a strong legal defense of their clients. Attorneys and social workers offer critical insights into the dominant types of mental health issues they see, with and without formal previous diagnosis. Furthermore, these professionals offer a more nuanced look at client disclosure and the possible reasons behind resistance towards mental health labeling. As well as the shifting beliefs and values around labeling and mental health are examined and illustrated by the themes, "My Mama Says" and "I'm Not Mental Health."

Chapter 7 looks at stigma management, i.e. how people resist stigmatized identities through the strategies that are employed to deflect, challenge, and educate others concerning mental illness. The last chapter will explore the potential impact of mental health labels, beyond the immediate necessity that has made them the practical choice. Ultimately, any future deleterious consequences across the individual's life course must also be considered.

Chapter 8 addresses the types of diagnostic pathways and processes people interact with as they become increasingly more labeled. A crisis in services, education and social, precipitates this, making it increasingly difficult for people to resist the structural and institutional mechanisms that have tethered educational and social services to serious mental health labels. Both implicit and explicit discrimination affects this process.

Prior to presenting the findings from this research, I need to clarify my position on mental health and mental illness in general. I do this so no confusion exists regarding the resultant beliefs and values that I bring to this research. I do not question the existence of mental illness,

nor do I underestimate how the judicious use of psychiatric medication and concurrent interventions can, and does, create windows of opportunity for people suffering from mental illness. The concerns raised are based on the great potential for the misidentification of mental health conditions that leads to highly stigmatized labeling and over-prescribing of psychiatric medications.

I also do not seek to demonize people who are committed to helping those who suffer from mental illness in forensic environments. Relentless promotion by pharmaceutical companies has led to a proliferation of biased research findings and oversimplification of the diagnosis process, and this reality has permeated the entire mental health medical field. Practitioners and mental health service workers are constrained within the parameters of information that has been presented by the medical profession (Mosher et al. 2013).

Prisons and jails have been legally obligated to provide medical and mental health treatment since the Supreme Court ruling in *Estelle v. Gamble, 1976.* However, discussion around the need for in-house health care and psychiatric services had been discussed as early as the 1930 American Medical Association (AMA) meeting where members adopted the resolution put forward a year before by the American Bar Association to "support the principles around 'psychiatric service in criminal courts'" (Roth 2018:102).

Connected to this principle was the idea that a psychiatric report would be generated for every prisoner convicted of a felony prior to their release, and psychiatric services made available to "every penal and correctional institution" (Roth 2018:102). Little was done to make this into a reality until 1976 when *Estelle v. Gamble* made the provision of health care in jails and prisons a constitutional right. Individual legislatures were closing state hospitals on the

grounds that they were no longer necessary or beyond repair, thus beginning the normalization process of jails and prisons becoming major health care providers.

6.1 Diagnostic Perspectives

Mental health stigma is complex, and the various perspectives of this study's participants are valuable to show how different perspectives affect the process. Often the immediacy of needs motivates the labeling sequence, the goal being practical outcomes and solutions for a specific situation. However, the diagnosis may then function as a stereotype. As conceptualized by Corrigan, "this classification system incorporates the assumption that all groups have clear discernable boundaries (2007:33). Groupness, homogeneity, and the perception of stability influence the cognitive structures of stigma, thereby exacerbating stigma. "Diagnosis adds salience to groupness" (34), which along with stereotypes, according to Corrigan, have a bidirectional causal relationship.

Formal diagnosis provides the label that activates the cue for stereotypes, i.e. schizophrenic equals unpredictable violence. Diagnostic criteria provided in the DSM has augmented the stereotypes of mental illness that have been amplified and diffused by various media sources (Corrigan et al. 2015; Stout et al. 2004; Wahl 1992). The negative outcomes of exposure are overridden when services are tethered to diagnosis, but unfortunately its pertinence is only overridden in the context of immediate need by those who are seeking services, and not by those dispensing them, or society at large.

The contextual perspective here is purposeful action, and the shift from personal choice to socially constructed patterns of decisions including consultation with others. According to the principles of sociology (Pescosolido 1992), individuals learn about, arrive at an understanding and attempt to come to terms with difficulties. This approach is premised upon a revised rational

choice theory, that fundamentally allows for the consideration of individual agency, social structure, and context.

6.1.1 Attorneys as de facto mental health care service facilitators

The ways in which the various study participants operationalized their positions and roles in the indigent defense dynamic are remarkably consistent with one another. Divergent perspectives toward mental health and the role assigned to it within the defense dynamic emerged, but not any significant outliers. Depending on their roles, the individuals involved had to consider the constraints of their positions and environment, while simultaneously acknowledging how these influence their decisions. Diagnostic perspectives are part of a larger sociological issue of purposive action and the mechanism of medicalization.

Due to the increasing numbers of people with mental health issues that have inundated the criminal just system, the legal system generally, and for our purposes the public defender offices specifically, have become a de facto mental health care service provider for the increasingly and disproportionately criminalized mentally ill. However, it must be reiterated that the role of these agencies is first and foremost the provision of quality legal representation. This responsibility can be predicated upon individual clients' ability to assist in their own defense, which can lead to psychological evaluation. However, a client who is judged able and competent by the legal standard may not have access to mental health services.

The prevalence of schizophrenia, and conduct or oppositional order, was unanimously verified in the data collected from attorneys' examples include the following attorney excerpts. Table 7 below illustrates the cohesion and agreement of the types of mental health diagnostic labels that are mostly being applied to their clients. Attorneys estimated that the percentage of

clients they represent who have mental health issues ranged from 50 to 65 percent. They

estimated that about 10 percent of their clients are profoundly affected by these issues.

Table 6 Attorney Prevalence of Client Mental Health Issues

Sylvia	We get a lot of paranoid schizophrenia. We get a lot of schizo-affective disorder. We get a lot of bipolar. We get a lot of depression. Those are the big ones. We do get a fair – a mentionable amount of mood disorder, those kinds of diagnoses. Yeah. But we get a lot of the heavy mental illnesses.
Pinetree	You run into a good percentage of people. I wouldn't say--probably about a third. You would hear about--there's something that's going on that's been diagnosed that they--yeah, that they take medications for…bipolar and schizophrenic. And a lot of anxiety.
Jen	A lot of them do have a formal diagnosis, even if it was 10 years ago or--and they may not have been getting care since then, but a lot of them can remember, at some point in time, going to the doctor and being diagnosed… Bipolar and schizophrenic are the two most common. Depression as well.
Steve	Yes. I mean, formal diagnosis, possibly and frequently receiving SSI for the formal diagnosis…Schizophrenia is most common, and PTSD is second.
Michelle	50 percent with a mental health diagnosis, profoundly affected 10 percent, and then how typical is it for a client to have a formal diagnosis? That's just the 50 percent? And it depends on age. Because I think, age wise, the diagnosis names have changed over the years because the diagnostic criteria has changed, but I don't think it's--but the symptoms seem to be--like, age wise, there seems to be a group of symptoms of people called this, this, but I, you know, kind of--and based on what their medications are, you can kind of figure out what they currently have.
Batgirl	But I think the most common ones we see are oppositional defiant, conduct disorder, some types of mood disorders, whether it's depressive disorder or anxiety disorder or unspecified mood disorder. I guess because they can't diagnose them with bipolar yet or whatever.
Max	Conduct disorder, oppositional defiant disorder, ADHD. You don't see as much depression, although that's probably what it all is.
Chris	Bipolar, schizophrenic. Depression – a lot of people say they have ADHD or say they've been diagnosed with ADHD. Anxiety I don't see a lot of. Depression I do see a lot of. Honestly, bipolar, schizophrenic are probably the most common ones that I see.

Schizophrenia and bipolar diagnostic labels were prevalent among defender descriptions. They also included oppositional and conduct disorder, as well as ADHD, supporting extant research around predominant conditions in the criminal justice system (Cole 2006; Crisp et al. 2005; Peterson 2008). It is interesting that anxiety is mentioned, both as something an attorney doesn't see that much, and conversely as something that another attorney does see a lot of. These disparate accounts show how variations occur within diagnostic perspectives.

Matters of competency or incompetency also come into play. The latter is defined in terms of an individual failing to meet the legal standards of the community and therefore unable to assist in their own defense. In such circumstances, specific recourses are assigned to restore that person to competency including but not limited to treatment at the jail with psychiatric medication, or full evaluation and being sent to Georgia Regional Hospital, for forensic psychiatric inpatient care. The main difference between the FCJ restoration-to- competency treatment protocols and Georgia Regional's is that Georgia Regional can medicate even if a patient objects (Roth 2018).

Part of the criminal legal system's attempt to cope with the influx of individuals with mental health issues has been the creation of diversion courts, including drug, mental health, and veterans' court. These courts were created specifically to address the needs of specific clients who may be better served by these courts. The attorney is put in the position of deciding when a psychiatric diagnosis (label) is appropriate, either through activating an existing label, or instigating the application of a new label. The goal is to do whatever is in the best legal interests of their client.

Attorneys make the decision to recommend that a social worker see a client on a case-by-case basis. A key factor is the perceived potential of a client's mental health to impact the case

outcome. Some attorneys are more comfortable than others in this area. Factors that influenced

attorney decisions included the ability of the client to function in the jail if being held pending

adjudication, or the likelihood that the client might act inappropriately in front of a judge.

Often if clients have been taking psychiatric medication at the time of arrest and do not

disclose this information during the initial intake screening, they will no longer have access to

medication. They will decompensate in custody, creating problems for themselves in the jail.

Some clients may act in ways that will sabotage their defense during adjudication hearings and

trial. Plus, they could miss opportunities for diversion courts and possible re-entry assistance

from social workers.

Having become "De Facto Mental Health Care Service Facilitators", attorneys are called

upon to act as the gatekeepers of mental health services. Decisions to access services and

treatment are based upon complicated legal situations pertaining to the seriousness of the charge,

the potential for increasing incarceration times, and the possibility of negative outcomes if the

state is included in evaluating their client. All of which are strategic defense decisions. Actively

seeking treatment for mental health issues may not be in the best interest of their clients and is

therefore not a forgone conclusion:

> Sometimes I do. Sometimes I don't. It just depends. I am very familiar, just due to
> my own background, with mental health issues, and so I'm very comfortable
> trying to determine whether or not this is something that is going to affect the
> outcome of the case or not. And so I'll involve them if there's a medication issue.
> I'll involve them if we need to set up some sort of housing scenario or some sort
> of external community support through an ACT team or something like that. Or
> for confirmation on someone who may or may not be having competency issues.
> (Michelle)

Michelle references Assertive Community Treatment Teams (ACT), which are a product

of the public defender partnering with the United Way. Clients fortunate enough to be assigned

to an ACT team receive case management and medical, educational, and community support and

counseling. Up to 30 Fulton County Jail inmates receive individual placements annually. The United Way's in-kind services totaling $30,000 were matched by Fulton County in the amount of $30.000. (FCPD 2016-17 Annual Report).

Conversely, attorneys without extensive experience in the area of mental health depended upon the advice of social workers to assess the best path forward. All of the interviewed attorneys expressed gratitude for being able to consult social workers in their offices. And if presented with a clear choice they said they happily accessed social workers' professional knowledge by asking them to see clients. Attorneys described the pressure they feel not to overlook a relevant mental health issue and their recognition that they lack the training to recognize more nuanced issues:

> Personally, I want somebody who's even more familiar with the demographic or the population to talk to them, see what's going on. Because sometimes the way that I ask questions, the way that I do things, may not be beneficial to getting the most information from a person, particularly if they're dealing with those mental health issues. So I don't want to be in a situation where I didn't get the information, not because I didn't try but because I didn't ask them properly, or I didn't do X, Y, Z properly as far as that's concerned. (Pinetree)

There are various impact points throughout the legal process where a client's mental health directly affects placement and positioning within the system and how they travel through it. Below, is an excerpt describing the impact of a client's mental health on an attorney's representation:

> It's a pretty tremendous impact. I would say mental health issues are probably the most significant medical contributing factor to people being arrested, I would say, is mental health issues. And it affects pretty much every aspect of the case. The reason why they got arrested a lot of times is connected to their mental health issues. Whether they're able to function in the jail well or poorly is connected to their mental health issues. If they can come to court and resolve the case – sometimes they're not stable enough. They're not able to be brought to court. (Chris)

The Defense takes into account multiple factors when deciding whether or not to have a client evaluated, and by extension automatically makes that information available to the court. Attorneys weigh how these decisions will that play out in overall legal outcomes, including impact on the length of time that person will be incarcerated. When a charge is more serious, the defense is more to seek a mental health evaluation leading to a diagnosis, either by activation or application. For less serious offenses and misdemeanors, such as criminal trespass, the choice on whether to evaluate is not necessarily straightforward.

The following presents how attorneys consider multiple factors around whether or not to request psych evaluations for clients, even if they are displaying signs of mental illness. Attorney Chris's description encapsulates this reasoning process. He provides in-depth insight into the complex realities of how these situations unfold, placing attorneys in the position of deciding whether or not to initiate diagnostic labeling, as well as the significance of the number three arrest which triggers felony charges and automatic sentencing protocols:

> I had a kid who I think had had some kind of break, and he got arrested three times. I mean, he got out, two days later, rearrested. He got out, 2 days later, rearrested. His dad had died. He was going to pharmacies and stealing cough medicine because he thought he had to take it because if he didn't take it, it would give him cancer. And he'd had this trauma. But, he's 18, 19, and all of a sudden, you've got three arrests—you know, this lovely, perfect, pristine criminal history of nothing, and now you've got 3 arrests on there. And if he gets out, there's no reason why he's not going to get another one. Nothing has changed. It's not like he's medicated. On the flip side, am I going to keep him in jail for a couple of months? And usually it would be, "Okay, well it's the client's decision." Are they competent or are they not competent? And opinions vary on, "Hey, get him out of jail. It doesn't matter. You always want to just get him out of jail," versus, "Hey, you've got to do what's in their best interest," and sometimes that's them staying in jail so they actually get treatment. It's a really complex issue. And it's kind of a good—it's a good summary in some ways of how challenging the mental health issues are to deal with. (Chris)

Concern about lengthening incarceration times is an issue of pretrial evaluation that attorneys face in many states. When an evaluation or restoration of competency is required to stand trial, a 2015 survey of State Hospitals found that 78 percent of 40 participating states had waiting times ranging from 30 days to six months to a year, meaning that in some states the waiting time exceeds potential jail time (Butterfield 2003; Biswas 2017).

Attorney Pinetree also acknowledged that potential for additional jail time influences his decision process. From his perspective, "Yeah. Psych evaluations are tricky. Because – you may end up with a case where a person's charged with something that they'll be out of jail in two or three weeks. But once you file that psych eval, you should assume that they're going to be in jail for at least three months."

Why this process adds significant time to a client's incarceration is also outlined by the attorney:

> Because you have to go, you have to see the doctor, you have to go through the process, you have to do all this stuff, and it's backed up, of course, and things of that nature, so I mean, a lot of times, I do, with those particular types of things—I try my best to avoid filing a psych eval because of the fact that I don't want it to be a situation where you're—somebody's stuck in jail for an extended period of time because they don't necessarily understand. And it's weird because I don't want you on probation and you're not going to be successful on probation, either.

The likelihood of successful probation is another consideration that attorneys take into account. Clients who would not be successful while on probation proved to be another impetus for mental health intervention. The exploratory assessment conducted with the DeKalb Public Defender by Tanya Link focused specifically on parole revocation and how to mediate it among this population. This assessment examined probation revocation and barriers to successful probation completion. Although not specific to mental illness stigma, increased costs of mental health evaluation and treatment were a noted factor.

Another factor that affects the attorney decisions regarding client mental health status is

which judge they will appear before. Attorneys must gauge how specific judges react to mental

illness issues and how their attitudes affect the best interests of their client:

> It's always questionable how much you want to reveal about their mental health
> anyway. Because some people, they hear, "Oh, this person is bipolar
> schizophrenic," and they say, "Well, they need to be locked up somewhere." And
> then sometimes it's, "Oh, well, yeah. We need to get this person some necessary
> treatment," and things of that nature. (Pinetree)

Attorneys will actively seek ways to assist their mentally ill clients without

compromising their legal cases as the following excerpt from attorney Sylvia illustrates:

> We don't—yes. We don't like to ask for that kind of involvement if we don't have
> to. Because it does, it completely slows things down. But also, you know, there's
> the court – there are the court-contracted psychiatrists who do certain evaluations,
> and then there's our social work department who does certain evaluations, and so
> the severity of their symptoms and all of those things come into play because, if
> you don't have to do the court-appointed psychiatrist – if you don't have to get
> them involved, you don't want to get them involved. You'd much rather have a
> social worker go and talk to them and try to educate them, and let's see if we can
> meet their needs that way. (Sylvia)

Stigma towards those with mental illness manifests throughout the legal system,

including each judge's level of understanding and experience, both personal and

professional. No standard exists for this dimension, making it a capricious factor in a

legal process that is already very much impacted by stigmatizing beliefs and both implicit

and explicit racial prejudice. Outcomes vary and are dependent upon an individual's

charges, your demeanor and how one is able to comport oneself in the courtroom, and jail

situations:

> So sometimes people run into issues with the jail staff because, of course, they're
> not mental health experts, either, so you know, they may see something, that a
> person is having some type of episode or something of that nature. They may see
> that as that person trying to be combative or something of that nature, and they
> may respond with force or other tactics, as opposed to trying to figure out how we
> can handle this in a better way. (Pinetree)

In sum, attorneys have come to occupy a position of De Facto Mental Health Service Facilitator within the legal system, which itself has come to occupy the position of mental health service agency. Although the gradual implementation of diversion programs and various specialty courts have attempted to address this reality, a disconnect still occurs in true access to services including the availability of timely psychiatric evaluations and provision of psychiatric inpatient treatment. Attorneys must weigh the benefits and costs of active mental health intervention for their individual clients from the perspective of successful case adjudication, and this evaluation does not necessarily encapsulate mental health treatment.

Because the decision is predicated upon a client's immediate legal reality, longer term ramifications are not considered, other than the effects on length of incarceration. The immediacy of the circumstances are most often the result of structural constraints that define the interaction, and the rational choices available to individual actors are limited in this dynamic.

Attorneys also provided nuanced insight into what may lead to a client's non-disclosure of a mental health issue. Clients themselves may not know how to articulate their experience. Too often failure to disclose is framed as noncompliance or intransience (Torrey and Zdanowicz 1999) predicated upon the premise of individual choice. However, failure to disclose is not always a choice and could be due to a lack of understanding on a client's part:

> Okay so—things that you learn during practice and representing. You learn that, for a lot of young men, the onset of that mental illness--when it manifests—is 18 to 23-ish—that young. And so that's the other time it comes up a lot because you'll have these young clients who don't know how to articulate what it is that they've been struggling with. (Sylvia)

Another client issue faced by the public defender offices is dual diagnosis. This challenge is not limited to mental illness and substance abuse but also can comprise mental illness and developmental issues, or intellectual disability (ID). Intellectual disability is very highly

stigmatized and also provides unique challenges around legal definitions of competency. A person may have a mental illness, but if sent to Georgia Regional Hospital and also severely intellectually handicapped, they may not be restored to competency and languish in the hospital for a very long time.

Fortunately, both offices involved in this study have actively taken steps to partner with other agencies and various community partners to address the unavailability of recourse for their mentally ill clients who are disproportionately involved with the criminal justice system. The focus is holistic involving mental health and substance abuse related treatment while concurrently addressing housing and other benefits, increasing the likelihood of success when the criminal case is adjudicated.

6.1.2 Social worker perspective of client diagnosis

For the clients that the attorneys refer to social workers, the issue may be one of competency, and the hope is to avoid the glacial process of formal evaluation. Or sometimes a specific judge may request a treatment plan. Attorneys can also refer because they think a client would be a good candidate for involvement with an ACT team. The excerpts below illustrate the likelihood of their clients having a pre-existing formal diagnosis. And if so, what do you see the most of and when do you get resistance to disclosure?

Table 7 Social Worker's Prevalence of client Mental Health Issues and Diagnosis

Giblet	It's typical…oftentimes we get the records, and yes, they do show an axis I diagnosis.
Jessica	Okay. Gosh, I'm trying to think. Of all of my mental health clients, most of them have a diagnosis. Every once in a while, I'll get a younger client who's having an onset or very recently diagnosed, but usually, they've got something somewhere.
LaToya	Most often ADHD. Bipolar.
Lisa	A good number of them have actual diagnoses… A large percent.
Minerva	Oh yes most of my clients do, probably 70%
Rhonda	I would say maybe about half my clients have a formal diagnosis
Susie	Many of them…many, many, many
Tequila	Since I've taken this job, I want to know why so many young black men have schizophrenia. It is overwhelming. I mean Jesus Christ, I've never seen – I don't get it. I know I'm not a mental health expert. That is not what I went to school for, but how is – and I'm not talking about playing schizophrenic. I'm talking about not knowing their name and flinging poo at people, real schizophrenic. Because this county's full of all kinds of people. But it's not full of white schizophrenic dudes. Latin schizophrenic people. I don't get it. I don't get why so many young African-American men are schizo. It is stunning to me.

The social workers provide further insights and nuances regarding clients' lack of disclosure about their mental health history. Severity of mental illness is a factor in whether or not a client discloses, but the point that not disclosing should not automatically infer intentional obfuscation on the part of the client is also reinforced by the social workers.

Social workers provide additional perspectives that are reflected in the studies around stigma. In the next excerpt, a social worker describes different types of clients, including those with severe mental illness and those who are dealing with more moderate mental illness but, in her experience, do not disclose. Possible explanations for nondisclosure include wishing to avoid stigma, not wanting people to interfere in their lives, and just wanting to be normal:

> Some of them. The ones that are—I'd say some of them. I can't tell you any percentage, but—yeah. I think the ones who are really, really, really severely mentally ill a lot of times aren't very forthcoming because you have, I guess, the stigma that's attached to that, and they don't—some of them just don't have insight into their mental illness (Rhonda).

> And then some of them don't want to acknowledge it. Some of them, I think, know they are mentally ill but don't want to acknowledge it. Because they don't want the help. They don't want you meddling in that, you know? And then you have some clients who and I'm just thinking in my mind that the clients who are less—who have less severe diagnoses—they just don't want to deal with the stigma, you know? They just want to feel normal (Rhonda).

Willingness of clients to disclose mental health issues varies for different reasons. According to social worker Giblet, they are often influenced by possible repercussion of stigma associated with mental illness, or they may be so ill that they cannot disclose:

> I'm sure that there are clients that they don't want to have a mental illness. Or they're embarrassed, the stigma, that they will not disclose. Or we have clients that are so ill that they just can't even disclose (Giblet).

Social workers also describe age as a factor when it comes to the likelihood of disclosure. Age also is presented not so much in terms of the actual chronological aspect as much as the cumulative life experience people possess:

> I would say younger people have a hard time disclosing mental health just by nature of—they're young. They don't want to have a mental health stigma. And people that are older, they're a little beat down (Giblet).

The fact that older people may be less recalcitrant about sharing personal mental health information could be reflective of consequences that individuals have experienced by living with stigma for a longer duration. Studies have shown that expectations lower as people age. One explanation may be that individuals with severe mental illness lower their expectations in terms of what they might participate in or achieve. Furthermore, narrowing aspirations and expectations have been shown to occur over time (Corrigan and Watson 2002; Killaspy et al., 2013).

Previous experiences around mental health treatment are also a significant barrier to disclosure. These experiences are combined with the wish to avoid stigma:

> Because I think there's really a stigma for mental health for everyone, unfortunately... Like I know some of my clients, when they're asking me to try to help them with medication, I always ask them, "Well, did you tell the jail that you needed this? Or that you have a diagnosis?" and an answer I get a lot of the time, "No, I didn't want them to put me in the padded room" (Jessica).

Education is the prevalent strategy used to respond to these types of concerns, demonstrated by Jessica's excerpt below:

> Well, I try to address any specific concerns, so if they say, "I'm afraid of going to the mental health floor," or "I'm afraid of going to the suicide watch," or whatever, then I explain to them… "Not everyone with mental health goes to the mental health floor. That's up to the jail," and I really just try to frame it in a positive way. "My job is to help you. That's why your attorney sent me" (Jessica).

Public stigma becomes personally relevant when it influences the expectations of individuals, per the modified labeling approach. Those who are labeled mentally ill share the belief that they will be discriminated against and devalued (Link 1987; Link, Cullen, Struening, Shrout, and Dohrenwend 1989). This fear of discrimination becomes a barrier to a client's full

disclosure. In the context of dual diagnosis, people fear that disclosure will keep them from being eligible for programs:

> The other thing is a lot of clients will not disclose mental health because they're afraid that it will keep them from getting into a program, for instance, a drug treatment program. And so I make sure to tell them that there are programs that take dual diagnosis clients. (Jessica)

This fear is not an unrealistic one. Studies have demonstrated that the harshest stigmas are, in fact, reserved for those who have a dual diagnosis of schizophrenia and substance abuse disorders. These individuals are not only viewed as dangerous and unpredictable but also responsible and guilty for their condition (Crisp et al. 2005; Schomerus et al. 2011). Ultimately, for individuals, it is more harmful not to disclose because of the possibility that that person will be put into a program that is not equipped to handle their entire mental health needs. The result may be that person getting kicked out and ultimately violating parole.

6.1.3 Client perspectives of being diagnosed

The responses of individuals to their own experience of being diagnosed with a mental health illness illustrate how the understanding of mental illness and its perceived causes and ramifications develop both within and across age cohorts. The etiology of mental illness impacts both the stigmatized and the stigmatizer—of others and/or the self. Link and Phelan's (2001; 2013) introduction of the "us" and "them" construct for the stigmatization of the other demonstrates the underlying foundation for persistent discrimination across multiple domains and various levels.

Participants reported being diagnosed at school, by psychiatrists, general practitioners, psychologist, and social workers. Participants had strong feelings about potentially being stigmatized for having a mental illness diagnosis. The three components of public stigma were prejudice, stereotype, and discrimination (Link and Phelan 2001). Both participants who have

and have not been diagnosed shared thoughts about how they would expect to be treated if they were mentally ill. Expectations were given as reason for not seeking help and is supported by much of literature (Angermeyer and Matschinger 2003; Corrigan et al. 2003). Interacting mechanisms between structural stigma (Link and Phelan2001) and individual stigma were found to impact mental health negatively (Griffith 2014; Yang et al. 2007).

Diagnostic labeling both helps and hinders individuals and their families because people receive services based on their diagnoses (Rosenfield 1997; Thoits 2016). However, another consequence of receiving treatment can be a diminished social circle overall, a phenomenon referred to by Perry as "the labelling paradox" (2011). Thus, acquiring a formal label can simultaneously be beneficial to core social networks, but have negative affects among peripheral ties (Perry 2011).

The original intended purpose of psychiatric diagnosis was to better understand mental illness. However, according to Corrigan (2007), it also has produced the unintended consequence of being the means by which the general public has come to formulate negative attitudes towards what they perceive not only as a homogeneous group, but also one that is not likely to change or improve significantly.

Participants were asked whether or not they had been formally diagnosed with a mental illness. The findings across age cohorts show that the younger participants reported that they have been formally diagnosed, or if they did not remember being formally diagnosed, they could recall being on medication. Although I question the motivation and profit margins that pharmaceutical companies have sustained, I do believe that people with mental illness can benefit hugely if they receive a correct legitimate diagnosis and drug protocol.

The following tables are provided to illustrate the general experiences around diagnosis. The tables are broken down from ages 18-30 and 31-44, although some participants between the ages of 18 and 44 did not report a mental illness diagnosis. No one over the age of 44 reported being diagnosed with a mental illness.

Of the participants between the ages of 17 and 41, 67 percent disclosed that they had been officially diagnosed with a mental illness. In comparison, a diagnosis was reported by only 17 percent of participants between the ages of 41 and 71. Of three white males under the age of 41, two reported mental illness diagnoses. The remaining two white males between the ages of 41 and 71 did not report a formal mental diagnosis. Both of the African American women in the study reported formal diagnoses; one was below age 41 and one was above. I relied entirely upon the self-reported experiences of participants. I did not question any self-reported diagnosis, nor did I assign to any participant a diagnosis that they did not self-report.

Table 8 Client Response to Diagnosis Ages 18-30

Participant	Response to Mental Health Diagnosis
Allen 18	ADHD No, I know I have it. But I'm saying, they, the doctors – something like that. It was something. I know what it probably was. I went to school, and they told me. I had pills when I was younger for it. I think that was after I got older. They just wanted to see was I okay mentally. But I had anger management problems, so they – I had to go to anger management.
Bobby 20	They did testing to see, when I was in middle school, to see if I had attention deficit disorder… But I never got tested for special needs class. Because like I said, my grades were pretty good. Yeah. They put me on the Adderall medicine, but I never would take it. I just faked like I took it and spit it out. I actually took it one time, and it just had me like a zombie. I just didn't like the way it made me feel.
Beastmode 21	Seizures when younger "I don't recall what kind" Never been diagnosed but I have been sick. I was taking medication for depression. Xanax and then something else. Because they were saying the depression I was going through"
Teddy 22	Yeah, I've been diagnosed with schizophrenia, and I don't know. I talked to a few different psychiatrists. I talked to somebody here, and they – I don't know. It seemed like they disagreed or something, but I've been diagnosed when I was 16, and I've been – when I was in the psych ward, they seemed to, I think, agree with that diagnosis, so I don't know.
Dwayne J 22	Developmental Disorder
Chris Smalls 23	"Bipolarism" - I don't know how that came to me, you know? But the doctor told me sometimes it don't show – you have schizophrenia and you don't know it, and it don't shows up until probably like you're 18 or whatever. So many times. I've been to the same hospital more than one time, like different hospitals In Miami. Even up here. I got called on.

Table 8 Client Response to Diagnosis Ages 18-30, (continued).

Participants	Response to Mental Health Diagnosis
Ninety-Three 25	I don't mind. I have bipolar disorder. Now I see. Now that I'm older and I've become more mature I'm like, "Yeah, you was bipolar." Back then, I was, "I ain't got no problem," but yeah, now I see it.
Morgan 25	In my adolescent years, I suffered from depression due to my grandmother's death in my earlier years, but I don't know if I ever got past it, but other than that, that's the only thing that I could say possibly to. So that's why I said possibly.
Constantine 26	I need to help myself Worried people would think I'm crazy
Abel 26	Been in treatment multiple times for Heroin Addictions
Reggie 30	No. I be in here so long, and it's done made me depressive.

Table 9 Client Response to Diagnosis Ages 31-44

Participant	Response to Mental Health Diagnosis
Teresa 31	Depression when I was 13. My dog got hit in front of me on the way to school. So I was kind of depressed. Yeah. And I went to school and got on top of the school building. I was trying to hurt myself. I was trying to kill myself.
Jon 32	I don't know. I was at my mom's house, and the sheriffs pulled up, and they took me to DeKalb Crisis Center. I guess it could have been an evaluation of some sort. I don't know what it was about. I didn't like it. And they asked me if felt like anything I was mad. I just wondered, "Why am I here?"
Week 36	They sent me to a private doctor, a psychiatrist, and he gave me the Ritalin. And he thought bipolar schizophrenic, and I had a hard time sleeping. Bipolar—I mean schizophrenic bipolar
Albert Einstein 40	I've been diagnosed with paranoia, a lot of issues. Paranoid schiz, grief – it's a whole – he said I had a whole set of this stuff going on. Yeah. Bipolar. Depression.
Kim K 42	Schizophrenia. At least I know that I might be crazy, I have a behavior disorder. I take my medicine. So at least I know somethin' goin' right with me. All these other people out here? Somethin' wrong with 'em because we all born with something that is wrong with us.
Draco 44	No, but I do feel that I have PTSD. I was assaulted 14 times last year. No, I have not been fully diagnosed. I am in the process of trying to get a dual diagnosis. I would like to receive some mental assessments, again, because I do believe I have PTSD.

6.1.4 Clients and mental illness in the family

Many of those interviewed in this project have lived with the mental illness of close family members, both officially diagnosed and anecdotally supported. These experiences have informed the subsequent beliefs and attitudes many participants have toward mental illness, those who are mentally ill, and the various etiologies ascribed to this condition. Familiarity and interaction with those who are mentally ill often has been seen as a factor that decreases stigmatization, an observation both supported and refuted by this study.

Research has indicated that if interaction has been positive, it can serve to counter negative media images; conversely very little negative media messaging can significantly reinforce stigmatizing belief systems (Corrigan 2007; Pescosolido 1991, 2003; Pescosolido et al. 2008: Pescosolido and Martin 2015). However, overall studies reviewed have indicated that no matter the quantity of experience or knowledge of family members of those experiencing psychosis, stigma will still factor into decisions to seek help (Boydell et al. 2013; Gronholm et al. 2017).

Both Chris Smalls and Ninety-Three had mothers who had been diagnosed with Schizophrenia. Chris, diagnosed with schizophrenia himself, had lived with an uncle in Georgia who because of his own mental illness, could tell when Chris may have missed a dose of medication. The uncle would tell him *"you've got medicine, take it."* He was able to recognize this because, according to Chris, he took medicine himself on account of "you know—he was mental because he was in the military, too." He was referencing his own father who had been in the army. Chris did not know his uncle's specific diagnosis but knew it to be "more than depression."

Constantine reported having a number of family members who are "crazy," and one of his uncles "was really crazy from being in prison so long." When asked to elaborate about what that looked like, he had this to say:

> It was like funny and ugly at the same time. He was just seeing stuff, like little green men, and you know, prison took a toll on him. He killed somebody by mistake, was driving or something like that. And they got killed by him somehow, and he spent like 15 or 20 years in prison. The prison made him crazy.

This etiology is significant for our purposes due to the stated impact that being incarcerated has had on interviewees' mental health and subsequent resistant strategies.

Draco's attitudes and fears about being labelled mentally ill were formed in early childhood and based upon his family's expressed perceptions towards other members with mental illness:

> Mental health and illness was just something you didn't really talk about. Um, my family has a history of mental illness… My second cousin. My mom's cousin graduated from high school at 14. She got her law degree by the time she was 18. And she was in the loony bin by the time she was 20. Oh, put away forever. She had a formal diagnosis of schizophrenia with delusions and paranoia.

Reacting to mental illness with secrecy and shame was also something that Michael Wright had learned from his childhood, growing up with his father who everyone called "Crazy Jack" and who was known for his violence. Michael felt the impact of this labeling as a lasting sense of shame. Michael also reported having other family members with bipolar mental illness, and he feels regret that he has not always been accepting or nonjudgmental toward them. "And Lord forgive me, because I've said things that are hurtful to my sister and brother—Yeah. I said, "I can't deal with you mental health motherfuckers."

Kim K's family also has a history of mental illness:

> Well, basically, my mom['s] mother had a behavior disorder. I don't know what was her diagnos [is]. My father, I think he was fine. We have come so far along with dealing with people with mental illness, behavior disorders, schizophrenia.

Other people in the study described their children's diagnosis and how earlier experiences of seeing a family member medicated informed how they responded when their own child was going to be medicated. For example, Cee Pressure was not supportive of his son taking medication for his recently diagnosed ADHD. His cousin had taken that type of medication and as a result, "all he ever did was stay in the house, stayed in front of the TV. It kind of made him worse… Yeah. It took away his drive. It took away his wanting to go outside and be a regular kid." This experience has impacted how he will navigate his own son's diagnosis.

6.1.5 "My mama says…"

A shift appears in the attitudes of mental illness stigma and the meanings associated with it that are passed intergenerationally (Mathews et al. 2006). The prevalence of schizophrenia diagnosis in the African American community is well-documented (Atkins-Loria et al. 2015; Metzl 2009). But one trend that social workers see in their younger clients is a willingness to disclose that they are schizophrenic, not that they necessarily have a formal diagnosis. As one social worker explained:

> You always have those who feel like they have a mental illness because their mama told them that they had a mental illness…My Mom told me I was bipolar," or, "Schizophrenia is in my family. My Mom said I'm probably schizophrenic," and so they may be going on that information and not ever have had a formal diagnosis. (Lisa)

However, when the social workers followed up, attempting to locate the relevant diagnostic paperwork, they would find that the client's mother diagnosis was not supported by the relevant medical records. This is reported by the clients as "my mama says…" Another social worker describes that she hears this a lot from parents, "we have a lot of kids—the parents will say, 'Something wrong with him. His daddy was crazy, too.' Both the social workers have characterized this labeling as being a powerful negative at a young age.

Three study participants under the age of 30 reported that their mothers had been diagnosed with schizophrenia, and as a result, they thought it was likely that their children (meaning them) would have the mental illness as well.

According to 25-year-old Ninety-Three, his mother has a schizophrenic disorder, and she has told him that he is schizophrenic as well. He describes it this way: "A piece of that it is in me and my brother—I suffered from it, you know, talking to myself and things like that, but it's controllable. It's not—I've never seen myself lashing out and not being able to control it." According to his mother, her doctor told her to have him and his brother examined or evaluated for schizophrenia because it runs in families. His mother signed him into Grady when he was 8 or 9 years old. Ninety-three believes he was bipolar at that time but no longer suffers from that condition.

Chris Smalls was familiar with mental illness before being diagnosed himself. When asked if he was the only one in his family who suffered with from mental health issues, his response was, "No. I got my mom. She suffers from schizophrenia. That's the only thing she suffers from. And she takes medicine for it. She takes Risperdal, too." He added:

> When I figured out she had schizophrenia, it was crazy because, first of all, I wasn't suffering from nothing at first. I don't know how that came to me, you know? But the doctor told me sometimes it don't show—you have schizophrenia and you don't know it, and it don't shows up until probably like you're 18 or whatever. And that's when I started going to mental institutions, when I was 18. I didn't start going to mental institutions until I was 18, but it started showing up when I was 16 or 17.

Chris Smalls' father was in the military and often away from home. But, because his mother would take her medication, she was able to manage when his father was away.

> Yeah, he did, but half of the time he'll be gone, so my mom is just there. But she takes her medicine anyway, so that would keep her stable, so it really wasn't like he was worried. Because she takes her medicine, so if we driving her crazy, she'll go take her medicine, and then, you know what I mean? When we were younger.

A point came when Chris's mother was not able to care for the children and his father had to leave the military to look after the family. Chris also shared that he felt that the time that he spent with me was therapeutic for him. This attitude is also how interviewees in a study about growing up with schizophrenic parents framed their interview experiences (Nieto-Rucian and Furness 2018).

A number of studies reference increasingly negative attitudes of those who are diagnosed with schizophrenia (Angermeyer and Matschinger 2003). Similar findings of intense negative stigma have been found to be directed at those diagnosed with schizophrenia, even if respondents have an understanding of biological models for mental illness (Angermeyer et al. 2011; Kvaale et al. 2013; Schomerus et al. 2012).

People suffering from schizophrenia and schizoid affective spectrum disorders are viewed as unpredictable and dangerous, and these perceptions are increasing worldwide. This phenomenon has been documented in Germany (Schomerus and Angermeyer 2017), England (Crisp et al. 2005), New Zealand and Australia (Vaughan and Hansen 2004; Reavley and Jorm 2012, 2014).

The younger participants are the ones who describe the "My mama says…" diagnostic process, however, the oldest participant, 71-year-old David, presents us with a startling contrast to the experience of Chris and Ninety-Three. His account indicates that everyone's mama was not always so relaxed around the idea of mental illness.

David tried to quit drinking. Because he had no insurance, he was given the opportunity to get treatment at Georgia Regional Hospital. However, he found the environment there so challenging that he didn't last a month and called home to his mother to get his brother to come and pick him up. David went to great extremes to make it clear to his mother when he called her,

that he was not a "lunatic" and that he had not gone "crazy." He implied that to have done so would have been disrespectful to her. The Excerpt describes David's anxiety around being seen as mentally ill:

> Not too long because--it wasn't even a month because I got on the phone and called my mama, and I told her--I said, "Mama, the only thing is now, don't get me wrong. I ain't crazy, but they've got me over here at Georgia Regional." She said, "What?" Then she sent my brother over there, and he came and got me out. Yeah. I explained everything to her first, you know? Where she wouldn't think no more about this…Think I'm a lunatic.

From David's perspective, to become mentally ill signified being disrespectful to his mother:

> No, yeah. Because I always gave my mama respect. My mama was my mama. She was my big sister, my best friend, everything. But she done passed now, so--Because me and my mom, we're tight. We were tight. Because she knew I wasn't crazy, and I wanted to let her know that I hadn't flipped on her.

> David's account presents us with what appears to be an extreme cultural shift in

contemporary perception of mental illness compared with other age cohorts and structural contexts.

Divergent examples include Cee Pressure's response to his son's diagnosis. And social workers with experience in the juvenile defender's office describe situations where parents do not support mental health intervention for their kids, "we have a lot of that, and the attorneys will say, can you go talk to the kid and see if you think that they need a referral because I think they could probably benefit from seeing talking to somebody." Again, we are seeing legal professionals in the role of deciding whether to instigate or possibly to activate a mental health diagnostic label.

6.1.6 "I'm not mental health"

Disclosure about previous medical treatment for mental illness also can vary according to age, and statements such as "I'm not mental health," are, according to social worker Lisa, really a short form for "I'm not sick," "I don't have a disorder," "There's nothing wrong with me." This expression of inserting "mental health" for "crazy" supports the findings of Mathews et al. (2006) in their examination of African American community norms involved in shaping attitudes and behaviors toward mental illness stigma. The results of their qualitative study suggested that a strategy for reducing mental illness stigma and increasing the use of mental health services (if available) included disproving the belief that mental health treatment is synonymous with "being crazy," "being hospitalized in state psychiatric facility" (Mathews et al. 2006).

The term "mental health" also shared a negative association among homeless youth in the UK (O'Reilly, Taylor, and Vostanis 2009). One of the participants described a typical exchange between inmates at the jail (Dekalb) during which they call each other "mental health" as an insult, as in "You're mental health." The implication of this was "crazy." This behavior also is supported by the 2006 findings by Mathew et al., in which the phrase "mental health" is strongly associated with being crazy, and a recommendation was made to change this language.

Interestingly, the term "mental health" was also applied by the professionals who were interviewed. Jessica uses the term to illustrate a strategy for helping her clients be more open about their conditions, after they have indicated that they believe any type of mental health diagnosis and treatment will automatically send them to that floor at the jail. "Not everyone with mental health goes to the mental health floor," she says. This example is also indicative of how previous experiences shape and inform disclosure.

Draco reported overhearing the following exchange: "Why are you getting angry? Your

mental health? You know. Now you're getting angry because you're being aggressive against this person and you're trying to take something that was theirs." The meaning was an insult, and Draco does not wish to be "stigmatized" (he was one of the few participants to use the words stigma and stigmatized):

> Yeah. It's absolutely an insult. And I don't want to be stigmatized having any kind of mental illness. And when I fill out my sick calls on the kiosk, I make sure nobody's watching because I don't want them to see I'm putting in mental health consult...Now, unfortunately, um, people know who these social workers are because these guys are in and out of this facility all the damn time. So when the social came around, "Oh! You're seeing mental health!?"

Not only does this example have implications for Draco personally, but it is indicative of how beliefs and attitudes affect willingness to seek help or disclose a mental health issue among those who are involved with the criminal legal system. The impact of labeling on social and peer networks is evident in how the term "mental health" has been connected to negative personal traits, as well as being incorporated into the vernacular as short hand for "angry" or being frustrating to deal with. This connotation could certainly impact help-seeking and does.

The use of the term "mental health" as derogatory can be seen in the excerpts below. Michael Wright describes his treatment of mentally ill siblings:

> And Lord forgive me, because I've said things that are hurtful to my sister and brother—Yeah. I said, "I can't deal with you mental health motherfuckers,"
> And to torment someone like that, actually you don't know that you might have an underlying--situation, issue going on yourself…

Kim K also discusses the reluctance in the black community to be labeled with a mental illness. Kim believes the African American community is especially resistant to mental health diagnoses, saying "They're in denial because they don't want to be labeled as crazy." She sees a counselor on a regular basis and compares it with being married and having someone to speak too:

So like husband and wife. Let's say husband and wife, they got married; and you're talking to your husband or your wife every day. "Well honey, this what happen today," and blahza, blahza, and "I did this, and I did that. I went to the store, I bought groceries. I got everything off the bed." They have somebody they can vent with, they can talk to. It's about talkin' to someone for that hour or that 30 minutes, and you're fine. So that's how I see it.

Kim has found that her family, however, has not taken her diagnosis well. Kim employs the education resistance strategy. During her interview, she interjected information regarding the "Georgia Consumer Network on Sycamore Drive in Decatur. They help people with mental illness problems or behavior disorders, and you know, and they have certified peer specialists and I think it would be good for people to familiarize yourself with that."

Social worker LaToya agrees with the existence of resistance in the African American community to diagnosis, counseling, and therapy among adults:

Oh, yes! And this is huge in the African-American community. You don't want a label. We have parents who clearly have mental illness who are in such denial they don't want--they're not going to go see anybody because they don't want anybody to label them. They don't want to get that diagnosis. And we have a lot of resistance for therapy… Because in African-American community, it is taught "What goes on in our house stays in our house, and you don't discuss business outside the house." So they don't want to talk about what's going on. They don't want to talk about what they're feeling—because you're a stranger and I'm not supposed to talk to you. And that is because that's how people are raised.

Tony is the exception in his older male cohort at 58 years old. He admonishes those who hold back from getting help. Cultural resistance on the part of the African American community to help-seeking can be identified in this response by a study participant when asked about seeking help for himself or those close to him. Tony's response was ultimately one of two who framed it in the following way. And of the two, his is unique because he himself attempted and failed to get a response from a mental health care provider:

If you need some help, always just--that's the problem with the black race now. You've got a lot of guys that—they won't go seek no help, and then it's too late when they try to get it because just saying you're going to the hospital--like, okay,

I say chain gang but… when they on the street they will not go seek help for mental problems, health problems.

The variation in responses to mental health issues and mental illness labeling demonstrates the overall complexity of this area, as well as the inherent contradictions in what people associate with mental illness. Confronting the stigma that is attached to mental illness has become a significant role for the public defender offices. Programs and community partnerships have provided options and improved outcomes for the clients of both offices. Although related to the criminal justice system, expansion of these partnerships will provide mental health services and treatment options that continue to improve the quality of lives of people who have been shut out of the social programs that should be addressing these issues.

7   STIGMA MANAGEMENT

Participants have experienced diagnosis and early treatment efforts differently. How participants deal with a mental health diagnosis, their own or that of family members, provides a basis for understanding how they respond to, cope with, and attempt to manage the resultant stigma. Public stigma is conceptualized as the aggregate of individual prejudices, stereotypes, and discriminatory beliefs held by society (Griffiths et al. 2014). Studies support that anticipated stigma is greater than actually experienced stigma (Thornicroft et al. 2009). However, Lasalavia et al. (2013) indicated that increases in actual discrimination experiences and greater illness awareness led to an increase in anticipated discrimination (2013).

Understanding how participants anticipate being the targets of public stigma is crucial, as is exploring the actual lived experiences of discrimination pertaining to being labelled mentally ill. We ask what strategies (if any) are employed and how to resist the stigmatization process. Through the analysis of the narratives provided, approaches can be identified that both parallel

and diverge from previous theoretical conceptualization and empirical findings (Clement et al.

2015).

Many study findings support that anticipated stigma is greater than actually experienced

stigma (Thornicroft et al. 2009). However, Lasalavia et al. (2013) indicated that increases in

actual discrimination experiences and greater illness awareness did lead to more anticipated

discrimination (2013). Clinical studies have found that greater perceived stigma is associated

with less likelihood of treatment adherence (Sirey et al. 2001).

Various deflection or challenging strategies were employed by participants, who

anticipated being stigmatized and experienced actual stigma. In some cases, they were more or

less flexible in their approach to speaking about their mental illness to others. Strategies

overlapped and often were indicative of anticipated stigma. Previous treatment experiences will

be described to provide additional context.

According to the social workers, reactions clients' have to actual experiences in relation

to mental illness can increase the likelihood that they will not share information regarding a

diagnosis. Often this reluctance is because they've been hospitalized, and they're afraid if they

talk about it, it will happen again. Jessica communicates very clearly that she is there to help that

person obtain services and support. She also notes that sooner or later she will have their medical

records anyway, so they may as well tell her:

> My goal is to get you services, get you what you need, and hopefully get you out
> of jail. And I can't do that if you're not honest with me. And the other thing I tell
> them is that, if they don't disclose things to me, then that really just prolongs the
> process. Which is true, because I get medical records for all of my clients. So if
> they don't tell me something and I see it in the records, then I have to go back out
> and see them. Then I have to do this, and it, you know.

Previous experiences around mental health treatment are also a significant barrier to

disclosure. These experiences are combined with the wish to avoid stigma:

> Because I think there's really a stigma for mental health for everyone, unfortunately... Like I know some of my clients, when they're asking me to try to help them with medication, I always ask them, "Well, did you tell the jail that you needed this? Or that you have a diagnosis?" and an answer I get a lot of the time, "No, I didn't want them to put me in the padded room" (Jessica).

As noted previously, confronting the stigma that is attached to mental illness has become a significant role in the public defender offices, Both offices are utilizing programs and community partnerships to improve options and ultimately outcomes for their clients. Although related to the criminal justice system, these mental health services and treatment options have the capacity to improve the quality of lives of people who have been shut out of other avenues and social programs.

7.1 Previous Mental Health Treatment Experience

The way in which people experience mental health treatment, either initially or generally, impacts their attitudes to disclosure and help-seeking. Like ideas of procedural justice and experience with the legal system, if people feel they have been treated fairly, they will consider their experience as positive. Those people who feel they have been treated fairly and with respect by mental health care providers tend to have not only better mental health outcomes, but also an increased likelihood of better criminal justice system outcomes (Canada and Watson 2013; Corrigan et al. 2014; Watson and Angell 2013).

Participant experiences with mental health treatment ranged from seeing their doctor to being hospitalized, sometimes by parents or as a result of state intervention. The length of time that was reported in hospitals ranged from a couple of days to over a year. Some people reported being hospitalized on multiple occasions.

Allen and Bobby have both been diagnosed with ADHD, and both were on medication. Allen felt the medication was helpful and described being able to concentrate better until for

some reason—he is not sure why—his mother did not fill the prescription. Bobby would hold the medication in his mouth and then spit it out. Beastmode has taken medication for depression and anxiety but only for around eight months.

Dwayne J has been evaluated for a developmental disorder, but "Mental Health. No. I ain't never—no, I ain't never had no mental health issues."

Teddy has been hospitalized twice, at Ridgeview and Anchor Hospitals, both in Atlanta, "I was in the psych ward for a week and a half, I believe, and then they released me, but when I was 16, I was in there for a few months. And I actually only was released because my insurance just wouldn't cover anything else."

Chris Smalls has had mixed experiences with regard to treatment In Miami. He felt threatened the hospital by older patients. He would have been 17 or 18 at the time. However, he felt his experience at Georgia Regional Hospital was helpful. There he realized that other people were dealing with more than just mental illness, and that made him feel better about himself:

> So, it's like, "Dang! I'm suffering from this," you know what I mean? I'm trying to wade through my depression, my schizophrenia, my bipolarness, and these folks are working through not just—that--but physical sickness, you know what I mean? Some have got birth defects, you know what I mean? It's like--you know, you're around that, and then you're like, "Wow." You're actually saying this yourself, you know what I mean? You in the environment of those people.

Morgan was not sure if he had been diagnosed with a mental health issue, but he was certain he had not been treated for depression. He says: "In my adolescent years, I suffered from depression due to my grandmother's death in my earlier years, but I don't know if I ever got past it, but other than that, that's the only thing that I could say possibly to. So that's why I said possibly."

Ninety-Three was taken to Grady: "I was 9--8 or 9 maybe. I was diagnosed with bipolar disorder." His mother brought him to the hospital because she thought, "I was having mood

swings, like I'd be happy, mad, happy, mad. She thought it was the environment or maybe our neighborhood, but it was really just me." Ninety-three describes how he would "use the drugs to hide it."

Abel has not been in treatment for mental health issues, but he has been in multiple long-term residential treatment facilities for heroin addiction.

Constantine has been in treatment at Georgia Regional because his parents thought he was going to kill himself. Teresa was hospitalized at 13. A caretaker at her school saw her go up on the roof and thought she was going to jump: "Yeah. And I went to school and got on top of the school building. I was trying to hurt myself. I was trying to kill myself." As a result, she was hospitalized for 72 hours: "Yeah. Because I was kind of hysterical. I had an asthma attack. I was having panic attacks. All types of stuff just going on." She was subsequently diagnosed with depression. She was prescribed medication and attended counseling sessions on her own and with her mother.

Jon described the first of what were to become multiple inpatient experiences that began when he was 20. "Right. They did send me to DeKalb Crisis Center one time." However, he has no idea why:

> I don't know. I was at my mom's house, and the sheriffs pulled up, and they took me to DeKalb Crisis Center. I guess it could have been an evaluation of some sort. I don't know what it was about. I didn't like it. And they asked me if felt like anything--I was mad. I just wondered, "Why am I here?"

He has been at the DeKalb Crisis Center at least one more time and was an inpatient at Georgia Regional.

Week was diagnosed early in his childhood. In 2000, he was taken to Grady at age 25 or 26 because he was "breaking stuff." He had not been able to access his medication. Week does not have a problem taking medication, psychiatric or otherwise, but his dosage was interrupted

when the place he usually got it closed down. Despite having Medicaid he could not get his prescription filled in Marietta. They kept him at Grady for "a night and a half. They gave me my medicine, wrote me a prescription, and let me go the next day."

Albert Einstein was diagnosed in Georgia around three years previously. He says: "I've been diagnosed with paranoia, a lot of issues… I was incarcerated at the time, too. Paranoid schiz, grief—it's a whole--he said I had a whole set of this stuff going on." I asked who "he" was, and Albert reported that he had been "seen by psychiatry." I asked if bipolar had been included in the diagnosis, and he said yes. They put him on Prozac, Tramadol, and Seroquel.

Kim K experienced an episode of extreme psychosis after her daughter was born. And more recently, she spent a year at Georgia Regional Hospital. After suffering a stroke at the Fulton County Jail, she was taken to Grady where she was finally identified as being in deep psychosis.

Draco has not been hospitalized for a mental illness, although he has taken medication for depression. He is HIV positive and homeless. He is able to get medication because he was honorably discharged from a branch of the armed services after sustaining an injury in training. He found out he was HIV positive at the Fulton County Jail a few years ago during a routine intake screening.

Five-Percent has been prescribed mental health medication and been in the psychiatric ward at Grady. He was taken to Grady after going to the fire department with drug-induced heart palpitations. Fearing he was having a heart attack, Five-Percent chose to leave his house and go to the fire department rather than have his neighbors see him being taken out of the house and put into an ambulance:

> I didn't want to call an ambulance. I went to the fire department. Because they
> would have to come to my house, and they have to put me on a gurney and bring me out,

and my neighbors looking, like, "Oh. He done OD'ed, this, that and the third" so I went to the fire department.

> The doctors thought he was trying to commit suicide which culminated in his being kept

on the 13th floor for 72 hours, much to his dismay:

> I could not leave. Yeah. They kept me for three days. And I found out later that the 13th floor—I noticed that the people that were on the floor were all kind of like, "Wait, what's going on here?" They were a little bit off. And they had me in the mental ward. They said because of the amount of narcotics I used. I'm just going to say it like that.

Five-percent has been very shaken by his experience at Grady. He does not focus on the fact that he may have died, but more on the fact that he was in the 'mental ward.' He also does seem to think that risking his life so his neighbors couldn't speculate as to whether or not he had 'OD'ed' was perfectly rational.

Stigma resistance ranges from being somewhat reluctant to complete refusal to acknowledge diagnosis. The researchers identified anticipatory stigma beliefs and actual experiences of prejudice and discrimination relating to mental illness stigma. Thoits' deflection and challenging theory has also been used to identify the ways in which individuals resist stigma (2011). Not only do clients resist stigmatization, but attorneys and social workers resist it on behalf of their clients.

By understanding how people manage stigma and their coping strategies, we can assess what methods have been successful and what have proven detrimental. Specifically, theorists point to three influences that impact people's willingness to seek treatment for a mental illness: experiences in previous treatment, media portrayals of mental illness, and perceptions of stigma that individuals believe are attached to mental illness (Thoits 2016). The studies conducted by Thoits (2016) and Thoits and Link (2015) also identify possible strategies of stigma resistance, a person's unwillingness to submit to the stereotypes that others wish to impose upon them.

Strategies were also identified by Clement et al. (2015). They were determined to facilitate help-seeking and investigated the effects of selective disclosure, normalizing mental health problems, and non-clinical approaches such as talk-based care and community help centers, with practitioners using terms that reflect the client's understanding of their problems (Clement et al. 2015). This meta-synthesis of 144 quantitative and qualitative studies ranked stigma as the fourth highest barrier to help-seeking and disclosure as the most commonly reported stigma barrier. The results discerned that ethnic minorities, youth men, and individuals in the military and health professions were most impacted by stigma (Clement et al. 2015).

Structural stigma was also identified in the meta synthesis as a factor in the willingness to seek help, with examples including "negative media representations and laws, policies and societal practices which position people with mental health problems negatively" (Clement et al 2015:20). The effects of media representation can be seen where participants used statements that qualified anything they were saying about mental health issues, including that they weren't considering hurting anybody.

From the data collected during this research, definite strategies emerged that are activated and deployed by those with mental health labels to resist being stigmatized, diminished, and excluded. These approaches are analyzed in the context of previous stigma research so that these findings can be located within the field of existing research concerning stigma management.

7.2 Anticipated Mental Health Stigma

Anticipated stigma regarding mental health was reported across all of the age groups (N=9). Often when participants anticipated stigma, they would add the "that's not me" caveat of deflection. This strategy was employed by 22-year-old Teddy, who was quick to point out during

his interview with me that despite his being diagnosed with schizophrenia at the age of 16, *"I've always been pretty normal. I hope you can tell?"*

"That's not me" is also part of the anticipation scenario that Dwayne J presents. Here it is important to remember that "dual diagnosis" can mean mental health issues and developmental and cognitive issues. Dwayne J, who is also 22, refused to go to a different school because he did not want anyone to think he had trouble learning:

> I was evaluated. Because when I was, I was staying on like (redacted) Road, but they started making me go to a school all the way—I started going to Kimberly Elementary. I think that's somewhere on the west side. I don't know. I was evaluated. But, you know, it was a little short bus I used be like nah… Yeah. Because I ain't—you know, when you're a kid--well, when I was little. The short bus, I used to say that was for the mentally challenged kids.

Mental illness and developmental issues were also conflated by Constantine, who included a cousin with Downs Syndrome in the category of mentally ill members of his family. He stated he would not want anyone "Thinking I'm crazy or something."

Chris Smalls does not like to be around people with mental illness. He was in group therapy at the hospital or "mental institutions," as he refers to them. However, in jail he does not attend any sort of group activity. "When I was in a mental institution, I was going to group. Here, I don't go to the group in here because I don't want to be around it. I stay in my lane…because it makes you more mental."

Although he has not been diagnosed with a mental illness, 40-year-old Cee Pressure is worried about his son's diagnosis of ADHD. He, too, is quick to rule out other cognitive issues:

> And I have a 13-year-old son. He's kind of mentally challenged. I'm not saying— [inferred intellectual disability] he's got ADHD, attention deficit disorder…He kept getting in trouble at school, and I had to take him to a psychiatrist and a therapist, and they diagnosed him with that.

Kim K expects to experience stigma due to her mental health issues. She is a pharmacy assistant and has this to say about job applications:

> Yes, I know when I apply for jobs at Emory or different hospitals like Grady, all the hospitals, they ask, "Do you have a behavior disorder or if you have lupus or if you're a schizophrenic or schizo-effective that you can check the box." I already know that you probably won't get the job. Or if you have cancer, that you may not get the job if you check one of the boxes off on the application.

Like 22 year-old-Teddy, 45-year-old Five-Percent anticipated being stigmatized, and so was quick. He described his current troubles as drug-related and using ice cream as an analogy. He clarified his position for me this way, assuming I was wondering how he was in this position at all (that's not me):

> Now, you're probably saying, "I'm listening to this guy and you know, you just don't fit the person that"—eats a lot of ice cream to get themselves fat," get yourself in trouble. "Why did you eat so much ice cream?" Well, it's addictive.

Draco was among the participants who directly connected that anticipatory stigma stopped him from getting help. He was one of those people who are considering reaching out for mental health intervention but will only do so if they can be sure it will not be placed on their permanent record.

> No, I have not been fully diagnosed. I am in the process of trying to get a dual diagnosis. I would like to receive some mental assessments, again, because I do believe I have PTSD. Ah, I toss and turn all night long and very much I'm sleeping [?]. I've been told I talk in my sleep… Ah, in fact, I'm kind of worried about having that kind of diagnosis on my permanent record. I'd rather go through, um, a service on the outside so that I don't have any kind of stigma associated with mental illness.

Draco is absolutely convinced that he will lose friends if he discloses to them that he has a diagnosed mental illness. He characterizes himself as being "very private." He goes on to elaborate (my mental illness is not who I am):

> I don't want to have a formal diagnosis because there's a difference… Oh,
> absolutely. If it ever came out that there's that history, man, first off in my family,
> and it's like I exhibit some of the signs? Oh noooo.

I asked Draco how he thought it would impact his life? His response:

"Employment and social situations. If it got to any friends or anything like that, I would

probably not have those friends for long." He related feeling the same way about being

gay and HIV positive.

Michael Wright shares Draco's assessment that having any mention of mental illness on

his permanent record is untenable: "Yeah. I didn't want it to be in my medical profile that I have

mental health issues…because people, they view you different. They view you different when

they feel like you've got mental health issues, you know what I mean?"

David's fear of his mother's misunderstanding and thinking that he was "a lunatic" is also

indicative of anticipated stigma from family members.

7.3   Actual Mental Health Stigma Experiences

Six of the participants in this study reported experiencing mental illness related stigma:

David, Jon, Week, Michael Wright, Cee Pressure, and Kim K. Teddy's experience with actual

discrimination was being tasered by the police before they took him to the hospital:

> …but before the psych ward, I was taken to a hospital. They handcuffed me and
> put me into the ambulance…I thought this was kind of a little ridiculous just
> because I was forced--they tased me, and they weren't supposed, I don't think,
> because I wasn't fighting or anything. I was in psychosis, and they tased me.

School and school-related involvement has been identified as a major source of powerful

negative stigmatization. Beastmode, who has been treated for depression, was in an altercation

with a teacher at school who hit him after repeatedly calling him names, including "stupid little

boy." He left the classroom and was arrested by a school deputy and taken to juvenile detention.

The truth ultimately came out because of security cameras in the classroom, and the teacher was

fired. He relates: "Yes. And they arrested me for it to investigate, but he got fired, and I was able to come back to school." When I asked for clarification, he added that "Yes, they put me in there when the altercation first happened because they thought he was innocent." And therefore, Beastmode was judged guilty immediately and without investigating the incident at the time.

Despite his son's diagnosis, Cee Pressure does not want his son to take medication because a cousin of his took medication when they were growing up and "And all he ever did was stay in the house, stayed in front of the TV. It kind of made him worse… Yeah. It took away his drive. It took away his wanting to go outside and be a regular kid." His son seems to be doing ok, he says. Cee also fought to keep him out of an alternative school and demanded that his son be signed out of school when one of the teachers told him that (not who my son is):

> One of the teachers had told my son that—told some bad stuff. They said that they see him going to jail. They see rape in his future and all type of crazy stuff. So I demanded that they sign him out. I demanded they sign him out, and then after I signed him out, the head principal, later on, in the next couple of months, she got fired. But not because of that. Because of other stuff.

At the time of the interview, school had not started for the year, but his son would be attending regular school. Also, his son hurt himself jumping over garbage cans:

> He had jumped—he tried to jump over---you know the green trash cans? He tried to jump. He's short for 13. He takes after me. He's a daredevil. He tried to jump over the trash can, clipped the bottom of his feet, and landed on the concrete, screwed his whole face up and everything, so when he went to school, they was acting like something happened to him at home.

The school called DFCS, and Cee describes how he had to prove that nothing untoward had happened to his son at home. This process involved getting witnesses together, taking his son to multiple doctors and dentist appointments, until DFCS was satisfied it was an accident. The teachers at the school kept asking him about what had happened:

> So when they came out, I had 10 witnesses, neighbors, everybody seen him do it, but I still had to go through the process. Even if it was in his mama's name, I told

them that his mama's not present. She's in the streets, and I'm going to deal with it. So I had to take him to three doctor visits, the dentist, the health doctor, and the mental doctor, and after I'd done that, I called them and let them know I did it, and then a couple of weeks later, they came out again, and they asked me a lot of questions, and they closed the case…And then—but see, then, when he went to school, it was teachers at school picking at him, saying stuff like, "Well, we still believe something happened." The school called DFCS.

Week has been diagnosed with severe mental illness when he moved in with foster parents after the death of his parents: "They sent me to a private doctor, a psychiatrist, and he gave me the Ritalin. And he thought bipolar schizophrenic, and I had a hard time sleeping." He reported having ADHD, bipolar, schizophrenia, and learning disabilities. He started skipping school in grade eight, because he was always being picked on and made fun of for "taking medicine… I didn't have no friends." He was called names because he was in special education. "I mean, name-calling, that I was in special education, and I got tired of it." Ultimately, he just stopped going to school. Week reported being diagnosed as a kid and again while previously.in prison.

Kim K, the second of two women in the group who was interviewed, has a significant history of mental illness. She is currently being supported by an ACT team from the Fulton County Public Defender Office. Recently, Kim experienced a very negative reaction from a counselor at a local university when she went in to discuss the possibility of changing her major to social work. Kim described this experience she had after disclosing her history to her academic counselor:

> Yes. I told her my problem with me, with the incarceration. And she went on and tell me, "Well you sure you wanna do that? It'll be hard for you to find a job" and things like that. I was like Okay, all right.

At this point in the interview Kim interjects some information about certified peer specialists here in Atlanta, before finishing about her experience with the counselor: "But back to the lady, she was just so negative. And I didn't know what to do. I was just baffled."

When I asked Kim if she said anything to the counselor about the way she felt, she said she hadn't, explaining:

> No I didn't. I jus' didn't say anything because she was African American. She was also in school trying to get her masters' or her doctoring degree. And I just felt like I'm gonna need more help from her when I go back up to the school, so it's best not to say anything to her about it and how you feel about it because you might need her help again.

I asked her how she had learned to think about things in such a non-reactive way. Her response was that this approach had come from experience, "Over time because I used to have a mouth piece. Any time you say somethin' to me, I'm jus' gonna tell you how I feel about it."

For Michael Wright, it was growing up where "they used to call my father 'Crazy Jack' because you know, we'd have to go running when we see this car coming. You know, we had to get in the house before he got there."

7.4 Stigma-Resistance Strategies

According to Thoits (2011), the tactic of deflection is a cognitive resistance to stigma. She introduces two types of resistance that those labeled mentally ill can use to protect their self-regard: "deflecting, impeding, or refusing to yield to the penetration of a harmful force or influence" and "challenging, confronting, or fighting a harmful force or influence" (Thoits 2011:11). For our purposes, resistance strategies are strategies deployed to manage stigmatization. How people spoke about mental illness during the interviews, their own or that of people close to them, indicated their own strategies to manage stigmatizing labels related to mental health. Previous research by Thoits (2016) and Thoits and Link (2015) utilized

participants or data that had been collected from those who met the criteria of having a moderate to severe mental illness, unlike this sample where participant criteria was current client status with one of two public defender offices.

According to Thoits and Link, the deflection tactics chosen by people reflect their experiences with discrimination, meaning that those who have experienced the most discrimination would deflect the most. In contrast, flexibility was the ability to shift strategies according to the situational context (Thoits and Link 2015).

When an individual can use the strategy of deflection to block mental illness stigma and stereotypes, it matters in a number of ways. They reduce threats to their own self-regard. When they do experience discrimination or attempts to devalue them in interaction, they can attribute these to others' ignorance and prejudice and not to some innate defect within themselves.

Challenging strategies differ from deflection strategies in obvious and subtle ways. The main difference between the two is that challenging involves changing another person's mind, beliefs which reflect the protection of their own self-regard. Challengers share deflectors' beliefs that the stigmatized condition is "not me," but challengers can take go a step further: "Those stereotypes are wrong, not only about me but about most patients with mental illness" (Thoits 2011:14).

7.4.1 Deflection

Thoits purports that a deflection strategy can significantly reduce and possibly eliminate a loss of self-regard (2011). If actively deflecting a mental illness label, a person maintains "that is not me" or "that is only a small unimportant part of me," or my problems are different and therefore do not come under the designation of "mentally ill" (Thoits 2011:14).

Furthermore, her concept of challenging can include changing the beliefs or values toward mental illness that other people hold and their subsequent behaviors. These strategies involve contradicting stereotypes by behaving in atypical ways, educating others, confronting people, and engaging in advocacy and activism (Thoits 2011:15).

This study found instances of deflection strategies *(N=17)*, including strategies identified in previous studies (Thoits 2016; Thoits and Link 2015) such as "that's not me" *(N=4)* and just "not who I am" *(N=3)*. Minimizing mental illness or defining the mental health issue in less discrediting terms *(N=6)* was also apparent, as was completely renaming a diagnostic term (N=2). Strategies also incorporated mindfulness and narrative enhancement (Rusch and Xu 2017).

7.4.2 "that's not me"

Teddy's comment about hoping I could tell he was intelligent was a good example of "that's not me" deflection, we also saw a "that's not me" approach in Dwayne J's refusal to get on "the short bus." Michael Wright also deployed "that's not me" deflection in his assumption that I would wonder how someone with "his obvious character and demeanor," who does not fit the profile for what you think of when picturing someone who is in his current position: "You're probably saying… 'You know, you just don't fit the person that – eats a lot of ice cream to get themselves fat,' 'get yourself in trouble.' 'Why did you eat so much ice cream?' Well, it's addictive."

7.4.3 "my mental illness is not who I am"

Draco is very quick to make it clear that although he may have HIV or a mental illness, those medical conditions are not "who he is." Draco is very open about his homelessness and feels he has been consistently discriminated against because of it.

7.4.4 "defining the problem in less discrediting terms" "it is temporary"

Chris Smalls feels that prospective girlfriends have a right to know about his mental health issues, but he doesn't tell them he has schizophrenia: "I don't--I tell them depression and bipolarism. I don't tell them schizophrenia. I just tell them bipolarism. But they find out and be like, 'Okay depression.' And they'll look it up and be like, 'Oh, yeah, yeah, schizophrenia.'"

Chris also takes the deflection strategy a step further into the "I'm not like them" category when he mentions that he does not like to be around other mentally ill people at the jail: "When I was in a mental institution, I was going to group. Here, I don't go to the group in here because I don't want to be around it. I stay in my lane…because it makes you more mental."

Kim K. demonstrated flexibility, the ability to shift strategies according to the situational context (Thoits and Link 2015) when it came to how she presented her schizophrenia diagnosis. She used the less discrediting term "brain disorder" in place of schizo affective disorder. Her use of terms also was dependent upon to whom she was speaking: "So, you know, it all depends on the type of person that I'm dealing with. I've learned how to accept it." She is both renaming and using a less discrediting term to communicate her mental health issue.

Teresa displays a subtle process of deflection. She is very open about being hospitalized at 13. For Teresa, the counseling was helpful, and she viewed the medication this way:

> I think the medication was just to slow my thinking down…. Like, I don't think it was to actually help. I just think it was to slow my thinking down to where I won't think so much period. Like, I won't be thinking at all.

She took Zoloft until she was 15, and again after her twins were born, but she did not find it helpful and did not remain on the medication for very long. She chose instead to go an alternate route:

Until I was 15? That's when I got off it. And I got back on it after I had the twins… I think I just had—you know, everybody got emotions. I probably got overwhelmed and then--that's the first thing they do, they give you medication.

Teresa meditates daily, and she finds this is how she is able to slow down her thinking.

She learned that slowing her thinking down would be helpful to her during her counseling:

Right. And see--I just always think back, 17, 18 years ago, what the lady said. She's said, "If you slow your thinking down, it will actually help you," so now I use that same tactic, like right now. So I don't have to go back and get on no medication, none of that. I just slow my thinking.

Like Kim K, Teresa demonstrates flexibility and significantly benefits from counseling.

Some people opt to go the mental illness was "only temporary route." Beastmode related that his depression was specific to what he was going through at the time. He couldn't remember the name of the medication he took, but he thought he may have taken it for about eight months.

Ninety-three's mother has schizophrenia disorder and told him that probably he and his brother had it, too. He thinks he had bipolar when he was younger. He remembers being diagnosed and describes how he would "use the drugs to hide it." He also put the diagnosis firmly in his past: "Now I see. Now that I'm older and I've become more mature I'm like, 'Yeah, you was bipolar.' Back then, I was, 'I ain't got no problem,' but yeah, now I see it."

7.4.5 "yes no sort of…"

Teddy, who was hospitalized and diagnosed with schizophrenia at age 16, does not entirely accept his diagnosis:

No, I don't. The only thing I do—I'll be anxious when I see, like a psychiatrist or something like that, because I just--a lot of times I don't agree with them, and all of them seem to have their own opinions, you know? Which is obvious…It can be intimidating and frustrating. Half the people say different things and disagree.

Morgan, who is 25, also feels like he may have suffered from depression but no longer does: "in my adolescent years, I suffered from depression due to my grandmother's death in my

earlier years, but I don't know if I ever got past it, but other than that, that's the only thing that I

could say possibly to. So that's why I said possibly."

> Reggie doesn't know what his "mental health" was related to and what wasn't:

> I'm saying how would you know. You're in them stages, like mental health stages. Like everybody has their ups and downs. You know, we wake up sometimes angry just because—you know, just being in this, this…You know what I mean? So you know, I can't just say that's mental health. That's just anybody who's been away from their family so long, so—ups and downs sometimes.

> As noted earlier, Michael Wright has demonstrated a somewhat conflicted

opinion about mental illness, and help-seeking. He shares many discriminatory views

about mental illness and uses the term "mental health" as a derogatory pejorative term.

When asked about being diagnosed or having a mental health issue, his response is the

following:

> Well, no, but you know, out of all the stuff I've been through with my family lay heavy on your mind and the disappointments… I feel depressed. A lot of times, like I say, I hold a lot of it in. Yes, I have questions. And I'm talking to myself in my head. I'm asking this, this, that, and the other because, you know, I call that beating myself up, you know? Because you can't sleep good.

> Michael tells me that he's not on medication for anything and that "I really don't try to

address it or tell people, tell them about it, you know what I mean?" When I ask him for

clarification, he explains:

> Because you—I'm more or less ashamed of it, you know what I mean? And I don't want to be labeled like that, but you know, you got something that needs to be addressed. Maybe I've lost something at a certain point. I don't know. But I know that there's too much going on in my head, like I don't contemplate hurting no one.

> Michael directly refers to not wanting to be labeled and goes on to make sure I

understand that he is not "contemplating hurting no one." This association with mental illness

and violence has permeated society through media (Stout et al. 2004; Wahl 1992), but also

Michael referred to his own father earlier as "Crazy Jack," a violent man who terrorized his family. He understands that at some level he has internalized something that is hurting him, and that this internalization has limited his own life outcomes and chances for happiness:

> I don't contemplate hurting no one. I don't do that. It's more or less me, you know, you beat up on yourself. You look at your past and present. When you're not happy, you're not really happy, and anger can set in on you. I try to keep it at bay, you know, under the bridge, but it's there, underlying the surface, it's there. You're unhappy. I'm very unhappy. And at one point, I was in a relationship, I was more or less happy, you know, but since I've been single for so long, I—I want to be something to someone, but at the same token, you know, I've got to work on myself. I've got to make sure that I could feel good myself, feel happy myself, before I could make someone else happy, so you know, I wasn't trying to enter into no one's life, you know what I mean?

When it comes to seeking help openly, Michael is deeply conflicted, linking his pride to stableness of mind:

> Okay. Well, the thing is I always pride myself on having good sanity. I always pride myself on being a stable-minded person. But then again, you know, it's scary to know certain things can trigger certain actions into your way of thinking. And I always felt like, you know, I didn't want to take medication for mental health issues. But it runs in my family.

Michael goes on to identify bipolar as the mental health issue that runs in his family. His reason for this belief is that his father used to talk to himself a lot.

7.4.6 Challenging strategies

Participants resisted stigmatization by educating others about mental health issues including the true nature of mental illness. Kim K's flexibility concerned the way she deflected about her diagnosis, including the education of others. She demonstrates this behavior through how she described helping a friend whose mother would not take her medication:

> So I told her there's a lotta people out here that don't know that they're crazy or have a behavior disorder and that need to be on medication. They know they need it and don't wanna take it. I said, "At least I know," this is me talkin', I said, "At least I know that I might be crazy, I have a behavior disorder. I take my medicine. So at least I know somethin' goin' right with me. All these other people out here?

Somethin' wrong with 'em because we all born with something that is wrong with us.

Kim also demonstrates how she moves from a purely diagnostic label, schizo affective disorder, to a behavior disorder, and then when she is comfortable, uses the word "crazy." It does indicate how much she can orient herself to her audience.

Five-Percent has an interesting take on addiction and mental illness. He has a specific way of describing the difference between functional addicts and addicts who cannot function on a daily basis and are possibly moving into the territory of mental illness. He says: "Well, yeah. I mean—you have functional addicts and then you have bugged-out addicts. I'm straddling the fence."

Five-Percent has been to residential treatment, and he believes that his addiction is a chemical brain-based issue:

> It's a devil looping inside your brain. It's damaged, you know? And the pleasure zone inside of my brain has become addicted to the overflow of euphoria, which is the endorphins. And my brain doesn't produce that at the sight of a newborn baby or at a party.

> My brain now needs a full—I need full-throttle impact right [snaps his fingers] directly like this, in order to feel happy about things that I should naturally rejoice about. So that part of the brain is damaged. It is a medical condition. It really is. And that's why I think the greatest thing that they could actually ever have done was start drug court to help people.

Five-Percent is also demonstrating a flexible dexterity in how he is framing his issues.

7.4.7 Complete rejection of diagnosis

Bobby did not agree with his ADHD diagnosis and actively resisted by not taking his medication: "Yeah. They put me on the Adderall medicine, but I never would take it. I just faked like I took it and spit it out."

Jon, who is 31 years old, does not acknowledge he has any type of mental illness. He has

been hospitalized on multiple occasions and medicated, although he discontinues all medications immediately upon release. Jon is adamant "there ain't nothing wrong with me," and when asked why he thought that people believed there was something wrong with him, he replied: "I don't know. I'm just not willing to fall for anything. I like substance and proof behind the things a person say, you know? Just because you say I'm ill—I mean, what made you come to that conclusion? You know? If you don't know me?"

No one could answer Jon's question to his satisfaction. He has been hospitalized at least three times, and he thinks that he has never been given a satisfactory response as to why. His mother does not know what the reason is, and Jon has decided it is because it is a successful method for getting him out of the way:

> No. And mom, she says she doesn't know. They actually sent me there again in 2012 for a week, right before Cinco de Mayo. And I got back out, and I didn't take the medication, and they released me. There ain't nothing wrong with me. It's like somebody wants me out of the way, and they use that like they use jail to get me out of the way.

The oldest participant David, who was 71 years old at the time of the interview, was absolutely and unequivocal in his denial of and protest to any sort of diagnosis or treatment that could be interpreted as indicating he was in any way mentally compromised. David became an alcoholic and couldn't quit. He also has taken medication that seems to have been for mental health and addiction issues, "Well, when I was locked up they gave me two or three different kinds of pills, but when I got out, the clinic on DeKalb Avenue made me have some pill, but since I've been in here, all I have is a blood pressure pill."

David had reservations about drinking and drugs being his only problems because he didn't start to drink until he was 22 years old. When I asked him why his family had such a strong negative reaction to the thought of a family member being mentally ill, he said he didn't

know. I asked if they had a bad experience with someone with a mental illness. He didn't think

so. Finally, I asked if there had ever been anyone in his family with a mental illness? His

response, "Not that they telling."

Thoits observed that those who practiced complete deflection resisted any type of

voluntary mental health treatment and possible diagnosis, and these individuals were likely to be

the most severely disadvantaged (Link and Phelan 2016; Thoits 2016).

7.4.8 No fly zone

The deflection reflex seemed to lean towards complete dismissal of mental health topics

or information. Participants, up to and after questions related to mental health and mental health

treatment, could be very loquacious for the majority of the interview. If they had not directly

experienced something, they would openly discuss their general opinions. That is, until the

mental health questions started. Then they gave single-word answers, the majority of which were

"No." Again this behavior was especially evident in the older interviewees. I introduce that

what's not said is also an important element of awareness in exploratory study research. Here,

we enter the No-Fly Zone.

In a general way, it became noticeable that as the participants got older, they were more

emphatic about their beliefs and quicker to deflect potential stigma. Tommy Moore self-

identified as an African American who converted to Islam about 30 years ago. He has graduated

from high school and lived in downtown Atlanta in a loft owned by his employer. He described

himself as "Always alert. Trying to pay attention to anything around me. Anything and

everything around me." I asked if he had always lived his life with that level of alertness? His

reply was: "You know, not necessarily, but like I said, things have changed. So you have to be

aware of your surroundings at all times." Tommy also specifically made that point that he did not

attribute his awareness of this necessity to having been incarcerated: "Well, I done been through things where—yeah—through prison life and stuff, but at the same time, we ain't going to just say prison. It's what's going on now in life period. It makes you think."

He believed that life over the last 50 years has gotten both better. "I done seen—in almost 50 years, I done seen right at 50 years of life. And when I was a small child, things were going on then that don't go on now. A lot of things done progressed, you know what I'm saying?" However, he also believed that there was a lot more violence generally today among kids and adults. "Yeah. You know, you got kids on the news, you got kids, then you got, you know, older adults doing stupid stuff, too."

Elliot, who is also 51, has been homeless for a very long time. He had a drug habit years ago but does not do drugs now. He has violated county ordinances, which means he stands on off ramps with a sign asking for money. The police know him. Some officers are kinder to him than others. Throughout the interview, Elliott is keen to share until the mental health section starts, after which he gave monosyllable answers with no demonstrable interest or curiosity about the topic.

Although not quite as no fly as Elliot and Tommy Moore, Two-Two's response to having ever been diagnosed with any issues around mental illness is "Never been depressed or anything." When asked about any issues with drugs or alcohol, his response is "Well, you know, not really." When discussing his neighborhood in Atlanta, he spoke to larger life circumstances "You know, it's where you make life, where you live. You got ups and downs, you know, it go all the way around."

John Brown, a 60-year-old African American army veteran, was not signed up for receiving benefits. He was completely within the no-fly zone approach to responding to the mental illness issue. He did, however, discuss being in Grady for over a month when he was

attacked with a hammer by a client who would not pay him for detailing his car. When John

learned that his attacker had not been charged with anything, he said he was angry and ultimately

had to be restrained: "Yeah I was carrying on in the room with the nurses. I was mad." He had

not known what exactly had happened to him, and when he found out:

> I didn't know. Then once I realized what happened, you know, I was real mad
> about it, and I wanted to do something to the person. The chaplain and maybe a
> lawyer and the doctors and my sister and my girl and my family, everybody was
> like, "Leave it alone. Let it go. Leave it alone." So I had to let it go. I had to just
> write it off and charge it to the game that he got away with one. But I haven't
> forgot it. I let it go at that time, but I haven't forgot it. I forgive, but I don't forget.

Although John was interested in possibly getting help from the VA, one

statement he made indicated he also was leery and wary of granting an agency of this type access

to his life. The following excerpt represents a series of answers that he gave when I was trying to

understand why he wasn't accessing his VA benefits which would be significant even though he

was only 60 years old:

> You don't get all of it—Probably. More than likely, that probably is, but like I
> said, just the idea of going out there and stuff and just--you know, it just deters
> you from going… never had to go... Never had to go. Never got sick…Yeah, I
> understand. Never got sick. Never had to go...Never went and got a physical or
> nothing… No. It isn't far away. It's on Clairmont Road out there. I know exactly
> where it's at…I know exactly where it's at… All right. I don't have no problem
> about where it's at. I know exactly where it's at…. But when I go out there, they'll
> probably keep me under their wings?

The idea of being under the control of this agency has stopped John from applying for the

benefits that he is entitled as an honorably discharged veteran of the United States Army. When I

looked back at his interview and through my notes, it became clear to me that in all likelihood,

John Brown had been very effective in practicing the deflection that Thoits has conceptualized

into Labeling theory. And upon readjusting my own analysis based on this conclusion, there is a

very strong likelihood that Mr. Brown was, in fact, homeless at the time of his arrest and that he has been hospitalized for mental health-related issues.

Tony's viewpoint diverged from that of his age cohort. At age 58, he had actually tried and failed to get help for a mental health-related issue:

> Yes, ma'am. I tried to get help while I was in the chain gang because I was staying in and out of the chain gang, and I figured there had to be a mental problem, but she said they didn't have time for my caseload because they feel like there wasn't nothing wrong with me.

7.5 No Stigma Resistance Strategy Evident

Some of the participants didn't seem to be resistant at all to a mental health diagnosis, Allen the youngest participant did not deflect at all, stating this about his ADHD diagnosis: "No, I know I have it. But I'm saying, they, the doctors—something like that. It was something. I know what it probably was. I went to school, and they told me. I had pills when I was younger for it." He found that the pills did help him concentrate and is not sure why he stopped them, maybe because his mother couldn't afford them. He may have been diagnosed with something else as well but could not remember: "I think there was one more, but I can't remember. I don't know what it is. Yeah. It's some—they backwards or something."

Albert Einstein is 40 years old and has been diagnosed by a psychiatrist while in prison in Georgia with "Paranoid schiz, grief—it's a whole—he said I had a whole set of this stuff going on…bipolar, depression." When asked if he was surprised by this, he replied: "A little, but not much, though. Because, you know, I can feel the changes going on." He thought it may have had a little bit to do with a car accident he was in, but also, "had to, did too with the way I was living."

7.6 Seeking Treatment: Will do…No Way.

Almost everybody in the interviews said they would seek mental health help for others and for themselves. But when answering for themselves, they tend to include caveats. Constantine would be reluctant to seek help citing: "if there was a reason, it'd be judgmental." Elaborating further, he added that he wouldn't want others "thinking I'm crazy or something." Constantine ultimately finished the question with this statement: "To tell you the truth, I wouldn't know how to."

Reggie was also hesitant around what would encourage him to think other people should seek mental health treatment. However, he doesn't describe someone as being crazy, just as doing something that wasn't normal. "Yeah. I see guys like that. Just like his action and certain things he do that a normal person won't do, so yeah, I might be like something's wrong…Yeah. I'd probably tell them, like "you need to see what's going on." And if Reggie thought one of his kids were acting in a way that made him think perhaps a mental health person could help, he would definitely support that. "I'd take them," he said.

Jon would seek help for himself, adding "Definitely. I'm even willing to prove that I don't have a problem." He took it further by pointing out: "help is good." Five-Percent said: "I mean I would love to talk with a psychiatrist to go a little bit further in depth with what's really going on with me."

Some participants, though, were very adamant that if they needed help, they would seek it. For example, 21-year-old Beastmode, who has seizures and also has been diagnosed when he was younger with depression, said, "I don't sit around and have problems and just keep trying to deal with it. That's—that's how people commit suicide." A similar sentiment about seeking help

was expressed by 28-year-old Jonathan who responded "If I ever need help, I would seek help. Yes, ma'am. That's the best way you get help."

Initially, Mr. J responded that "I wouldn't go see a mental health doctor…because I don't believe I have mental health issues." However, he agreed to take his kids if they were exhibiting mental health symptoms.

Michael Wright included the statement, "I don't want to be evasive on that." I assured him that I did not think being private was being evasive, and then he described how he equated his pride with being a 'stable-minded person'

Week, who is white and both has severe mental illness and is intellectually disabled, was adamant about wanting and needing help, repeating twice "I need help, I can't read or write. I need help I can't read or write." He is 36 years of age.

The various strategies that were used to deflect, challenge, and reframe having a mental illness diagnosis indicate that for the most severely mentally ill, the ability to be agile and flexible in describing or speaking about their condition seemed to help them accept it and subsequent treatment and medication. Kim K, demonstrated her verbal agility, switching back and forth, using "schizophrenia," or more generic "brain disorder," and even using the label "crazy" to make a point. Also, she explained the cognitive processes that underpinned her decision on what description to employ. Kim also specifically spoke about how having the support of people who came to her home and checked on her helped, and she clearly appreciated being able to access peer group support.

Chris Smalls also seemed to benefit from talk therapy and used various strategies to cope with his diagnosis. He framed it as "bipolarism," not schizophrenia when he refers to himself. However, he only used the term schizophrenia to describe his mother. Peer support also mattered

a great deal to him, in Florida and to some extent in Georgia, although it seemed to be family

networks and connection here.

The potential benefits of helping people to understand what it is they are experiencing

and how to talk about their experience with others would be very beneficial. Teaching them how

to avoid sharing detrimental information would also be smart, especially when it comes to

younger people:

> I feel like if, number one, if—let's say, for instance, this is your—it could be your
> first time in any type of legal trouble or your 100th time. Preparing you for how
> people—how society reacts to you once you get a charge, you know what I mean?
> Preparing you for how your neighbors are going to treat you. Because people talk,
> so once you get in trouble, everybody in the neighborhood's going to talk. They're
> going to want to know what happened. What happened when you went to jail.
> (LaToya)

Teaching people, especially juveniles, how to articulate experiences and maintain

personal boundaries is very important. The potential ramifications of not being able to do so

include harsh immediate impacts such as loss of their home, for them and for the rest of their

family as well. The alternative is for parents to choose having a place to live over their child, and

this decision puts that child on the street, the experience of our youngest participant Allen. If a

family chooses eviction, the ensuing stress will also have a great impact on the family and the

legal process, for example:

> One of the other attorneys and I had one of our clients who was living in their car,
> and she, the mom was living in the car, and she said, "I know that my son had
> court. I don't know if they have a warrant out on him, but if you could get the
> court date reset, I can meet you back at the Starbucks so you can give me the
> notice. (LaToya)

Another reason to fully prepare people for what to expect can be seen in the experiences

that Teresa had being involved with the criminal justice system, this is at the pre trial phase. She

has pending charges with no adjudication, and so it must be remembered that she is innocent

until found guilty, in theory at least. Teresa describes, the impact on her ability to find employment was immediate and extreme, "I don't know if it's because of what's going on, but I've put in 47 applications, and nobody's called." Teresa had been acknowledging that she has been charged with a criminal offense, "Because they say it's better to be honest on applications, so I guess me saying that I have criminal charges pending...has had a negative effect." The immediate harsh effects of a recently acquired stigma can impact multiple domains, including fundamental life requirements such as economic opportunity and housing.

8   LABELING AND ACCESSING SERVICES

8.1 Over Diagnosis…Wrong Action for Right Reason

Diagnosing mental health issues is a complex area full of contradictions. The reduction of services for those in poverty has led to a growing acceptance of mental health diagnosis of all ages among the poor. In the previous chapter, we saw that those receiving the labels are aware of the negative outcomes that arise from labeling. Viewed from the perspective that this is a fundamental example of institutional and structural factors increasing the prevalence of stigma, a situation has been created whereby the necessity of a disability benefit-related diagnosis is a means to counter the harsh welfare reform policies which have been described by Hansen et al. as the "pathologization of poverty" (2014:2).

A diagnosis (label) can mean many things for those involved in the criminal justice system, including the difference between remaining in jail and being granted bond. A diagnosis may help an inmate qualify for a re-entry plan that includes housing, court-ordered substance abuse programs, and mental health treatment and support. It can mean access to federal educational resources for children, the kind of medication that is being credited with giving

privileged kids an edge. Thus, underprivileged kids gain the ability to concentrate and not get into trouble resulting in expulsion or worse, juvenile detention.

The ongoing criminalization of poverty mirrors the intense pathologizing of African Americans. The increase in mental health diagnosis generally has meant an increase in the number of people taking prescribed psychotropic medications. The removal of alcoholism and substance abuse from qualifying criteria meant a rise in a dependency diagnosis coupled with psychiatric diagnosis. This dual diagnosis is subject to harsher political policies regarding any type of assistance. A mental illness or chronic pain diagnosis remain the only options left to qualify for social security benefits that can be relied upon for relative stability (Hansen et al. 2014).

This qualification has become a matter of survival for some, according to Marcia Angell the former editor of the New England Journal of Medicine, "as low-income families experience growing economic hardship, many are finding that applying for Supplemental Security Income (SSI) payments on the basis of mental disability is the only way to survive" (Angell 2011; Hansen et al. 2014:77). Furthermore, Angell questions, how have "structural stressors and bureaucratic pressures" to obtain a psychiatric diagnosis shaped and defined their personal identities? (Angell 2011; Hansen et al. 2014:77).

Like psychiatry generally, the diagnostic protocols for childhood mental health issues have been racialized and weaponized in ways that reinforce the process of pathologizing people, mainly poor minorities, who increasingly support a diagnosis of ADHD for their school age children. The benefits are considerable, as one attorney points out:

> Well, there's the federal stuff, like there's IDEA (Individuals with Disabilities Education Act) and IEPs (Individual Education Plans). So it's kind of like a—it's one of those things. Because sometimes, if I were a parent of one of these children, I would maybe want them to get the ADHD diagnosis, just so that they

could get some extra services through the 504 plan (1973 or IEP or
something…But yeah, it's kind of messed up because it's really—you know, like,
if they'd be doing those jobs and providing those services in the first place, you
wouldn't need to have an ADHD diagnosis to get a break every two hours, you
know?

The 504 was intended for children with a wide range of disabilities who are able to

participate and succeed in a general education classroom. An IEP, on the other hand, was offered

for children with a specific diagnosis who require special education services.

Labeling, of course, can lead to malingering accusations. Another attorney Max describes

the phenomena of diagnosis acceptance, even when the label has the potential to be far more

crippling. An example is a conduct and oppositional disorder diagnosis. When asked who was

diagnosing these kids, Max, a juvenile defender, explained, "well, sometimes. Sometimes a state

doctor. But a lot of times, it's the children's own—Yes. Their psychiatrists. And you know it's

hard, because I think sometimes parents and teachers see those as a way to get help."

Research supports that more resources will be directed to the child when a diagnosis/label

has greater potential for danger (Atkins-Loria et al. 2015). So essentially, application of a

severely stigmatizing label becomes necessary for adequate access to educational resources, but

outside of the child's immediate environment, the diagnosis basically ensure his/her exclusion

from mainstream opportunities of the greater society. When faced with the absolute lack of

alternatives, this strategy becomes the practical choice.

The diagnosis of younger children with mental illnesses is often seen as a way to

circumvent the Personal Responsibility and Work Opportunity Act (PRWORA) and access

services for families exposed to unmitigated poverty. Add the defunding of public education in

Georgia and elsewhere, disaster is faced by those who are struggling, most notably single

mothers, but two- parent working families as well. Well-intentioned clinicians may exacerbate

the situation by connecting diagnostic labeling and the signification of urgency, using more severe diagnostic labels in the attempt to access scarce resources for treatment (Atkins-Loria et al. 2015).

> They are desperate. They are desperate. And if you put somebody in a situation where they have to make some decisions on what needs to be done in order for X, Y, Z to be taken care of, they're going to do that. They're going to figure out a way to do it. And if me getting my child a diagnosis, getting my child an IEP, can get my child disability, can get some money in this house, so that we can eat, that's what I've got to do. And they'll do it. And what pisses me off about—I don't know if I'm supposed to say "pisses me off" (LaToya).

SSI supplemental income thus begins as a mechanism to secure services for a child or to provide at least a modicum of stability for the most disadvantaged. Another intention may be to gain educational attention and facilitate a more conducive learning environment. But while these programs may initially meet needs and improve situations, they also provide the justification for harsher societal treatment and greater negative impacts.

This process is the same that impacts adults, the hope of services with a diagnostic label to qualify specifically for Social Security Benefits or (SSI). Without SSI, little chance exists for securing housing or any type of medical services, mental health or otherwise.

The over-diagnosis of African Americans in childhood, adolescence, and adulthood contributes greatly to the multidimensional stigmatization of this population, further compromising life chances and outcomes. Therefore, as noted previously, to study individual stigma neglects the identification of the ways in which multiple stigmas, and their social categories mutually construct and reinforce each other (Cole 2009; Collins 1990; Collins and Bilge 2016).

In the forensic context, the requirement of a label, i.e. diagnosis is mandated to access treatment:

> When someone comes into jail and they're psychotic and they're trying to get them some help, they'll give them medication, and they'll put a diagnosis of, like, "psych, NOS," not otherwise specified. That'll give the doctor enough to be able to start treating the person without having to call around and confirm the medication before they give them treatment…When I want to put them in a mental health program, "psych, NOS," won't get you in. (Tequila)

Individuals must have a diagnosis to qualify for the option of outpatient psychiatric services as an alternative to incarceration (West et al. 2015).

Having a diagnostic label also means accessing benefits in and out of the criminal justice system. Outside of the criminal justice system, labeling can lead to education benefits and medical coverage, and within the criminal justice system, to housing and re-entry assistance. As noted earlier, much of this access is Judge-dependent, and attorneys may investigate mental health status to provide the best legal representation possible. Unfortunately, many labels have the opposite effect of producing more, rather than less punitive outcomes (Mizock and Harkins 2011; Washburn et al. 2008).

Differences in perception with respect to different mental illness labels are not limited to judges in criminal legal systems. Studies have found that other professionals, including clinicians and probation service workers, also have strong biases related to specific mental illness diagnoses and consider future "dangerousness" on this basis and not necessarily on actual behaviors (Rockett, Murrie, and Boccaccini 2007).

8.2   Over Diagnosis…Wrong Action for Wrong Reason

Situations of negligent or improper diagnosis also leave kids and their families worse off than before and a routine dismissal of options available to help children. Many possible reasons account for this, but a significant motivator is financial. Drug companies have been found on numerous instances to have given doctors financial incentives to prescribe drugs (Mosher et al. 2013). One social worker had this to say, "I just personally think that these kids get diagnosed

with stuff that's—they get improperly diagnosed." A disconnect emerges between what is

described by families and by medical professionals who are eager to find a pharmaceutical

solution:

> if you just listen to what people tell you, a lot of times, this is not what this is. This child is hurting because this child saw X, Y, Z—or this child experienced X, Y, Z. And this probably doesn't need a pill. They probably need to talk to somebody. This child probably needs a hug. They probably need some stability. So, I just think that they get diagnosed improperly and for stuff that – like, "You just sat here and talked to me for 45 minutes in that same seat. You did not fidget. You did not jump. I did not have to say, 'Hey, hey, come back to me the whole time,' and you're not on medication, but somebody tells you that you're severe ADHD. No, you're not." (LaToya)

The ramifications of labeling are not lost on social workers who often have little recourse

but to accept the situation. "You are labeling this child! This child does not need medication.

Why would you even do that? And we do have some clients who need medication. Yeah." The

point is not anti-medication, but correct diagnosis and treatment options:

> I just don't think that you should be 12 and 13 years old with a bipolar diagnosis. I just don't think so. Especially if that's your first diagnosis. You know what I'm saying? A few months ago, we had a kid like that, and one of the attorneys and I were talking, and I was like, do you think his doctor would talk to me? Because I just don't know how you came up with that. (LaToya)

The doctor would not speak to the social worker, more from a position of professional

arrogance that privacy protection. The proper documentation was in place for the release of

information. What is also alarming, even with the consent, is the likelihood that the medical

records would be edited, "No. Oh, no. No. Even with parental consent, they would send the part

of the record that they want to." Issues of privacy are important and too often conflated with

general disclosure issues, but to intentionally hold information that could substantiate a mental

illness diagnosis from a defender? This action is irresponsible. A potential legal remedy could be

sought, but budgets of indigent defense are already strained.

In some situations, parents are in the position to get a second opinion and sometimes do, "And we've had a few kids who we've actually referred to a different doctor and a different agency...and I'll tell them, "Just say you're coming for an evaluation." There have also been instances of extremely questionable diagnostic outcomes. "We have had one kid who has had four different doctors diagnose that child with four different things. Four different things... Four different diagnoses. Really?" In other instances, doctors have been legally charged with defrauding Medicaid relating to antipsychotic drug distribution practices (Harris 2009).

8.3 When Schools Don't Help

The social worker also discusses the unrealistic expectations that schools place on kids who have mental health issues, the same kids who will accrue too many late for class/school infractions and be disproportionally disciplined, suspended, and ultimately expelled, "And then what I don't like, though, is when they put these kids who truly do have mental health issues in these impossible situations." In Georgia, the main reasons reported by high poverty high schools for disciplinary actions is attendance issues (28), students were late to class or did not get to the next class in the allotted time. Elementary schools were less punitive around these issues because it was usually due to circumstances beyond the child's control, for example the instability of homelessness (29). Officials in Georgia also provided examples of trauma common to students, including homelessness, being taken from their parents, or having been through violent situations (31). Nevertheless, the accrual of these types of minor infractions led to suspensions and expulsions.

This data has been reported in the GAO assessment of schools, and Georgia was cited specifically for the majority of their disciplinary issues leading to school suspensions as the result of rules around being on time:

They can't. They're not going to go—you have to go to school every single day on time every single day, maintain a C or better every single day, not get in any trouble, not get any referrals, every single day, and you're sitting over here trying to figure out how to get your brain to calm down long enough to get through it. It's not going to work. And usually the ones who are not successful are the ones who have mental health issues.

This example is but one that shows how multiple stigmas impact the life trajectory of young people. Schools can also be aggressively pro-medication, and if due to an incorrect diagnosis, can promote negative outcomes for the child:

I have issues with DeKalb County Schools. I've heard parents say, "The school said if I don't get them on medication, they're going to get kicked out." I can say I don't want my child vaccinated, and you can still let me come to school, but if I tell you I don't want my child on medication, you're going to tell me, "But your child's going to be kicked out of school." (LaToya)

The choices made around this issue are complex and cannot be explained through the investigation of a single dimension. Decisions take place over time and in reaction to social conditions and realities. Changing circumstances require an individual to act and to make practical choices based upon preset availability. The process is dynamic, and often those involved are required to cope with uncertainty. Choices made in coping with problems can alter the trajectories of those impacted in profound ways

The process by which individuals decide to accept a potentially highly stigmatizing label is the same one that has been conceptualized to frame the attorneys' process. This individual purposive action is predicated upon immediate needs and therefore a practical approach. The negative outcomes of exposure are overridden when services are tethered to diagnosis, but unfortunately its pertinence is only overridden by those who are seeking services, and not by those dispensing them or society at large. As such, this observation fits into greater socially constructed patterns that allow for the consideration of individual agency, social structure, and context.

The effects of racism can be observed in the resistance of the court to accept certain diagnoses of children involved. If the diagnosis diverges from what a judge and the state considers valid and appropriate, it will be rejected out of hand and not taken into consideration when implementation of resources are being considered. This dismissal happens despite a child being formally diagnosed with one of the more stigma-inducing labels:

> I've had a couple of Autism/Asperger's clients… That one's probably one of the ones that I see more white kids with than black kids, honestly… Those cases are always--I don't know--I haven't had very many of them, so it's like I can picture these kids, and usually, they're just so different from the regular clientele, it's like they're almost outliers (Batgirl).

Attorney Max describes attempting to convince a court that a black child, does in fact have a legitimate, and appropriate diagnosis of autism:

> Where I've had the most trouble is when I've had kids diagnosed with autism. Because, for some reason, black children who are diagnosed with autism are not really—it's, like, not a valid diagnosis… It's not treated the same way. And when I saw that happening here, I actually did some research. I mean, that's a common problem throughout the country, that the face of autism is a cute little white kid…and so usually how it's perceived in black kids, it's ODD or conduct disorder (Max).

Such examples provide evidence of the negative ongoing racialization in the area of mental health. The prevalence of this problem is troubling and indicative of the multiple layers of simultaneous stigmatized identities:

> Right. So then, even when I have kids who have actually been diagnosed with autism, judges don't hear it or see it. Psychologists, you know, and I've had a child evaluated for competency, and I'm like, "Well, I met the child, and he had his head down on the desk the whole time, and I couldn't have a conversation with him, but I guess he's competent, and you won't even recognize or acknowledge his autism diagnosis. "Great" (Max).

This situation has occurred often enough for Max to have personally researched the issue extensively, and she shows me the information she as collected: "Yes. That's where I've had the most trouble, is getting doctors and the judge and the prosecutors to find credible these diagnoses

of autism". According to the other defenders interviewed, the overall trend also indicates a shift toward an increasing diagnosis of oppositional and conduct disorder among African American girls, "I think it is definitely increasing. And I think it's definitely increasing with African-American girls, a push to criminalize them" (Batgirl). Recent research and documentation supports the inequity and misdiagnosis of autism among African American children and other children of color (Mandell et al. 2007). White children get fidget-spinners, and black children get dragged out of the classroom in handcuffs.

8.4 Impact of Labeling

The potential for negative outcomes related to mental health labeling is overridden by the need to address issues with more immediacy. Essentially, this dilemma is the crisis being faced today. Unfortunately, while an inmate's current situation may benefit from labeling, this assessment does not negate the ongoing stigma impacts that will limit that individual's life choices and opportunities (Rosenfield 1997; Perry 2011). The effects of diagnostic labeling are not easily unpacked. Actively seeking a diagnosis or passively accepting one is a choice usually predicated upon the need for services and shaped by practical choices and actions across various systems. The results are often critical, such as getting help with housing or education, or being viewed as willing to take responsibility and make changes required to function in society at large in a way that will assure state actors in the criminal legal system that they will not regret their actions.

However, some ramifications are not immediate and may prove to be deleterious. For those who are younger, often an ADHD diagnosis will be coupled with a conduct disorder diagnosis. This dual diagnosis happens with significant disproportionality among African

American youth, historically mostly in boys, but is increasingly being applied to young girls as well.

Essentially the equivalent of older labels such as psychopath or sociopath, this label when applied to a child will negatively impact every interaction that involves the state throughout that person's life. The underlying premise of these types of diagnosis is intractability or resistance to treatment. Research has consistently demonstrated that African American men are far more likely to be diagnosed with schizophrenia and conduct disorder, while being significantly less likely to be diagnosed with affective disorders (Atkins-Loria et al. 2015; Kilgus et al. 1995; Mandell et al. 2007). Despite the claims that the structural development of the DSM-V (2013), with the combination of the five-axis system and new behaviorally focused criteria, would generate diagnostic consistency and decrease clinician bias, research demonstrates that a client's race and ethnicity still are commonly correlated with specific diagnoses (Atkins-Loria et al. 2015; DelBello et al. 2001; Mandell et al. 2007).

Both the mental health and criminal justice systems incorporate DSM-based diagnosis when defining an individual's problems in relation with these systems. The stigma of conduct disorder and its association with psychopathy leads to a more pessimistic view of treatment effectiveness (Mizock and Harkins 2011). Also, if misdiagnosed according to the DSM, an individual faces additional impediments to correct, and appropriate treatments. They are often headed instead to increasingly punitive measures, an example of which is transferring a youth to adult courts with the ultimate result of longer sentencing (Mizock and Harkins 2011).

African American youth were far more likely to be sent to juvenile justice correctional systems then their Caucasian counterparts, who have a higher likelihood of accessing services

through the hospital system despite having similar or lower scores using the Child Behavior

Checklist (Cohen et al. 1990).

Labeling theory proponents and their critics both acknowledge the significance of

services that individuals can access if they are diagnosed with a mental illness label versus the

negative weight of stigma-influenced outcomes they may also have to endure. Do the benefits of

labeling outweigh the negative outcomes associated with the label's stigma? Rosenfield attempts

to answer this question by comparing the importance of perceived stigma and services received.

Her results indicated that both the received services and stigma are associated with quality of

life, but in opposite ways (Rosenfield 1997).

When professionals make similar decisions based on immediate needs, they do not

undergo the same types of vilification to which the poor and mentally ill are subjected.

Alarmingly a pharmaceutical-motivated push encourages proactive treatment with medications

based upon criteria that measure the likelihood of a young person experiencing a psychotic break

or episode. Some see indications that diagnosis is moving into a forecasting posture:

> When we have the kids, it's too early, I think, for them to make that diagnosis, but
> we'll see, you know, that they have "thoughts." It's kind of like—I don't remember
> how the doctors put it, but it's something that's like—it's going that way or there
> are signs that that might be developing… Yeah. Or they'll have, like, "mood
> disorder with psychotic features" or something like that. I think that's how it's
> written now. (Batgirl)

The takeaway about the legal system and their relationship with mental illness is the same

for all levels from juvenile defense through to the Capital trial level. The main interest of the

court is always a straightforward one. Batgirl continues: "So that's the million-dollar question,

right? I mean, you could have a psychological, and it talks about all this trauma the kid's had, and

it mentions that trauma is an issue… Court wants to know, can he be rehabilitated?" Because if

they can't, if the behavior is deemed to be a choice, because they are oppositional, there is not an

underlying issue to treat, therefore the state's posture is going to be, "Well, this kid knows right

from wrong." The most unhelpful diagnosis, are conduct disorder and oppositional defiant

disorder, she says:

> Those diagnoses are not helpful to the children because a lot of times, the courts
> will look at that as indicating that their behavior is by choice and that they're not
> very amenable to rehabilitation. Because those aren't easy disorders to treat…Like
> with depression or some of the mood disorders, we know you can give them a
> pill. (Batgirl)

The cumulative effects of an early stigma-laden label on a child's life course trajectory

are rarely taken into consideration at this juncture. This diagnosis can mean the difference

between a jury sentencing someone to death or not.

The sociological significance of the way labels are being applied in schools or while

people are incarcerated is demonstrative of how structural stigma impacts people who are

already struggling with multiple labels (Cole 2009; Collins and Bilge 2016). This study

contributes to the increasing amount of research investigating stigmatizing attitudes toward

people with mental illness, racial minorities, poverty, and criminal offenders. The study of

multiple and simultaneous stigmatizing labels taken together and not in isolation helps to

illustrate this sociological importance.

Because stigma operates at the micro and macro levels of human interaction, research

must also investigate multiple levels. to effectively support actions and policy that will reduce its

impact. Assessing the civil legal needs of indigent clients of the public defender, the greater

overall study supported the many common contexts for discrimination in the areas of education,

employment, and housing (Pescosolido and Martin 2015). Public education needs to focus on

actively dispelling myths of violence and psychiatric diagnosis in order to facilitate an increase

in the successful integration of those with mental illness into community (Mezey et al. 2016).

Sociology deals with social questions and problems, especially focusing on cultural and environmental factors. However, sociological study does include individual characteristics as well and as such is well positioned for this type of multi-level research. Through the study of social institutions and social relationships, the sociological perspective looks at human behavior and how it connects individuals with the structures of the society in which they live. The Public Defender offices provided a unique opportunity for the study of multiple levels of social interactions, at the institutional and individual level and thus allowed for micro-macro linkage.

The stigmatization process and labeling theory are relevant to the findings of this research in many ways. First, they help us to understand and organize how the ongoing dehumanization process acts upon these poor, mostly minority populations to their intense detriment. The relentless pathologizing of the poor has been facilitated by political policy that have targeted specific groups of the population. Their response is to make practical decisions to address their immediate needs in as concrete a manner as possible. They are then vilified for this outcome, by attempting to navigate in a situation that has been constructed for exclusionary purposes.

9   DISCUSSION AND CONCLUSIONS

During one-on-one semi-structured interviews, I assessed the civil legal needs of indigent clients of two public defender offices in the Atlanta area. In this study, I have considered the participants' individual experiences, as well as the various ways that public stigma was experienced or anticipated and the different strategies developed to manage stigmatized identities. The experiences of these participants are significant sociologically because they are routinely excluded from larger community surveys (GSS, NCR-R, Catchment). They are subject to socially sanctioned stigma via the routine disenfranchisement of people with criminal records.

Although, it is imperative to remember that the participants in this study are involved with the criminal justice system, it should not be assumed that they are guilty. Their cases have not yet been adjudicated, so technically they are part of the pretrial jail population (Kang-Brown et al. 2018).

This research builds on and contributes to the body of knowledge around individual perceptions of private and public stigma of mental illness in two ways. The first is generally in the context of legal institutions and organizations. The second is specifically by looking at the ways in which indigent defendants facing criminal charges in Georgia both resist and acquiesce to a system that can at times (not always) assist them through mental health treatment.

The context for the information gathered includes not only the criminal legal system, but also the disproportionate representation of race and poverty of those ensnared by it. For the most part stigma research has focused on how a single stigma impacts individuals. This research could not consider mental illness labeling without attempting to situate it as one of multiple simultaneous stigmatized identities with which our participants are living. For those involved with the criminal justice systems especially, the negative consequences of this coexistence are significant. The overlap of stigmatizing labels uniquely affects racial minorities (Pavkov et al. 1989; West 2015; West et al. 2015).

Therefore, the study of structural stigma has been necessary to fully appreciate how historical, economic, and political forces shape individual interactions and choices. Investigating stigma from the multiple perspectives of attorneys, social workers, and their clients within the legal system was a unique opportunity which allowed us to expand our analysis to how structural influences have disadvantaged the stigmatized (Corrigan 2004; Corrigan et al. 2005; Link and Phelan 2001).

By providing the context for contemporary institutional practices through tracing their development, I have shown how deleterious outcomes were created and reinforced for certain groups of people. In particular, present day practices of psychiatric labeling have facilitated the disproportionate diagnosis of African Americans (Metzl 2009) with highly stigmatized mental illnesses (Read 2009). Negative attributes have been attached to people with these diagnoses such as dangerous, lazy, and untrustworthy, just some of the cultural beliefs found to be held about the mentally ill (Corrigan 2007; Kroska and Harkness 2006, 2008; Link 1987; Rosenfield 1997). The investigation of political policy over time, and the evolution of the DSM and subsequent patterns of diagnosis, also supported Metzl's assertion that "incarceration, misinterpretation, and stigmatization are connected by the variable of history" (2009:190).

The extent to which public stigma influenced our study participants could be seen in the disclaimers they provided around their own mental illness diagnosis, i.e. Teddy "I've always been pretty normal, I hope you can tell?" Or Michael "Now, you're probably saying, "I'm listening to this guy and you know, you just don't fit the person that…""

Looking at anticipated and actual stigma experiences of participants, our findings concurred with Eisenberg et al. (2009) in that participants did have higher expectations of stigma then they actually experienced. Our results around decreased help-seeking and higher personal stigma also aligned with Corrigan et al. (2003); Gove (2004); and Watson et al. (2009). This conclusion is evidenced in the concerns our participants voiced around having information about mental health diagnosis on a permanent record.

Also relevant to our research, the empirical work in Modified Labeling Theory developed ideas relevant to active stigma, avoidance, and resistance (Link et al. 1989, 2002; Link, Mirotznik, and Cullen 1991; Thoits and Link 2015). The results of this study supported these

findings in the way individuals provided information to dispel stereotypes. They also exhibited

challenging behavior and outright rejection of potential labels (Thoits 2011; Link et al. 1989,

1991).

I, too, identified the type of distancing a person employs when cognitively separating

themselves from a stigmatized group (Thoits 2011). Individuals in this study purposefully

presented statements indicating "I'm not like them…your stereotypes of them are misapplied to

me" (Link and Phelan 2013:537).

Participants also employed multiple coping strategies to protect themselves from the

negative effects of being labeled mentally ill. However, deflection strategies can help people to

adjust negative stigma and assumptions, allowing for participants to receive mental health

services that actively assist, not only in their own defense, but potentially in qualifying them for

programs and services that facilitate integration into the community at large and thus better life

outcomes.

I have looked at various conceptual ideas of stigma deflection as conceptualized by

(Thoits 2011; Thoits and Link 2015; Corrigan 2006) etc. Other examples include Narrative

Enhancement and Cognitive Therapy (NECT), Psychoeducation, and narrative strategies

focusing on cognitive restructuring (Yanos et al. 2011). Psychoeducation is a method of

correcting stigmatizing beliefs but has been used extensively to disseminate the biology-based

model of schizophrenia.

Narrative therapy encourages people to tell their stories, along with achievements. In an

example from this study, interviewee Michael Wright described how learning to include positive

life experience as part of his resume or in a job application had a huge impact on his outlook and

attitude about searching for employment. Although not specific to mental health, this outcome was supportive of this intervention model.

Other interventions reduce structural discrimination in education, on an individual level and in structural level attitudes, legislation, media messaging to improve attitudes of journalists, and of course, funding, access to support, and outpatient psychotherapy. Increasing participants' ability to navigate a world in which they are managing stigma and reducing its impact could be life altering for those who are able to learn a form of stigma resistance that works for them.

This study fills a gap by including the voices of people who are not usually included in research and providing insight into their actually lived experiences of stigma, including participants' attempt to deal with both structural and individual constraints. Understanding the ongoing structural limitations faced by much of the population with mental health issues can illuminate the various mechanisms that promote the pathologizing of the poor while simultaneously criminalizing poverty.

This study has also identified a cultural shift in attitudes and opinions about mental illness. The American public appears to exhibit a growing willingness to accept mental illness, and to identify it as being mainly genetic among younger people. This shift is directional and not a wholesale change in belief systems. Resistance still lingers around mental illness labels, as seen by the rhetoric around "mental health" described by Draco.

Among older study participants, a few indications of shifting beliefs have emerged, leading to the conclusion that, for them, nothing outweighs the detrimental impacts of the stigma of mental illness. Fifty-eight-year-old Tony is the exception to this trend and should likely be seen as an outlier

The inclusion of the social workers and public defenders actively partnering with the community and other outside agencies has proven beneficial to everyone involved. These developments have increased the options for successful client outcomes including incarceration alternatives involving treatment that will facilitate successful community integration. Simultaneously, these practices demonstrate to other government agencies how to address the needs of people with nowhere to live and who cannot find employment and are barely scraping by on subsistence means.

This study also has provided insight into why despite tangible benefits from disclosing mental health issues that may impact their defense, many clients do not do so. Conversely, the research suggests approaches that could be helpful to encourage disclosure. The strategies deployed by the participants to minimize personal stigma impact are indicative of how personal interaction and involvement of counselors and mental health service workers could help to expand the rhetorical repertoire of individuals in useful ways.

By working with this hard-to-reach population, the underlying structural dimensions of how individuals interact with harsh policies has been demonstrated. Notably in the ACLNID study, a predominant theme identified was "process as barrier to accessing services" (Sudeall Lucas and Richardson Forthcoming). And the need to act and to act purposively can be seen by everybody involved in choosing whether or not to label young people. Constraints in both the educational and legal institutions have significant impacts on individuals and reduce life chances.

Changing values toward mental health treatment are reflected in attitude differences among the clients toward mental health issues, particularly the number who had extensive interaction with mental health services starting from a very early age. The prevalence of diagnostic labels in the younger cohorts and the absence of them in the elder parallels public

policy decisions and reduced funding for social welfare programs and education. These factors have further disadvantaged marginalized populations.

Furthermore, this study adds to the existing literature regarding the helpfulness of attribution theory and the excessive focus on genetic factors in mental illness. And thus, its results support the findings of Corrigan et al. (2003) and Phelan (2005). In addition, this research has found greater likelihoods of coercive treatment around etiologies that support mainly genetic or brain-based beliefs of mental illness.

This study also corroborates modified labeling theory's premise that socialization of individuals occurs in culturally specific ways that include beliefs and value systems around mental illness. Furthermore, the researchers have sought to identify the economic and political power that has been exercised to facilitate various stigma and solidify "us" and "them" notions that stigmatize others (Link et al. 1989, 1997, 1999; Link and Phelan 2001, 2013; Scambler 2011).

The findings illustrated the processes that override individuals' aversion to labeling, namely immediate needs, and thus extend the literature pertaining to perceptions of subsequent devaluation (Kroska and Harkness 2011; Perry 2011). As introduced by Link and Phelan in their conceptualization of Stigma Power, Bourdieu's theory of symbolic power included his ideas of the "misrecognition, hidden taken for granted aspects of culture" (2014:25).

Thoit's ideas around deflection and mental illness stigma provided the common terminology for our analysis of stigma management and allowed us to situate this research in relation to stigma research generally. "The wish to avoid" has found that values and beliefs are experiencing a contemporary shift around mental illness that may ultimately change this theory

significantly. Cultural acceptance of mental health also appears to be trending towards normalization.

In terms of barriers to disclosure of mental health information, study findings mostly reinforced but occasionally contradicted previous research conclusions. For example, younger clients resisted disclosure because of their fear and anticipation of being segregated on "the mental health floor" or being put in a "padded room" (Corrigan 2004; Link and Phelan 2001; Thornicroft 2008). The participants who demonstrated greater agility in framing their mental illnesses around their situations indicated significant benefits from learning coping strategies that include reacting to discrimination with indignation and advocacy (Corrigan 2004; Thoits 2016).

As described by Metzl (2009), the racialization of psychiatry and psychiatric diagnosis is illustrated by the reluctance, bordering on complete refusal, of the court to accept an autism diagnosis for African American juvenile clients. Also, congruent not only with Metzl's scholarship but also Cass and Curry (2007); Cohen et al. (1990); Mandell et al. (2007), both juvenile defenders and social workers described an increased use of a joint Oppositional and Conduct Disorder diagnosis for young African American girls.

9.1 Limitations

This study has several important limitations. First, the sample was purposive and conducted at only two urban public defender offices in Georgia. It therefore reflected the experience of a small group of public defenders, social workers, and indigent clients. As such, the results may not generalize through or beyond the state. Nevertheless, this project has gathered knowledge from people who are living within institutional and government constraints that have altered decision-making alternatives around labeling and illustrate the deleterious effects of mental illness stigma.

Based upon self-report, this research suffers from all typically acknowledged weaknesses of self-reported data, including impression management, poor comprehension of questions, and low motivation to engage in response to questions. This study is also limited with respect to having participants who self-identified in only two racial categories as African American or Caucasian. The inclusion of only two women is also a deficiency.

9.2   Implications

This research is reflective of the unique opportunity to speak to people in this particular situation. Located in the south, and therefore particularly illustrative of the insidiousness of institutionalized racism, this study offers unique opportunities to investigate the mechanisms of stigma at macro and micro levels, as well as the links between them. The results could be used to concretely demonstrate the need for more resources to be allocated to public defender offices in general and to mental health services within those offices in particular. It could also support the benefits of more community partnerships to increase treatment options for clients with mental illness and to address the negative effects of stigmatization upon clients.

Furthermore, the data collected may inform questions pertaining to procedural justice. Poor offenders are more likely not to be able to afford bail/bond and so will be incarcerated, while someone from a higher socioeconomic background will not. Whether guilty or not, they will suffer the deleterious consequences that being incarcerated entails. Modified labeling theory is a means by which we can understand how perception of the stigma process adversely affects various life outcomes of these individuals.

Through the ongoing collection of data, means can be found to address the mechanisms by which people see a mental health diagnosis as a potential threat to their own well-being and other potential deleterious consequences. The ultimate goal is to develop strategies to help this

population and to reinforce the likelihood of positive outcomes, either generally or specifically, in the framework of the criminal justice system.

Future research could focus specifically on women and stigma in the criminal justice system. A qualitative study with women who are being represented by the public defender would address a gap in the literature. The mental health of women facing potential incarceration or who have been incarcerated is an area that is under-researched.

The mental health diagnostic process of children needs to be better understood in the context of poverty and race. Research also should address the predominant practitioners and practices responsible for conduct disorder and oppositional disorders among children. The potential for negative consequences over the life course as a result of these labels warrants a thorough understanding of all the mechanisms that facilitate this process. Potential checks and balances can be identified that can increase the likelihood of correct diagnosis, and by extension correct treatment options. Treatment interventions could present a more holistic approach to helping people with mental illness, encompassing community development and support.

Additionally, more research should be done to investigate stigma and self-stigma within a larger sample of those involved with the criminal justice system. Such studies could focus on multiple stigmas including mental illness, race, and the impact of a criminal record within the greater context of ongoing poverty and disadvantage.

This study has extended the literature around stigma, mental illness in the criminal justice system, and attorneys taking the de facto role of mental health provider for the indigent. Issues of disclosure among this understudied and under-resourced population have indicated that education and strategies of deflection can be used to resist stigma, as well as to protect individuals undergoing treatment from additional devaluation.

The ongoing overrepresentation of those with mental illness in incarcerated populations warrants research that will increase the likelihood of successful treatment outcomes and diversion court success. Negative associations around "mental health" interfere with disclosure and hampers intervention. Connotations need to be altered, and switching labels will not change what needs to be addressed. Positive commentary should be given a higher profile in public discourse with an emphasis on addressing the ongoing stigma of mental health. Concurrently, the direct-to-consumer advertising of mental health medications must stop.

Future research should also investigate current psychiatric symptoms (particularly negative symptoms of schizophrenia) and diagnostic criteria as it has been applied to forensic populations and their treatment protocols. Also, studies must critically assess the diagnostic protocols being used in the treatment of children. Research must address and support public policy to untether qualification for social services from diagnostic labels. This process must be done in such a way as not to reduce social services, but to stabilize and create a solid platform for their disbursement. In terms of tangible positive impacts, the findings of this study can be expanded by investigating strategies that support community interaction and successful integration of those with mental illness into the community, such as providing affordable housing and equitable education opportunities.

9.3 Conclusion

Generally, "literacy" is thought of as the ability to read and write, but the definition also includes the connotation of knowledge that relates to a specific area or topic. Calls have been made to increase literacy around mental health (Corrigan 2014; Pescosolido 2010; Reavley and Jorm 2012). However, this study supports that contemporary public mental health literacy has been constructed from language created for the specific purpose of categorization by the

Diagnostic Criteria and Statistical Manuals and by extension to promote qualification for and access to pharmaceutical remedies. Scales created by academics come with extensive financial backing by pharmaceutical companies that produce, market, and sell the drugs that the symptom criteria encapsulate and for which third payer insurance parties, e.g. Medicaid, will pay.

Seen in this light, the term "literacy" is a misnomer for what has occurred and how people have learned about described mental health issues. Though this planting of specific language and vague descriptions have taken root in the vernacular, it does not follow that anyone has gained any sort of true literacy based on actual knowledge. On the contrary, this association is spurious. What we have been witnessing is the insidious embedding of superficial and rudimentary talking points, acquired through the deployment—sometimes intentional, sometimes not—of just enough information to justify massive increases in prescriptions for psychiatric medications. Perhaps this consequence was unintended, but it is a significant consequence nonetheless.

The Reavely and Jorm (2011:44) study identified a need for "targeted" intervention in order to increase the mental health literacy of "younger, male, born outside of Australia and of a lower level of educations." In their research, the young people, from age 12-25, showed the same lack of knowledge other such studies have found (50).

Education interventions are conceptualized to counter myth and false stereotypes, which generally speaking is a good thing. However, researchers need to be cognizant of the motivation of funding sources and not inadvertently be reduced to carry water for large pharmaceutical corporations. One such successful campaign developed in Australia, "Mental Health First Aid" (Rusch and Xu 2017:452), also called for mental health literacy (Jorm et al. 2010; Kitchener and Jorm 2006). However, in the United States, non-profit consumer groups, such as Children and

Adults with Attention Deficit/Hyperactivity Disorder (CHADD), are strong advocates for identifying and treating adult attention deficit disorder, but the majority of their funding is by Ritalin's manufacturer Novartis. The National Alliance for Mentally Ill (NAMI) also receives most of its financial support from pharmaceutical industry interests.

Campaigns to improve mental health literacy and decrease stigma are supported by a claim to increase evidence-based knowledge among the public, central to which is the concept that mental illnesses are biologically based. Many of these movements have ignored research about environmental and societal forces related to increases and decreases in prejudicial attitudes toward mental illness (Read 2004). In particular, as presented in various anti-stigma programs (Jorm et al 2010; Kitchener and Jorm 2006), the mental health literacy goals sound good at first. But when the ideas and beliefs of mental disorders and management that are the basis for the desired literacy are examined, the only recourse for patients is to access psychotropic drugs for biologically-based illnesses (Read 2008).

The study of stigma must clarify and separate itself from research supported by funding from pharmaceutical companies whose ultimate goal is the creation of larger markets for their products. The darker side of this scenario is increasing corporate profits though the administration of copious amounts of psychotropics, based upon unchecked diagnosis of a literally, captive population. The dissemination of the idea that mental illness is an illness like any other has not reduced stigma. The mental health literacy goal is a positive, worthwhile endeavor if aimed at increasing quality of life, raising the chances of positive life outcomes and lived experiences. But it must be accompanied by a growth in awareness around the unintended or deleterious consequences that include paving the way for unchecked, unquestioned, and unhelpful dispensing of psychiatric medication based upon diagnosis.

The comprehensive involvement and influence by pharmaceutical interests in the research and development and subsequent marketing of psychiatric drugs has been and is still being documented. Through the infiltration of many organizations and both state and federal agencies, they become enormously powerful in shaping legislation and political policy concerning their products.

But also, many, many professionals and parents are just trying to help those with mental illness. They have been ensnared in this process and are inadvertently and unintentionally perpetuating the pathologizing and discriminatory targeting of minorities. Speaking up about the insidiousness of the inclusion of psychiatric disorder criteria and pharmaceutical medications is to risk the appearance of attempting to cut off the last avenue to any stable social assistance that remains an option for increasingly marginalized people living in poverty in the U.S today.

Large pharmaceutical companies have managed to be everything to everyone, and as such have intrinsically woven themselves into the very fabric of society. The cost of this development may not be fully discernible for generations, although the field of epigenetics is pointing to the value of avoiding reductionist reliance upon pharmacological interventions, as well as the "existing weakness" explanations of why more black and brown people may be legitimately diagnosed with mental illness. At the level of gene methylation, epigenetics research demonstrates how high-stress, resource-poor environments can produce risk factors for disease that last for generations (Johnstone and Baylin 2010). Meanwhile, neuroscientists show neuronal linkages between social exclusion, poverty, hampered brain development, and mental disorders (Buwaldaa et al. 2005; Evans and Schamberg 2009; Metzl and Hansen 2014). Again, the truly difficult piece of this puzzle is how to address the issues of

misconduct while being very clear that some who suffer from mental illness are helped by psychiatric drug interventions.

Theoretical implications of this study include the identification and call for a thorough examination into how studies of stigma are being funded and how research results have impacted the stigmatized. It does not automatically follow that research and researchers who received pharmaceutical funding are themselves or their findings less legitimate. Nevertheless, academics should step up and retroactively identify previous study funders. Moving forward, professional associations can demand that all funding sources be listed on any article that is submitted for publication, augmenting the rather vacuous non-conflict statements that are offered presently to cover any instance of possible undue influence.

The resiliency of stigma has proven to be a very complicated phenomenon to eliminate. This qualitative study of stigma contributes to the growing body of research about how the mentally ill subjectively experience and cope with stigma. Hopefully these findings will improve the understanding of the dimensions and scope of stigma consequences. The reality of stigma's impact across multiple social domains ties together the focus on mental health-related stigma and disclosure with the overall study to assess the civil legal needs of indigent defendants (ACLNID).

During this research, civil legal needs have often emerged as the material manifestation of the deleterious consequences of stigma as it becomes operationalized. The disparity of opportunities in areas of education, employment, and housing among others reflects the reality of the reduced life chances of marginalized populations overall.

Stigma research needs to find avenues for translating findings into action including government policy that addresses inequities and resists pathologizing those who have multiple

intersecting stigmatized identities and are increasingly marginalized. The study and findings do not address the realities of relentless pathologizing and criminalization processes aimed at the indigent. The perpetuation of the deficit-focused categorization of minorities suffering from mental illness and those with criminal records originated in targeted rhetoric and political and economic policy. These forces have been revealed and this tragedy should be addressed.

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APPENDICES

Appendix A: Supreme Court Decisions re Sixth Amendment

1932 *Powell v. Alabama*

The initial provision for representation began with the Supreme Court decision that confirmed the constitutional right to counsel for indigent clients facing the death penalty.

1938 *Johnson v. Zerbst*

The court ruled that by failing to provide the defendant with counsel, the federal court had denied him his Sixth Amendment right.

1942 *Betts v. Brady*

The indigent cause received a setback when the Supreme Court held that the state of Maryland was not constitutionally required to provide representation for indigent clients.

1963 *Gideon v. Wainwright*

The Betts decision was unanimously overruled. The Supreme Court held that Gideon had a constitutional right of counsel provided by the Sixth and Fourteenth Amendments and expanded this constitutional right to include anyone facing felony charges

1967 re *Gault*

The next expansion came in the Supreme Court's decision to extend the right to counsel to juvenile delinquency proceedings

1972 *Argersinger v. Hamlin*

The Supreme Court further decided that the Sixth Amendment included misdemeanors

1984 *Strickland v. Washington*

The Sixth Amendment does not establish a standard for adequate representation. However, the Court has held that the right to assistance of counsel encompasses effective assistance of counsel. This decision set the standard for meeting constitutional requirements of defense so low as to uphold the defendant's right to counsel on one hand but remove any meaningful effective assistance requirements on the other.

1985 *Ake v. Oklahoma*

2002 *Shelton v. Alabama*

The right to counsel was stretched to misdemeanor cases in which incarceration is not immediately imposed, but may be if a defendant fails his probation/parole restrictions. Most states, Georgia included, use some form of suspended sentences (probation) as a form of punishment.

2008 *Rothgery v. Gillespie County Texas*

Here the Court held that the defendant's right to counsel is triggered at his initial appearance regardless of whether a prosecutor is involved in the proceedings.

Appendix B: Indigent Defense in Georgia

The state of Georgia left the indigent defense system up to the individual counties, with representation rights and rules varying greatly in the 159 counties that make up its 49 judicial circuits. The reality was that most counties underfunded indigent defense, and representation was haphazard and substandard. The state-funded circuit public defenders provide representation in superior and juvenile court and in direct appeals from these courts.

1990s
Partisan strength was more-or-less equally divided between Republicans, Democrats and Independent. Democrats were historically supported by African American voters both in urban and rural counties. However, since 2004 the Republican party has controlled the governorship, the majority of congressional seats and both the houses (Bullock and Rozell 2007).

2003
The Georgia Indigent Defense Act of 2003 created a statewide public defender system. Georgia has 43 full-time circuit public defender offices throughout the state. The legislation allowed counties to opt out of the statewide program, and six did. In addition, regional conflict defender offices handle conflict cases and overload from the public defender offices (SCHR 2003; Stevens et al. 2010).

2003
The bill also created the Georgia Public Defender Standards Council (GPDSC). Initially an independent agency within the executive branch of the state government that is responsible for overseeing indigent defense in Georgia.

2004
The legislature actually begins funding for statewide public defender system. The General Appropriations Act, passed by the state general assembly, funds the circuit public defenders, but additional funds may be supplemented by counties and cities. Counties in the judicial circuits provide the funding to cover office costs of public defenders.

2005
Statewide public defender system does not begin to operate until January. Georgia's system changed to create judicial circuit-based public defender offices set up in each of the state's 49 judicial districts, replacing a county-based system. The state-funded circuit public defenders provide representation in superior and juvenile court and in direct appeals from these courts.

2008
According to the 2010 American Bar Association (ABA) report on State, County, and Local Expenditures for Indigent Defense Services Fiscal Year 2008, Georgia indigent services were over 50 percent county-funded and 37.2 percent state-funded, breaking down into $35,010,269 in state expenditure and $59,103,357 in county local expenditure for a total expenditure of $94,113,626 (Stevens et al. 2010: Appendix 4).

2009 *Flournoy v. Georgia, Cantwell v. Crawford*
Compared with the previous complete lack of any system for indigent defense in Georgia, the new system could be characterized as an improvement. It has not been without its problems, however. Civil rights organizations have filed multiple lawsuits on the behalf of indigent defendants in Georgia.

2011 *Miller v. Deal*

2014 *N.P. v. Georgia*
The most recent by the Southern Center for Human Rights was on behalf of juvenile defendants in Cordele, Georgia (N.P. v. Georgia 2014).

2015 House Bill 328
The public defender system has been the target of politicized attacks since its inception, the most recent being House Bill 328. The bill proposes to change previous legislation of 2003 and 2008, eliminating requirements such as a defendant's right to an attorney within three business days of being charged and that circuit defenders have specific divisions. Additional proposed changes include removing a requirement that lawyers have training matching the level of complexity their cases call for and changing the name of the Georgia Public Defender Standards Council to the Georgia Public Defender Council.

Appendix C: Instructions for clients (to be given or read to client by attorney)

Researchers from Georgia State University are working on a study about the problems and needs of people facing criminal charges. They will not be able to help with your criminal case. They will not ask you about your criminal case. Instead, they are interested in other problems you may have and whether those problems could be solved with help from a legal aid attorney. At this point, the researchers cannot offer such assistance.

Participation in the study will mean that someone will come to visit with you and ask you questions. Those questions will not have to do with your criminal case, but with other issues you have or have had recently. For example, they might ask you questions having to do with your housing, your job, or whether you receive food stamps. They may also ask if you have ever tried to get help from a legal aid attorney. You can choose to answer some or all of the questions—it is completely up to you. Participation in the study is 100% voluntary and your name will not be included with your responses.

The researchers have asked for us to pass along the names of people who would be willing to be part of such a study. Depending on how many names we give to them, there is chance they may not be able to get in touch with everyone. They will not tell me whether or not you choose to participate in the study. I cannot answer any questions about the study or advise you whether to participate. We are only asking if it is ok to pass your name on to the researchers. You will be able to ask them questions before deciding whether to actually participate in the study.

Is it ok for me to pass your name on to the researchers, so that they can contact you?

Appendix D: Client Card Template

Contact Information:

_____

_____

YES ☐   NO ☐

Study: Assessment of the Civil Legal Needs of Public Defender Clients

Lauren Sudeall Lucas (lslucas@gsu.edu; (404) 413-9258)
Ruth Richardson (rrichardson364@gmail.com)

Georgia State University College of Law
c/o Lauren Sudeall Lucas
P.O. Box 4037
Atlanta, GA 30302-4037

Appendix E: Consent Form

<div align="center">

GEORGIA STATE UNIVERSITY
CONSENT FOR RESEARCH PARTICIPATION

</div>

Study Title: Assessment of the Civil Legal Needs of Indigent Criminal Defendants

Principal Investigator: Lauren Sudeall Lucas

Principal Student Investigator: Ruth Richardson

IRB Study Number:

I am a student at Georgia State University, in the Sociology Department. We are conducting a research study in which we invite you to take part. I am doing this study with Professor Lauren Sudeall Lucas from the GSU College of Law, Dr. Erin Ruel from the GSU Department of Sociology, and Dr. Leah Daigle, from the GSU Department of Criminal Justice and Criminology. This form has important information about the reason for doing this study, what we will ask you to do if you decide to be in this study, and the way we plan to use information about you if you choose to be in the study.

Why are you doing this study?

The purpose of this study is to provide a clearer picture of the problems experienced by those facing criminal charges and, in particular, those times when help from a legal aid attorney would have been or would be useful. For example, this might include issues relating to your housing, job, family, or benefits. We do this in the hope that by gaining a better understanding of the needs defendants face, opportunities can be provided to help people who will be in a similar situation in the future.

What will I do if I choose to be in this study?

If you choose to be part of this study, you will be interviewed. This means that I will ask you a series of questions that may or may not relate to you personally; everyone is asked the same questions. None of the questions will be about why you are here, what you have been charged with, or anything about your criminal case. Your participation is 100% voluntary and you can choose not to answer any question during the interview. You can change your mind and decide not to participate at any point during the interview, including after the interview has

concluded. If you decide not to participate at any time, your interview will not be used. If you choose to participate, your name will not be attached to the interview, and there will be no way to connect you in any way to the information you give during the interview.

If you decide to participate we will go over this consent form together, you can ask as many questions as you like about what we are doing. If you are comfortable and decide to proceed, I will turn on a digital recorder and ask you for your consent to participate. You will not sign a consent form, therefore there will be no record of your participation, and no way to connect your name to the answers you provide. We will then begin the interview using a nickname. At no time, will you be asked to identify anyone in your life beyond referring to your partner, brother, mother, etc.

Study time:

Study participation will take about one to three hours, depending on how many of the questions apply to you, and may take up to two visits depending on the allotted time for visitation.

Study location:

All interviews will take place at the jail / at a location of your choosing (if they are out on bond).

What are the possible risks or discomforts?

Your participation in this study does not involve any physical risk. You may feel uncomfortable when answering some of the questions. If that happens, you can take a break, or we can stop completely. You may feel uncomfortable with some of the questions and topics I ask you about, if you are uncomfortable, you are free to not answer or to skip to the next question.

What are the possible benefits for me or others?

You will not get any direct benefit from being in this research study. The study results may be used to help people in your situation in the future. Being in this study will have no effect on your current legal situation or representation, nor will it affect any future decisions regarding your eligibility for probation or parole. Participation will not improve your general living

conditions, medical care, food, or other amenities. I am in no way connected to your legal defense and you should not discuss any of the issues relating to your criminal case with me.

<u>How will you protect the information you collect about me, and how will that information be shared?</u>

I would like to record this interview to make sure that I remember everything you tell me. I will keep these recordings password protected and secure on my computer and they will be sent to a transcription service that has to keep the recording confidential (*and certificate of confidentiality – if necessary with approval of IRB application*). Only the individual who transcribes your interview and myself will have access to the recorded interview. Once the recording of your interview is transcribed, I will review and verify the transcription and then delete/destroy the recording. The things you say as part of this interview may be quoted in presentations or articles resulting from this work – you will not be identifiable because we will be using a made-up name. Results of this study may be used in publications, presentations, or other academic works. There will be no way to identify you from the information that will be retained.

<u>Financial Information</u>

Participation in this study will involve no cost to you. You will not be paid for participating in this study.

<u>What are my rights as a research participant?</u>

Participation in this study is voluntary. You do not have to answer any question you do not want to answer. If at any time and for any reason, you would prefer not to participate in this study, please feel free not to. If at any time you would like to stop the interview, please tell me. We can take a break, or stop altogether. You may withdraw from this study at any time, and you will not be penalized in any way for deciding to stop participation. If you decide to withdraw from this study, any information collected from you will not be used.

Consent

The research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact.

Waiver of Documented Consent Verbal Consent - If you agree to participate in this study, please say so now.

Appendix F: Client Interview

Client Interview Guide

Semi-structured Civil Legal Needs Assessment of Public Defender Clients

Introduction: Thank you for agreeing to voluntarily participate in this study. I appreciate your time and willingness to discuss your civil legal needs honestly and openly. I would like to say how very sorry I am about your current situation. However, I have to stress that we will not be talking about why you are here, or your criminal case.

(Read and acquire verbal Informed Consent—including consent to recording)

Interviewer Role: This is an opportunity for you to tell me about problems you may have or have had in the past and the effect those problems have had on you and those closest to you. My job as an interviewer is to listen to you, hear what you have to say, and ask follow up questions.

Do you have any questions? (*Address any questions or concerns*.) Do you give permission to participate in the study? (*If the respondent says "no," thank them for being willing to consider participating, end the interview. If yes, thank them, and begin the interview*.)

This interview is confidential and the information you provide will not be connected to your name in any way. It may be helpful if you choose a pseudonym, or fake name – not your real name – for me to use, one that would not allow others to identify you or that you have used in the past. Or we can pick a letter from the alphabet and I will call you Mr. or Ms. A, B, C, etc. This is what we will use during the interview itself; it is also how you will be referred to in my notes and any future write ups. Please note that the information collected may be made public in written form, including articles, reports, and other scholarly publications. In such works, we would only use your pseudonym, or fake name – not your real name.

Do you have a name in mind? (*If yes, let them disclose, if not give them a couple of options.*) Once a name has been selected, check in with participant's level of comfort (emotionally, physically). Are you ready to begin? I will begin recording now.

[select "record" on the recording device.]

Thank you again for agreeing to participate in this study. We are now recording. My name is Ruth Richardson; I am a graduate student in the Sociology Department at Georgia State University. And I have the pleasure of speaking with (give agreed upon pseudonym). I would like to ask your permission to record the interview, which will be transcribed for study purposes. If you are ok with recording, please state your pseudonym, or fake name – not your real name. (If participant is not "ok" with recording, thank them for being willing to consider participating and end interview).

I realize that the circumstances that brought you here are most likely on your mind, and I thank you again for agreeing to discuss any other problem that you may have or have had in the past. In the event that you slip and accidentally begin to relate any information about your criminal charges, here is what we will do: I will very politely yet firmly point out that you have started to talk about matters that do not concern us presently. I will then stop the interview, let you gather your thoughts, and restart the interview. If at any time during this process you would like to discontinue entirely, that is absolutely ok—please just let me know.

If at any point you decide that you would rather not participate that is absolutely ok—if that is the case, your interview will not be transcribed and included. Whether or not you decide to participate will have no effect on your criminal legal representation, or your relationship with your attorney. If you do decide to go through the entire interview and that we can include your interview in the study, your attorney will not know unless you decide to tell them.

This interview is 100% voluntary and confidential, and you may decline to answer any, or all of the questions I ask. The information you provide will not be connected to your name in any way.

*<u>Reminder</u> before beginning interview: You should NOT give any names, or provide information, that could identify you or others.

<u>Background</u>

1. What is your current age?

2. How do you identify your race?

3. Are you an American citizen?

4. Is English your primary language?

5. Do you speak any other languages?

<u>Legal Assistance</u>

6. Have you ever tried to get legal assistance from a civil legal services organization – i.e., one that does not handle criminal cases (like Atlanta Legal Aid, Georgia Legal Services Program, or the Atlanta Volunteer Lawyers Foundation)?

   a. Why/why not?

7. Have you ever paid to get legal assistance from a private attorney?

8. What are your general views or feelings about lawyers (<u>not</u> the public defender in your criminal case)?

<u>Education</u>

9. Are you in school currently? [***reminder: do not give anyone's name—although relationship (e.g., daughter, son, grandmother, sister, wife's mother, etc.) is ok—or any information that could identity you or others**]

   a. If no: How far did you go in school?

   b. If did not graduate, do you have a GED?

10. Were you ever suspended (in school or out of school) or expelled from school (or sent to an alternative school)? How old were you? What was the reason for your suspension/expulsion?

    a. If so, did it lead to a youth detention placement?

    b. Did you receive any help—from a lawyer or from a parent or other relative?

11. Did you ever have any issues with truancy (getting in trouble for not attending school)?

12. Were you ever arrested at school or have interaction with the juvenile justice system as a child?

13. Did you voluntarily drop out of school? Why?

   a. How old were you?

14. Would you be interested in returning?

15. Did you take special education classes?

   a. If no, were you ever evaluated? Do you think you should have been evaluated? Do you know if your parents ever tried to have you evaluated?

16. Do you find reading and writing difficult?

17. What challenges did you face in school?

18. Did you ever have legal assistance (or other help) for a suspension, expulsion, delinquency or special education matter?

19. Do you have children in school? Do they take any special education classes?

Family Situation

20. The next set of questions are about the place you were last living and who you were living with: [*reminder: do not give anyone's name—although relationship (e.g., daughter, son, grandmother, sister, wife's mother, etc.) is ok—or any information that could identity you or others]

   a. Did you live there by yourself?

   b. If not, who lived there with you? If spouse or partner, how long have the two of you been together?

      i.   Have you ever sought a divorce?

      ii. Do/did you feel safe where you live and/or with the people you live with? [domestic violence]

   c. Do you have any children living with you? If yes:

      i.   Are they yours with your current partner? Or yours from a previous relationship? Or your partner's from a previous relationship?

      ii. Boy or Girl(s)? Ages?

      iii. Who is looking after them while you're here?

      iv.   Do you have any concerns about how your children will fare (i.e., where they will live, where they will go to school, etc.) while your criminal case is being resolved?

21. Do you have any children from a previous relationship who don't live with you?

    a. Who do they live with?

    b. Are you paying child support? If yes - how is that going?

22. Do you have any concerns about your child(ren)'s safety?

    (**For next question, remind interviewee that they can choose not to answer and that we are not talking about anything related to criminal charges**)

23. (*If not already covered*) Have you ever had to deal with DFCS in any way? If yes—do you mind telling me what happened? [***reminder: do not give anyone's name—although relationship (e.g., daughter, son, grandmother, sister, wife's mother, etc.) is ok—or any information that could identity you or others**]

Housing

24. Can you describe to me where you were living before you came here? If homeless:

    a. How long have you been homeless?

    b. Where was the last place you were living before becoming homeless?

    c. Did you decide to leave?

    d. Have you ever stayed in a shelter?

25. If not homeless—What type of housing? [***reminder: do not give anyone's name—although relationship (e.g., daughter, son, grandmother, sister, wife's mother, etc.) is ok—or any information that could identity you or others**]

    a. House—do you or a relative own it? If renting—is the lease (remember no names) in your name (or in a relative's name)?

        i. If own—are you having issues making your mortgage payments or facing foreclosure?

    b. Apartment—is lease in your name? Or a relative's name?

    c. Room in boarding house?

    d. How long have you been living there?

26. Have you had any issues with your housing—for example, repairs your landlord refused to make; heat/AC, plumbing, bugs, mold, lead, etc.? Conditions that may have been affecting your health?

    a. Have you received any shut off notices for your power, gas, or water?

    b. How have you tried to handle these issues in the past?

27. Have you ever applied for housing vouchers/subsidies* or other housing assistance? If not, why? If so, what was the outcome and reason for outcome? (waitlisted, denied, etc.) Where did you apply (state and county)?

    *If clarification is needed: when the amount of your rent changes based on income at the time

28. Have you ever been evicted from housing?

    e. What happened? Was it for non-payment of rent, or another issue? (If another issue, what?) Did you seek help and, if so, from where or whom?

29. Are you concerned about whether your housing will remain stable or available while your criminal case is being resolved? Will you have somewhere to live when you are released?

Employment

30. Are you currently employed? Full time? Part time? [**reminder: do not give anyone's name—although relationship (e.g., daughter, son, grandmother, sister, wife's mother, etc.) is ok—or any information that could identity you or others**]

    a. What do you do?

    b. Have you had any issues being paid by your employer? (To clarify: are you paid at least minimum wage, when you work over 40 hours per week were you always paid overtime, etc.?)

        ii. If so, were those issues resolved? How did you resolve them?

    c. Does your current situation put your employment in jeopardy? Will you have a job when you are released?

31. How long have you been looking for a job? What type?

32. Have you gone to temp agencies? If yes, what kind and where?

33. What kind of assistance would be the most helpful to you to find a job?

34. What has been most difficult about finding steady employment?

35. Have you ever been fired from a job? If so, what was the reason given by your employer?

    a. Did you apply for unemployment benefits? Were you approved or denied? Did you seek assistance from an attorney?

36. Do you think that you were ever disciplined or fired (terminated) because of your race, gender, religion, etc.?

<u>Financial, Benefits and Subsidies</u>

37. Do you receive childcare benefits (subsidies)? If yes, amount? If no, did you apply? What happened? Were you ever aware that you might be eligible?

38. Do you receive food stamps? If no, did you apply? What happened? Describe your experience with DFCS. Were you aware that you might be eligible?

39. TANF? If no, did you apply? What happened? Describe your experience with DFCS. Were you aware that you might be eligible?

40. Do you live in public housing? Do you know if you qualify? Have you ever lived in public housing? If yes, but no longer—what happened?

41. Do you have a bank account?

42. Do you own a car?

    a. Has your car ever been impounded or repossessed? If yes, were you able to resolve it? How?

    b. Have you ever pawned the title of your car? If so, how often?

43. Do you have outstanding debts?

    a. Court-related debts (like probation monitoring fees)?

    b. Have you ever had your bank account or wages garnished?

44. Have you ever paid a company to process your tax return quickly? How much did you pay? Were you aware that these services are free?

45. Have you ever paid money to have a check cashed? If so, how often?

46. Have you ever taken out a payday or title loan?

    a. Why? What happened? Did you seek help (from a credit counselor, for example) before taking out the loan?

47. Have you experienced any harassment (phone calls or threats) about outstanding debt—from a creditor?

48. Are you feeling overwhelmed by or having issues making payments?

49. Have you ever filed, or thought about filing, for bankruptcy?

<u>Safety and Security</u>

50. Did you feel safe in the neighborhood where you grew up? And, do/did you feel safe in the last neighborhood you lived in before coming here? [**reminder: do not give anyone's name—although relationship (e.g., daughter, son, grandmother, sister, wife's mother, etc.) is ok—or any information that could identity you or others**]

51. Do you think that the police were doing a good job with problems that concerned people in your neighborhood? For example:

    a. Do you feel the police were doing a good job in preventing crime in your neighborhood?

    b. Do you feel like the police did a good job responding to people in your neighborhood after they had been victims of a crime?

    c. Did the police ever use force against people in your neighborhood?

<u>Health</u>

52. Do you have health insurance? If yes, what type?

53. Have you applied and been turned down for health insurance?

54. Do you have any health or medical conditions? If yes, what type?

    a. If so, do any of those conditions affect your daily living?

55. Do you/have you had issues accessing healthcare or filling prescriptions?

56. Do you currently receive disability? Have you ever received disability? If yes-

    a. What did you receive disability for?

    b. Why was it terminated?

    c. Do you have a pending disability claim?

    d. Have you been turned down? If so, why was that?

57. Have you ever been diagnosed with a mental illness? If yes, where? When?

58. Have you ever been prescribed medication?

    a. Are you receiving medication at this time?

    b. How useful is this treatment?

59. Have you ever been hospitalized for mental illness? If yes, When? Where?

60. Have you ever sought help with regard to mental health issues? From whom?

61. Do you have any issues around addiction? If yes, would you mind telling me about that?

    [**reminder: do not give anyone's name—although relationship (e.g., daughter, son, grandmother, sister, wife's mother, etc.) is ok—or any information that could identity you or others**]

    a. Has drug or alcohol use caused problems for you? Health, social, legal, or financial?

    b. Have you had difficulty doing what you are supposed to do because of drug or alcohol use?

    c. Has a friend or relative expressed concern about your drug use?

    d. Have you been in treatment for drug or alcohol abuse?

    e. Residential? When? Where? How useful was the treatment?

    f. Have you had times when you quit drugs or alcohol altogether? If yes, do you remember why you took them back up?

62. Is there any reason you have not or would not seek help for a mental health issue, either your own or that of a family member?

63. (*If applicable*) Do you have any concerns about medical/health care you will need to receive while incarcerated?

Military

64. Have you ever been in the military? If yes-

    a. What branch?

    b. How many years did you serve?

    c. Where did you serve?

    d. Did you see active combat? Could you tell me about that?

    e. What type of discharge did you get when you left the military?

    f.   Do you still have your military ID, and documents? If no:

       i.   Have you ever tried to replace them?

    g.   Do you receive VA healthcare benefits? Or VA disability benefits?

    h.   Are you currently receiving treatment or participating in a program?

<u>Other</u>

65. Do you have [or did you have] access to a computer or smart phone?

66. Do you have access to a car or public transportation? [i.e., in order to access services]

67. Do you have or have you ever had a valid driver's license?

    a.   Is your driver's license suspended? Do you know why your license is suspended?

    b.   Do you know what to do to get it reinstated? Do you know the cost of reinstatement?

68. Many people do not have proper ID, what type do you have (i.e., birth certificate, state ID, social security card, etc.)?

    a.   If do not have ID, why? (Example: sometimes people lose ID because of incarceration, has this ever happened to you?)

    b.   If you have lost your ID for any reason and had to replace it how did you go about doing that?

69. Are you registered to vote? Do you know if you are eligible to vote?

<u>**Concluding the Interview**</u>

Do you have any questions for me? Are there any questions you feel I should have asked but didn't? If interviewee provides questions, ask: how would you answer these questions?

Express appreciation to the interviewee for agreeing to participate, remind them that they can still decline to be part of the study and you will exclude their interview from your research. Remind them that their attorney will not be told what their decision was, unless they choose to tell them. Also, inform the interviewee that if they have changed their mind regarding participation in the study, they can at this point still decline to participate and their interview will not be used.

Reiterate that there are no advantages for participating, nor are there any disadvantages for not participating. If the participant is ok with interview and you do not need to return, thank them, and turn off the recorder.

<u>**Leaving the Jail**</u> (Note: interviewer will terminate interview completely before allotted visitation time is up, to normalize interaction to general topics—including sports, the weather, etc.—before leaving, it is important to remember that the interviewer is going out into the world, while the interviewee is returning to a small cell, and therefore it is very important to make sure that he/she leaves feeling as positive as possible, and not like they were rushed/brushed off when no longer useful.)

Appendix G: Attorney Interview Guide

Semi-structured Civil Legal Needs Assessment of Indigent Criminal Defendants

Introduction: Thank you for agreeing to voluntarily participate in this study. I appreciate your time and willingness to discuss your views on the civil legal needs of your clients.

Interviewer Role: My role as an interview is to listen to you, hear what you have to say and ask follow up questions.

Do you have any questions for me before we begin? Are you willing to participate in the study?

This interview is confidential and the information you provide will not be connected to your name in any way. It might be helpful if you choose a pseudonym for me to use, one that would not allow others to identify you or that you have used in the past. [Once name is selected, check with participant's level of comfort.] Are you ready to begin? I will begin recording now.

[Select "record" on the recording device.]

Thank you again for agreeing to participate in this study. We are now recording. My name is Ruth Richardson; I'm a graduate student in the Sociology Department at Georgia State University. And I have the pleasure of speaking with (give agreed upon pseudonym). I would like to ask your permission to record the interview, which will be transcribed for study purposes. If you are ok with recording, please state your pseudonym.

This interview is 100% voluntary and confidential. The information you provide will not be connected to your name in any way. The questions I am about to ask you are 100% voluntary, and you may decline to answer any or all of them.

*Reminder before beginning interview: You should NOT give any names, or provide information, that could identify you or others. General, anonymous anecdotes will be useful, we do not expect you to disclose information that is protected by attorney client privilege.

My first questions are general questions about you and your background

Background

1. What is your current age?
2. How do you identify your race?
3. Are you an American citizen?
4. Is English your primary language?
5. Do you speak any other languages?

Professional History/Background

6. How long have you been practicing law?

7. How long have you worked in this office?

8. Have you always practiced in the area of criminal defense?

      a.   If no, in what area(s) of law have you previously practiced?

9. Do you have any experience litigating civil cases, or otherwise handling civil legal issues?

      b.   If yes, ask them to elaborate

      10. Have you ever worked in private practice? If yes:

      c.   Ask them to elaborate

      d.   Why did you choose to give up private practice?

11. Are you licensed or do you have advanced degrees in any field other than law (e.g., social work)?

Transition

Thanks for your answers. I would like to switch gears a bit here, as you know we are conducting research to identify and assess the civil legal needs your clients may have, or may have had in the past. To help us get an idea of what these may look like, your experience and impressions are very important. We are also very interested in how unmet civil needs that your clients may be experiencing could impact their cases and/or his/her ability to focus and therefore your ability to represent them? (Remind interviewee about the importance of anonymizing or generalizing, so as to avoid attorney-client privilege issues.)

Client Demographics (general)

12. Can you give me an idea of the age range of the clients you have represented?

13. Have you had more male clients than female? Or vice versa?

14. What is the racial makeup of your client population? Which groups tend to be most represented?

Clients' Civil Legal Needs

15. Can you describe what first comes to mind when you think about your clients' "civil legal needs"? Please discuss.

      a. Are any of these issues particularly common or pervasive? Which do you see most among your clients?

16. Does the nature of civil legal needs experienced by your clients tend to vary by age? By gender? By race?Do you think your clients understand the difference(s) between the civil and criminal court systems?

      a. What about the difference between civil and criminal legal issues?

17. In your opinion, do your clients typically understand whether an issue they are experiencing could be addressed by civil legal assistance?

      a. Do you think they would seek such assistance? Why/why not?

18. Tell me, in your experience do the clients you represent usually get out on bond or do they remain in custody during their representation?

(*after this let the attorney know that you are now going to work through civil legal need areas that will correspond to the questions that were addressed to clients*)

<u>Housing</u>

19. People generally tend to associate the word 'indigent' with 'homeless', what are your thoughts on this?

20. Are any of your clients homeless?

      a. Roughly, what percentage of your client base would you identify as homeless?

21. If your clients are not homeless at the time of their arrest, do you know or have a sense of what type of housing they are living in?

      a. Public?

      b. With family?

      c. Long term motel?

      d. Boarding house?

      e. Other? Please elaborate.

22. Do you notice that most of your client seem to come from a particular area or neighborhood?

23. Can you recall ever having a client or hearing about another attorney's client that was in the process of being evicted or foreclosed upon while their case was in the process of being adjudicated?

      a. What impact, if any, did this have on their criminal case or your ability to defend them?

24. What impact *might* a client's eviction or housing instability have on their criminal case?

Financial, Benefits and Subsidies

25. Are you aware of any benefits or subsidies your clients may be receiving at the time of their arrest?

      a. For example, food stamps? TANF? Child care? Disability or SSI?

      b. Among your clients, how typical is it for them to be receiving some form of public assistance?

            i.   Which types of assistance are most common?

26. Have you ever had a client, or known other defenders with clients, who have lost such benefits in the midst of their criminal case?

      a. If so, what impact, if any, did it have on their criminal case?

27. How *might* the loss – or the fear of a loss – of benefits impact a client's criminal case?

28. Tell me generally your thoughts around the issue of financial benefits and subsidies as they pertain to the people you represent?

      a. Are they accessible?

Health

29. Do you see clients with preexisting medical conditions? If yes, what type? Are there certain types that are more common than others?

30. Have you had to advocate on behalf of a client so they could see medical personnel and acquire prescriptions while in custody?

      a. Is this something that happens routinely?

31. Do any of your clients have existing mental health diagnoses?

      a. How typical (or atypical) is it for a client to have a formal mental health diagnosis?

      b. Are there certain types that are more common than others?

32. When a client is suffering from mental illness, do you recommend that a social worker from your office see them? How often? Why/why not?

33. What impact have mental health issues had on your clients' criminal cases or your ability to defend them?

34. What impact *might* mental health issues have on your client's criminal case or your ability to defend them?

35. When deciding to request a social worker see your client do you take into consideration:

    a. Intensity of symptoms?

    b. The potential for these symptoms to impact your representation of that person?

    c. The availability of social workers, the current caseload they are carrying?

36. Do you see clients that have issues around addiction? If yes:

    a. Were they alcohol related?

    b. Drug related? If yes

    c. What kinds of drugs? Prescription? Street?

37. In your opinion, would access to treatment around addiction issues be beneficial to your clients? How? Please elaborate.

Military

38. Have you represented veterans? If yes:

    a. How often, or what percentage of your clients (rough estimate)?

        ii. Is there a predominant branch of the military represented among the office's clients?

    b. Do you see clients who have experienced active combat?

    c. Have you ever been aware that a client was eligible for VA healthcare or disability benefits that they had not received?

Education

39. Are you aware of the level of education your clients have?

    a. Can you generalize about the education level of your clients? How many (what percentage) have graduated from high school? Have a GED?

40. Are you concerned about the level of comprehension your clients have in your discussions with them and their case?

Family

41. Do any of your clients have children? If so:

a. If a client is unable to get bond, does the issue of childcare come up?

b. If it is the parent who is facing criminal charges is the primary caregiver and is in custody, who is caring for the child in their absence?

42. Have any of your clients experienced custody issues during their criminal case?

a. What impact, if any, did those issues have on their criminal case or your ability to defend them?

b. What impact *might* they have on their criminal case or your ability to defend them?

43. Do any of your clients owe child support? In your experience, have any of them had difficulty making these payments? If so, what happened?

a. Has a client's inability to pay child support ever had an impact on their criminal case or your ability to defend them?

b. What impact *might* it have?

44. Are you aware of any concerns your clients have about their child's or children's safety?

Employment

45. Are your clients typically employed?

46. For those who are employed, how would you describe their level of job security?

47. What impact might their employment (or unemployment) have on the criminal case (either your ability to litigate the case, or the outcome)?

48. What impact might the client's criminal case have on their employment?

Identification

49. Many people do not have proper ID: Are you aware of identification issues your clients may be experiencing or have experienced in the past? If yes, could you give an example?

a. Would your clients benefit if there was a process in place for them to get government-approved identification, that your office could help to facilitate, while you are representing them?

General

50. Do your clients and/or their families approach you with questions regarding civil legal needs?

      a. If so, for what type(s) of need are they typically or most often seeking assistance?

51. Can you recall a client that was so distracted by a civil issue—for example, child custody, losing a job—that it impacted their criminal case negatively?

      b. If so, please elaborate.

52. Have you ever personally addressed a client's civil issue in the context of providing them criminal representation?

      a. If so, what outcome?

      b. If not, why not?

53. Have you ever reached out to another party (legal aid, for example) to help address a client's civil legal need?

      a. If so, what outcome?

      b. If not, why not?

54. What do you see as the greatest benefit that could arise from your clients having access to civil legal advice while you are representing them?

55. Are there questions you feel I should have asked but didn't?

      a. If yes, what questions?

      b. How would you answer these questions?

Concluding the Interview

Thank you so much for taking the time to talk to me, I appreciate how busy you are.

Do you have any questions for me? If you do think of something else you would like to add, please do not hesitate to contact me at [give email/mobile #]. And, if you know of someone else who would like to talk to me, or to whom I should talk, please put them in touch with me.

Appendix H: Social Worker Interview Guide

Interview Guide Social Workers

Semi-structured Civil Legal Needs Assessment of Indigent Criminal Defendants

Introduction: Thank you for agreeing to voluntarily participate in this study. I appreciate your time and willingness to discuss your views on the civil legal needs of your clients.

Interviewer Role: My role as an interview is to listen to you, hear what you have to say and ask follow up questions.

Do you have any questions for me before we begin? Are you willing to participate in the study?

This interview is confidential and the information you provide will not be connected to your name in any way. It might be helpful if you choose a pseudonym for me to use, one that would not allow others to identify you or that you have used in the past. [Once name is selected, check with participant's level of comfort.] Are you ready to begin? I will begin recording know.

[Select "record" on the recording device.]

Thank you again for agreeing to participate in this study. We are now recording. My name is Ruth Richardson; I'm a graduate student in the Sociology Department at Georgia State University. And I have the pleasure of speaking with (give agreed upon pseudonym). I would like to ask your permission to record the interview, which will be transcribed for study purposes. If you are ok with recording, please state your pseudonym.

This interview is 100% voluntary and confidential. The information you provide will not be connected to your name in any way. The questions I am about to ask you are 100% voluntary, and you may decline to answer any or all of them.

*Reminder before beginning interview: You should NOT give any names, or provide information, that could identify you or others. General, anonymous anecdotes will be useful, we do not expect you to disclose information that is confidential.

Introduction Thank you for agreeing to participate in this study, your input is very valuable to us and we appreciate it.

My first questions are general questions about you and your background

General Background

1.   What is your current age?

2.   How do you identify your race?

3.   Are you an American citizen?

4.   Is English your primary language?

5.   Do you speak any other languages?

Professional History/Background

6.   How long have you been a social worker?

7.   How long have you worked in this office?

8.   Have you always worked in the area of criminal defense?

    a.   If no, ask them to elaborate (what other areas of practice)?

9.   Do you have any experience with civil legal issues, or with legal aid agencies?

10.   Have you ever worked in private practice? If yes:

    a.   Ask them to elaborate

    b.   Why did you choose to give up private practice?

11.   Are you licensed or do you have advanced degrees in any field other than social work (e.g., law)?

Transition

Thanks for your answers, I would like to switch gears a bit here, as you know we are conducting research to identify and assess the civil legal needs your clients may have, or may have had in the past. To help us get an idea of what these may look like- your experience and impressions are very important. We are also very interested in how unmet civil needs that your client may be experiencing could impact their cases and/or his/her ability to focus and therefore your ability to represent them? (Remind interviewee about the importance of anonymizing or generalizing responses.)

Client Demographics (general)

12.   Can you give me an idea of the age range of clients with whom you have worked in this office?

13.   Have you had more male clients than female? Or vice versa?

14.   What is the racial makeup of your client population? Which groups tend to be most represented?

Client's Civil Legal Needs

15. Can you describe what first comes to mind when you think about your client's "civil legal needs"? Please discuss.

   a. Are any of these issues particularly common or pervasive? Which do you see most among your clients?

16. Does the nature of civil legal needs experienced by your clients tend to vary by age? By gender? By race?

17. Do think your clients understand the difference(s) between the civil and criminal court systems?

   a. What about the difference between civil and criminal legal issues?

18. In your opinion, do your clients typically understand whether an issue they are experiencing could be addressed by civil legal assistance?

   a. Do you think they would seek such assistance? Why/why not?

19. Tell me, in your experience do the clients you represent usually get out on bond or do they remain   in custody during their representation?

(*after this let the interviewee know that you are now going to work through civil legal need areas that will correspond to the questions that were addressed to clients*)

<u>Housing</u>

20. People generally tend to associate the word 'indigent' with 'homeless', what are your thoughts on this?

21. Are any of your clients homeless?

   a. Roughly, what percentage of your client base would you identify as homeless?

22. If your clients are not homeless at the time of their arrest, do you know or have a sense of what type of housing they are living in?

   a. Public?

   b. With family?

   c. Long-term motel?

   d. Boarding house?

   e. Other? Please elaborate.

23. Do you notice that most of your client seem to come from a particular area or

neighborhood?

24. Can you recall ever having a client or hearing about a client that was in the process of being evicted or foreclosed upon while their case was in the process of being adjudicated?

    a. What impact, if any, did this have on their criminal case or your ability to work with them?

25. What impact *might* a client's eviction or housing instability have on their criminal case?

<u>Financial, Benefits and Subsidies</u>

26. Are you aware of any benefits or subsidies your clients may be receiving at the time of their arrest?

    a. For example, food stamps? TANF? Childcare? Disability or SSI?

    b. Among your clients, how typical is it for them to be receiving some form of public assistance?

    c. Which types of assistance are most common?

27. Have you ever had a client, or known other social workers or defenders with clients, who have lost such benefits in the midst of their criminal case?

    a. If so, what impact, if any, did it have on their criminal case?

28. How *might* the loss – or the fear of loss – of benefits impact a client's criminal case?

29. Tell me generally your thoughts around the issue of financial benefits and subsidies as they pertain to the people you represent?

    a. Are they accessible?

<u>Health</u>

30. Do you see clients with preexisting medical conditions? If yes, what type? Are there certain types that are more common than others?

31. Have you had to advocate on behalf of a client so they could see medical personal and acquire prescriptions while in custody?

    a. Is this something that happens routinely?

32. Do any of your clients have existing mental health diagnosis? If yes,

    a. How typical (or atypical) is it for a client to have a formal mental health diagnosis?

b. Are there certain types that are more common than others?

33.   When a client is suffering from mental illness, do attorneys recommend that a social worker from your office see them? How often? Why/why not?

34.   What impact have mental health issues had on your clients' criminal cases or the attorneys' ability to defend them?

35.   What impact *might* mental health issues have on your client's criminal case or the attorneys' ability to defend them?

36.   When deciding to request a social worker to see their client do attorneys take into consideration:

a. Intensity of symptoms?

b. The potential for these symptoms to impact the representation of that person?

c. The availability of social workers, the current caseload you are carrying?

37.   Do you see clients that have issues around addiction? If yes:

a. Were they alcohol related?

b. related? If yes

c. what kinds of drugs? Prescription? Street?

38.   In your opinion, would access to treatment around addiction issues be beneficial to your clients? How? Please elaborate.

Military

39.   Have you ever represented/worked with veterans? If yes:

a. How often, or what percentage of your clients (rough estimate)?

iii. Is there a predominant branch of the military represented among the office's clients?

b. Do you see clients who have experienced active combat?

c. Have you ever been aware that a client was eligible for VA healthcare or disability benefits that they had not received?

Education

40.   Are you aware of the level of education your clients have?

a. Can you generalize about the education level of your clients? How many (what percentage) have graduated from high school? Have a GED?

41. Are you routinely concerned about the level of comprehension your clients have in your discussions with them and their case?

Family

42. Do any of your clients have children? If so:

a. If a client is unable to get bond, does the issue of childcare come up?

b. If it is the parent who is facing criminal charges is the primary caregiver and is in custody, who is caring for the child in their absence?

43. Have any of your clients experienced custody issues during their criminal case?

a. What impact, if any, did those issues have on their criminal case or the ability of the attorney to defend them?

b. What impact *might* they have on their criminal case or the attorneys' ability to defend them?

44. Do any of your clients owe child support? In your experience, have any of them had difficulty making these payments? If so, what happened?

a. Has a client's inability to pay child support ever had an impact on their criminal case or their attorneys' ability to defend them?

b. What impact *might* it have?

45. Are you aware of any concerns your clients have about their child's or children's safety?

Employment

46. Are your clients typically employed?

47. For those who are employed, how would you describe their level of job security?

48. What impact might their employment (or unemployment) have on the criminal case (either the attorney's ability to litigate the case, or the outcome)?

49. What impact might the client's criminal case have on their employment?

Identification

50. Many people do not have proper ID: Are you aware of identification issues your clients may be experiencing or have experienced in the past? If yes, could you give an example?

a. Would your clients benefit if there was a process in place for them to get government-approved identification, that your office could help to facilitate, while you are representing them?

Re-entry

51. Can you explain to me how you (social worker) become involved in an individual's re-entry process?

52. On average, how many of the clients represented by your office get assistance with re-entry?

53. In your opinion, would more of your clients benefit from this type of assistance?

a. If so, in what ways?

b. How could your office include more clients in re-entry assistance?

General

54. Do your clients and/or their families approach you with questions regarding civil legal needs?

a. If so, for what type(s) of need are they typically or most often seeking assistance?

55. Can you recall a client that was so distracted by a civil issue—for example, child custody, losing a job—that it impacted their criminal case negatively?

a. If so, please elaborate.

56. Have you, or an attorney you were working with, personally addressed a client's civil issue in the context of providing them criminal representation?

57. Have you (or, to your knowledge, have any of the attorneys) ever reached out to another party (legal aid, for example) to help address a client's civil legal need?

c. If so, what outcome?

d. If not, why not?

58. What do you see as the greatest benefit that could arise from your clients having access to civil legal advice while your office is representing them?

59. Are there questions you feel I should have asked but didn't?

e. If yes, what questions?

f. How would you answer these questions?

Concluding the Interview

Thank you so much for taking the time to talk to me, I appreciate how busy you are.

Do you have any questions for me? If you do think of something else you would like to add, please do not hesitate to contact me at [give email/mobile #]. And, if you know of someone else who would like to talk to me, or to whom I should talk, please put them in touch with me.

Appendix I: Client Coding Index

1. Access Computer Smart Phone

    1.1 Computer
        No
        Yes

    1.2 Smart Phone
        Consistent Coverage
        Inconsistent Coverage

2. Access Transportation

    2.1 Family or Friend's Vehicle

    2.2 Own Vehicle

    2.3 Public Transportation

3. Addiction

    3.1 AA or NA Non-Residential

    3.2 Alcohol Addiction

    3.3 Drug Addiction

    3.4 Residential Drug Rehabilitation

    3.5 Self- Medicating

4. Background

    4.1 White Self-identification of race

    4.2 Black Self-identification of race

    4.3 Age

    4.4 Gender
        Female
        Male

5. Driver's License

    5.1 No DL

    5.2 Suspended DL

    5.3 Suspended DL for nonpayment of child support

5.4 Suspended DL for nonpayment of traffic tickets or fines

5.5 Yes DL

6. Education

   6.1 Developmental Disability

   6.2 Expelled
       Alternative School
       Expelled no Representation
       Expelled w Representation
       Youth Detention

   6.3 High School Graduate
       GED
       No
       Yes

   6.4 School Environment

   6.5 Suspended

   6.6 Suspended Falling Behind

   6.7 Tested ADHD

       6.7.1 Medication Prescribed
           Not Taken
           Taken
           Taken Intermittently

7. Employment

   7.1 Applied for Unemployment
       Denied
       Received

   7.2 Facing Unemployment after Release

   7.3 Felt Pressure to Leave Employment

   7.4 Job Placement Needs

   7.5 Temp Agency Experience

8. Family

   8.1 Children

8.2 DFCS Involvement

8.3 Family of Origin
      Physical Abuse by Parent of Sibling

8.4 Spouse or Partner

9. Financial Benefits and Subsidies

    9.1 Applied for Benefits
        Benefits Denied
        Benefits Obtained
            Lost Benefits
        Food Stamp Experience with DFCS During Application Process

    9.2 Child Support

    9.3 Child Support Issue

    9.4 Civil Forfeiture

    9.5 Debt Management and Bankruptcy

    9.6 Disinterest in Receiving Benefits

    9.7 Private Probation Debts and Court Costs

    9.8 Reliance on Family for Financial Help

10. Health

    10.1 Access to Prescribed Medication

    10.2 Concerned re Medical Treatment While Incarcerated

    10.3 Existing Medical Condition

    10.4 Health Insurance
        No
        Yes

11. Housing

    11.1   Evicted bc of Child Involvement with DOJ

    11.2   Eviction

    11.3   Experienced Negative Stigma re Homelessness

    11.4   Homeless Stayed in Shelter

11.5   Homeless Stayed on Street

11.6   Homeless Stayed w Friends/Family

11.7   Public Housing

11.8   Repair Upkeep Issues

11.9   Seeking Family Support in Time of Eviction

11.10   Weekly Hotel

12. Identification
      No
      Yes

13. Legal Assistance

13.1   Attempt to Access CLA

13.2   Attitude re Attorneys in General

13.3   Attitude Toward CLA

13.4   Does Not know about CLA availability

13.5   Expresses Need for Credible Information

13.6   Has Hired Private Attorney

13.7   Impact of Poverty on Accessing CLA

13.8   Issue Where CLA Could Have Been Sought But Wasn't

14. Mental Health

14.1   Attitude toward Medication

14.2   Attitude toward Seeking Help for Others
          Negative
          Positive
          Unsuccessful Attempt

14.3   Attitude toward Seeking Help for Self
          Negative
          Positive
          Unsuccessful Attempt

14.4   Attitude Toward Telling Others About MH Issues

14.5   Attitudes of Family Members or Friends Toward MH Issues

14.6   Childhood MH Issue

14.7   Confusion Around Inpatient Treatment for MH Issues

14.8   Consistency re Medication

14.9   Diagnosis
        Family Member Anecdotal MH
        Family Member w/ Formal MH Diagnosis
        Informal Diagnosis
        Yes w/ Medication
        Yes w/o Medication

14.10   Impressions of AA and Seeking Help w MH issues

14.11   Inpatient Mental Health Treatment

15. Military
        Eligible but no VA Benefits
        Parent in Military
        VA Benefits

16. Plans for Life after Case Adjudication

17. Safety and Security

17.1   Most Recent Neighborhood
        Do Not Feel Safe
        Feel Safe
        Police Are Doing Good Job
        Police Are Not Doing Good Job
        Police Are Doing Somewhat of a Good Job
        Wx or Experienced Police Violence

17.2   Neighborhood Growing Up
        Did Not Feel Safe
        Felt Safe
        Police Did a Good Job
        Police Did Not Do a Good Job
        Police Did Somewhat of a Good Job
        Wx or Experience Police Violence

18. Have Taken Plea to Get out of Jail regardless of Guilt of Innocence

19. Voting Registration

    19.1   No
                No Eligible
                Yes Eligible

Appendix J: Attorney Coding Index

1. Addiction

    1.1 Attorney Attitude to Drug Alcohol Treatment Sentencing

2. Attorney Emotional Cost of Job

3. Attorney Ability to Contact Client by Phone

4. Bonds

5. Client Demographics Generally

    5.1 Age Range

    5.2 Gender
    Female
    Male
    5.3 Race
    Approx. Asian /Black/Latino/ White

6. Client's Civil Legal Needs

    6.1 Attorney's Reached out to CLA services for Client
    No
    Yes

    6.2 Benefit of Client Receiving CLA

    6.3 Civil Needs Impact Criminal Case

    6.4 Client or Families Approach Attorney with Civil Question
    No
    Yes

    6.5 Criminal Case Impact Civil Needs
    No
    Yes

    6.6 Most Common

    6.7 Understand Difference Btwn Civil and Criminal
    No
    Yes

    6.8 Would Client Seek Civil Need Assistance

7. Education

    7.1 Developmental Disability

13.2 Existing Medical Conditions

14. Housing

   14.1 Eviction

   14.2 Highly Represented Area or Neighborhood

   14.3 Homeless

   14.4 Type of Housing at time of Arrest

15. Identification

16. Luck of the Judge

17. Mental Health

   17.1 Access to MH Treatment

   17.2 Client MH Diagnosis
            No
            Yes

   17.3 Concerned with Level of Client Comprehension
            No
            Yes

   17.4 Impact of MH Issues on Criminal Representation

   17.5 Most Common Client MH Issue

   17.6 Percent Clients with MH Issues

   17.7 Reasons not to Identify MH issue

   17.8 Self-Reporting Issues and Client Attitudes Towards Mental Illness

18. Military

19. Probation

20. Professional History~Background

21. Reliance on Personal Contacts to Help Clients

22. Setting Clients up for Failure

23. Stigma re Poverty

24. Thoughts re Term Indigent

25. Unasked Question Suggestions

Appendix K: Social Worker Coding Index

1. Addiction

    1.1 Dual Diagnosis

    1.2 Social Worker Attitude to Drug Alcohol Treatment Sentencing

2. Attorney Ability to Contact Client by Phone

3. Bonds

4. Client Demographics Generally

    4.1 Age Range

    4.2 Gender
        Female
        Male
    4.3 Race
        Approx. Asian /Black/Latino/ White

5. Client's Civil Legal Needs

    5.1 SW's Reached out to CLA services for Client
        No
        Yes

    5.2 Benefit of Client Receiving CLA

    5.3 Civil Needs Impact Criminal Case

    5.4 Client or Families Approach SW with Civil Question
        No
        Yes

    5.5 Criminal Case Impact Civil Needs
        No
        Yes

    5.6 Most Common

    5.7 Understand Difference btwn Civil and Criminal
        Does Not Know
        No
        Yes

    5.8 Would Client Seek Civil Need Assistance

6. Education

6.1 Criminalization of Children's Behavior

6.1 Developmental Disability

6.2 High School Graduate
     No
     Yes

6.3 Information Deficit

7. Employment

7.1 Potential Loss of Employment

8. Family

8.1 Child Custody Issue

8.2 Child Support Issue
     DL Suspension

8.3 Client Concern for Client Safety

9. Financial, Benefits and Services

9.1 Access to Benefits

9.2 Court Costs and Fines
     DL Suspension

9.3 Loss of Benefits
     No
     Yes

9.4 Most Common

10. General Background

10.1 Age

10.2 Gender
     Female
     Male

10.3 Self-Identified Race
     Black
     White

11. General Civil Legal Needs

12. Health

    12.1 Access to Medical Treatment in Jail

    12.2 Existing Medical Conditions

13. Housing

    13.1 Eviction

    13.2 Highly Represented Area or Neighborhood

    13.1 Homeless

    13.2 Type of Housing at time of Arrest

14. Identification

15. Luck of the Judge

16. Mental Health

    16.1 Access to MH Treatment

    16.2 Client MH Diagnosis
        Georgia Regional
        No
        Yes

    16.3 Concerned with Level of Client Comprehension
        No
        Yes

    16.4 Impact of MH Issues on Criminal Representation

    16.5 Most Common Client MH Issue

    16.6 Reasons not to Identify MH issue

    16.7 Self-Reporting Issues and Client Attitudes Towards Mental Illness

17. Military

18. Non-Legal Non-Profit Organizations

19. Predatory Legal Behavior

20. Probation

21. Professional History~Background

22. Re-entry

23. Setting Clients up for Failure

24. SW Emotional Cost of Job

25. SWs Personal Contacts

26. Thoughts re Term Indigent

27. Unasked Question Suggestions

28. Word of Mouth or Word on the Street