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Exploring the Barriers to Mental Health Treatment among Justice-Involved Women living in the U.S.-México border region

Rebekah Ruth Adair-Russell
University of Texas at El Paso

EXPLORING THE BARRIERS TO MENTAL HEALTH TREATMENT AMONG JUSTICE-INVOLVED WOMEN LIVING IN THE U.S.-MÉXICO BORDER REGION

REBEKAH R. ADAIR-RUSSELL

Doctoral Program in Psychology

APPROVED:

Jennifer Eno Louden, Ph.D., Chair

Osvaldo Morera, Ph.D.

Theodore V. Cooper, Ph.D.

April Gile Thomas, Ph.D.

Hyejin Jung, Ph.D.

Stephen L. Crites, Jr., Ph.D.
Dean of the Graduate School

Dedication

I dedicate this piece of work to my late father. The person who inspired me to ask questions and take the journey to find the answers.

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by

REBEKAH R. ADAIR-RUSSELL, M.A.

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Abstract

For women in the criminal justice system, mental illness is a complicated and prevalent factor, with rates ranging from 49.2% to 67.9% (Bronson & Berzofsky, 2017). To address the mental health care that justice-involved women need, scholars have called for a closer examination of barriers that hinder access to mental health and substance use treatment among this population (Winham et al., 2015; Wilfong et al., 2021). Barriers to treatment can be attitudinal (i.e., stigma and fear) or structural (i.e., transportation, cost of treatment), yet few, if any, studies have examined how these barriers present in a group of justice-involved women living in the U.S.-México border region. The current project explored the relationship of barriers to treatment among 85 justice-involved women living in the Paso del Norte border region located in El Paso, Texas, and surrounding areas. The project investigated (1) what barriers women frequently identified as hindering their treatment, (2) how the barriers contributed to receipt of services, and (3) whether internalized stigma mediated a relationship between endorsed attitudinal barriers and perceived public stigma. Findings show attitudinal barriers were more frequently endorsed as barriers to seeking treatment compared to structural barriers. For the second aim, attitudes and public stigma were at decreased odds for past treatment seeking, yet internalized stigma was associated with increased odds of past treatment seeking and future treatment seeking. However, structural barriers did not emerge as significant predictors for past, present, or future treatment seeking. Finally, internalized stigma was a significant mediator between public stigma and attitude barriers. Results suggest that stigma and attitudes, while complex, are associated with help-seeking and should be addressed to increase utilization of treatment services for justice-involved women in the Paso del Norte border region.

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Chapter 1: Introduction

Women's rates of incarceration have increased more than 700% between 1980 and 2019 (The Sentencing Project, 2020). Many women in the criminal justice system experience some form of mental illness: 49.2% to 67.9% of justice-involved[1] women, depending on the setting (Bronson & Berzofsky, 2017; Substance Abuse and Mental Health Services Administration (SAMHSA), 2012). Even more women in the justice system report experiencing psychological distress but may not necessarily have received a formal diagnosis of mental illness (60%—70%; James & Glaze, 2006). Some estimates suggest that among justice-involved women, 53% meet diagnostic criteria for posttraumatic stress disorder (PTSD) and 43% meet criteria for serious mental illnesses (e.g., major depression, bipolar disorder, and psychotic spectrum; Lynch et al., 2014). The cyclical relationship between trauma, mental health symptoms, and self-medication through substance use creates an entangled array of symptoms and issues that must be addressed to adequately resolve harmful patterns among justice-involved women. For example, women involved in volatile relationships often suffer from past trauma or victimization (Salisbury & Van Voorhis, 2009) and those traumatic experiences may lead women to alleviate reminders of such trauma through self-medication with substance use (DeHart, 2018; Lynch et al., 2012).

High quality mental health care, which includes treatment of co-occurring substance abuse, is a crucial component of programs to effectively rehabilitate justice-involved women (Messina et al., 2014; Wilfong et al., 2021). Ideally, such treatment should be available at various levels of the criminal justice system considering self-report data shows that women with mental health problems are more likely to report criminal behavior after release from prison compared to women with no mental health problems (Bakken & Visher, 2018). Women with

[1] Smith (2022) defines "justice-involved" as anyone who has contact with the criminal justice system including, awaiting trial, former incarceration, and/or on community supervision.

mental illness have more difficulty reintegrating back into communities compared to women without mental illness (Mallik-Kane & Visher, 2008). To increase the likelihood that justice-involved women receive the mental health care they need, scholars have called for a closer examination of factors that prevent justice-involved women from accessing mental health and substance use treatment (Winham et al., 2015; Wilfong et al., 2021).

To adequately address barriers to mental health treatment for justice-involved women, it is important to consider under-studied groups, such as women who are members of ethnic and cultural minority groups and those with intersectional identities (Carson, 2020; Eghaneyan & Murphy, 2020; Schuk et al., 2004). The U.S.-México border region is home to many such women, who likely experience unique barriers to seeking mental health treatment. El Paso, Texas is one of the largest U.S.-México border cities with an 82% Hispanic[2] population (U.S. Census Bureau, 2021) and about 20% of people living in this border city have a mental health disorder (Emergence Health Network, 2022). Additionally, around 20% of people in El Paso are unable to afford to see a doctor (Healthy Paso del Norte, 2018) and only 70% of people in El Paso County have health insurance (Healthy Paso del Norte, 2019). Moreover, research indicates that cultural factors may be related to stigma of mental illness in the El Paso region (Eno Louden et al., 2023). While justice-involved Hispanic women are largely overlooked in criminal justice research (Lopez & Pasko, 2017; Schuck et al, 2004), even more understudied are justice-involved women in the U.S.-México border region (Lopez & Pasko, 2017; Eno Louden & Manchak, 2018). Therefore, understanding the barriers to treatment among justice-involved women in the border region is important to investigate.

[2] Pew Research Center (2020) found that among Hispanic/Latino-identifying people, 61% prefer the term 'Hispanic' to describe themselves, whereas 29% prefer Latino, and 4% prefer Latinx. Therefore, this paper will use the term 'Hispanic' to refer to people identifying as being of Latin American origin or decent.

The present study aims to examine the barriers that prevent justice-involved women in a U.S.–México border region from seeking mental health and substance use treatment. The following literature review examines key topics surrounding justice-involved women and their treatment needs. First, the role mental illness plays in the lives of justice-involved women will be described, followed by a review of work examining the impact of untreated mental illness on justice-involved women's rehabilitation. Next, barriers to mental health treatment-seeking will be discussed including topics such as stigma of mental illness, doubts in the effectiveness of treatment, and affordability and accessibility of treatment. Lastly, the aims and hypotheses of the project are presented.

JUSTICE-INVOLVED WOMEN, MENTAL HEALTH, AND REHABILITATION

While the rate of incarceration among men is higher than the rate among women (The Sentencing Project, 2020), research demonstrates that mental illness is more prevalent among justice-involved women compared to justice-involved men (Bronson & Berzofsky, 2017; Winham et al., 2015). Girls are around two times more likely to have mental health issues compared to boys (Vincent et al., 2008), with 74% of justice-involved girls having met criteria for at least one mental health diagnosis, compared to 66% of justice-involved boys (Teplin et al., 2013). Over half of incarcerated women (56%) report a need for mental health care prior to entering the criminal justice system (Blitz et al., 2006) and more than half (66%) of justice-involved women report history of mental health problems compared to 35% among men (Bronson & Berzofsky, 2017). Major depressive disorder is the most common diagnosis seen in carceral settings (24.2% in prison vs. 30.6% in jail vs. 6.7% in general adult population), followed by bipolar disorder (17.5% in prison vs. 24.9% in jail vs. 2.8% in general adult population; ADAA, 2021; Bronson & Berzofsky, 2017; Harvard Medical School, 2005). Women

on probation and parole are two times as likely to have a mental illness compared to women in the general population and are three times as likely to have a serious mental illness (28.5% parole vs. 21.5% probation vs. 7.8% general population, SAMHSA, 2012). Justice-involved women also have higher rates of co-occurring substance use and depression compared to men (Bloom et al., 2003). Chronic mental illnesses, such as major depression, require long-term treatment which can exceed the average time spent in jail (Zeng, 2019). The mental health needs of justice-involved women are prevalent in all areas of the criminal justice system and the challenges that prevent women from accessing treatment services vary based on the circumstances of each woman.

The role that mental health plays among justice-involved women comes with challenges. Women on probation and parole are no more likely to use mental health services or substance use treatment compared to non-justice-involved women (Lorvick et al., 2015), despite their increased need for such services due to prevalence of trauma, mental illness, and substance use (Fournier et al., 2011; Lynch et al., 2014). Lifetime substance use and mental illness has been shown to mediate the relationship between victimization and number of convictions among justice-involved women (Lynch et al., 2017), further demonstrating the impact victimization has on offending within this population. Salisbury and Van Voorhis (2009) noted the cyclical relationship between victimization, mental illness, and substance use on women's admission into prison. Oftentimes for girls, abuse is directly related to running away from home, which leads to their first involvement with the criminal justice system (Bloom et al., 2003). Even staff and officers within the criminal justice system remark on the unique difficulties that women and girls face due to past trauma and mental illness (Belknap, 2016; Burson et al., 2019).

When considering the prevalence of mental illness among justice-involved women and the impact that women's unique experiences can have on their mental health, it seems obvious that rehabilitative treatment for justice-involved women should focus on mental health care. However, this is not always the case. Two approaches to rehabilitation advocate for justice-involved women's needs differently when it comes to treatment. First, the gender-neutral approach treats men and women the same when addressing the risks associated with reoffending (Bonta & Andrews, 2017). Treatment can be individualized within the gender-neutral approach, yet the focus is to immediately address risk factors that have direct links to recidivism. However, as described later, these risk factors often do not include mental illness specifically (Vitopoulos et al., 2012). Second, the gender-responsive approach advocates for treatment of women's unique needs, including mental health and past victimization, in addition to addressing re-offending risk factors noted in the gender-neutral approach (Van Voorhis et al., 2010).

Gender-Neutral Approach to Mental Health Treatment in Rehabilitation

Women have often been examined through the same lens as men regarding how they become involved with crime and how they can be rehabilitated. Most approaches that examine criminal behavior involve a gender-neutral approach – suggesting that men and women can benefit from the same programs and treatments to curb recidivism. One such approach is the Risk Need Responsivity (RNR) model, which stems from the General Personality and Cognitive Social Learning (GPCSL) theory of rehabilitation for offending (Bonta & Andrews, 2017). Within RNR, there are eight risk factors (called the "Central 8") underlying criminal behavior: history of criminal behavior, procriminal attitudes, procriminal associates, antisocial personality pattern, family and martial problems, problems with education and employment, substance use, and lack of prosocial leisure and recreation activities (Bonta & Andrews, 2017). Multiple needs

are highlighted in RNR, particularly among people considered "high-risk", but there are two distinct classifications: criminogenic needs and non-criminogenic needs. Criminogenic needs are those that encompass all but one of the eight listed risk factors (criminal history). These criminogenic needs are dynamic – meaning when they are changed, they can reduce or increase recidivism. An example is substance use, where reducing substance use can subsequently reduce recidivism for an individual. Non-criminogenic needs can also be dynamic but are not strongly related to recidivism (Bonta & Andrews, 2017). These non-criminogenic needs can include major mental health disorders (e.g., bipolar, schizophrenia), self-esteem, and anxiety (Bonta & Andrews, 2017). Due to non-criminogenic needs having a weaker association with recidivism (i.e., symptoms of mental illness are rarely directly related to offending; Peterson et al., 2014), they are not prioritized in rehabilitation to the same extent as criminogenic needs. However, non-criminogenic needs may be addressed if they indirectly influence a criminogenic need (Bonta & Andrews, 2017). A common example is seen when people are abusing substances to subdue unwanted symptoms of mental illness and their risk of offending is heightened (O'Keefe & Schnell, 2007).

The responsivity component of the RNR model addresses how to deliver treatment programs to address criminal behavior that are individualized for justice-involved people (Bonta & Andrews, 2017). Yet individualized treatment is challenging, especially considering the difficulties of implementation of treatment in carceral and community settings that struggle with staffing problems, overwhelming need of services, and other restrictions (Messina et al., 2014; The Marshall Project, 2018). Bonta and Andrews (2017), under the responsivity principle, recommend four areas for justice supervision to address criminal offending in the community: 1) fostering a therapeutic alliance, 2) increase cognitive-behavioral skills, 3) ensure concepts and

skills are easy for all clients to understand and relevant to their profile, and 4) structure supervision into individual and easy-to-follow steps. The RNR model was conceptualized as an approach applicable across people of differing ethnic backgrounds (Bonta & Andrews, 2017). Research is mixed regarding how effective the responsivity model is for people in minority groups compared to programs that account for culture-specific needs (Cervantes et al., 2004; Gondolf, 2007; Wooldredge et al., 1994).

According to the RNR model, gender and mental illness are distally related to criminal offending (Bonta et al., 2014). The more pressing components of the GPCSL and RNR are to address the "Central 8" risk factors, regardless of gender, due to the more associated relationship these factors have with offending behavior. The responsivity model suggests that targeting specific gendered factors is not as effective as targeting criminogenic risk factors (Gehring et al., 2010) with some studies demonstrating no differences when introducing gender-specific programs (Brannen & Rubin, 1996; Vitopoulos, 2016). Unfortunately, most work examining the gender-neutral perspective is done with majority samples of justice-involved men (Bonta et al., 2014; Kane et al., 2011) and not women. Some scholars believe that women face more unique risks (i.e., mental illness and trauma; Hardyman & Van Voorhis, 2004) that fall outside the gender-neutral conceptualization of criminogenic risk factors and should be addressed to improve recidivism (Gehring et al., 2010).

Feminist Criminology and Rehabilitation

Feminist criminology emerged from the recognition that justice-involved women are subject to treatments and programs that were widely tested on men, but not on women (Belknap, 2007; Van Voorhis et al., 2010). Feminist criminologists' main criticism of gender-neutral approaches is that the unique experiences of women are different from men and therefore male-

based research findings cannot be indiscriminately applied to justice-involved women under the assumption these findings will work the same across both populations. In fact, work examining the effectiveness of treatments that have been specifically created for justice-involved women find that gender-informed services have advantageous outcomes for women who enter the criminal justice system due to gendered reasons (Day et al., 2015; Gobeil et al., 2016; Saxena et al., 2014). These specific gendered reasons, better known as feminist pathways into crime, are at the core of feminist criminology and suggest that women become involved in crime differently than men and therefore would benefit from specialized rehabilitative services that focus on women's unique needs.

According to the pathways research, justice-involved women are more likely to experience trauma, mental illness, and substance use (Daly, 1992; Salisbury & Van Voorhis, 2009). Particularly, past and present victimization experiences co-occur with mental illness and substance use in a few ways for justice-involved women (Logan et al., 2006). First, past victimization can create exacerbated mental health issues, which leads to substance use as a coping mechanism. Second, a history of mental health problems and comorbidity of substance use can lead to future victimization. Lastly, substance use can exacerbate mental health symptoms that may lead to future victimization. The overlapping relationships between victimization, mental illness, and substance use create obstacles for treatment, specifically when determining which needs should be addressed first. Additionally, these components overlap in a way that can influence future criminal behavior, with findings indicating that mental illness and substance use mediate the relationship between past victimization and number of convictions (Lynch et al., 2017). Women who become involved in the criminal justice system through the interaction between victimization, mental illness, and substance use, benefit more from gender-

responsive treatments (Bartlett et al., 2015). However, complex treatment plans are difficult to implement with incarcerated populations due to lack of funding and overcrowded facilities (Dickson et al., 2018; Hoke 2015; Pugh et al., 2015), as is continuity of care when women are released on probation (Grella & Rodriguez, 2011; Staton et al., 2019).

Gender-Responsive Treatment and Rehabilitation

Feminist scholars advocate for gender-specific or "gender-responsive" treatment options for women involved in the criminal justice system based on research demonstrating the high prevalence of victimization and mental health problems within this specific population (Fournier et al., 2011; Severson, 2019). Yet, some debate exists whether gender-responsive treatment is more effective than gender-neutral approaches. Gender-neutral approaches suggest the "Central 8" criminogenic risks are paramount to prevent reoffending and meta-analytic research supports this claim (Bonta et al., 2014). However, feminist scholars argue that gender-responsive needs have not been examined to the same extent as gender-neutral work and findings that explore women's unique needs demonstrate hopeful outcomes. Van Voorhis et al. (2010) found six out of eight studies examining gender-responsive treatment approaches had significant results for women on certain treatment targets (mental health and adult victimization) compared to gender-neutral treatment. For example, women who received gender-responsive treatment (i.e., trauma-informed treatment) had lower odds of depression symptoms and less substance use compared to those who received non-gender-responsive treatment (i.e., standard treatment without trauma-informed emphasis; Saxena et al., 2014). Further, Messina et al. (2014), examined how gender-responsive treatment (i.e., incorporating trauma-informed services and substance use treatment together) impacted justice-involved women with post-traumatic stress disorder (PTSD). Findings show women who received gender-responsive treatment had symptom improvements at follow-

up compared to women who received "mixed gender" treatment (i.e., treating PTSD and substance use separately; Messina et al., 2014).

Complex treatment needs, both in correctional and community settings, are at the core for addressing the rehabilitation of justice-involved women due to the interconnected nature of trauma, mental health problems, and substance use. Gender-responsive treatment needs are often greater for justice-involved women who have past abuse history, mental health problems, substance dependence, unstable housing, and first arrest younger than the age of 19 (Grella & Greenwell, 2007). While most women are incarcerated for drug or property offenses (Chesney-Lind & Pasko, 2013; The Sentencing Project, 2020) the complexity of women's treatment needs should extend beyond focusing on one symptom (i.e., substance use) of a larger, more interconnected relationship between mental illness, trauma, and substance use (Green et al., 2005). Research shows treatment needs assessed in prison are not always predictive of women completing community-based treatment after they are released on parole (Grella & Greenwell, 2007). More beneficial treatment outcomes are noted among women who continue receiving treatment services upon release from prison, whereas women who only receive treatment in one setting (i.e., either in prison or in the community) have worse treatment outcomes (Saxena et al., 2016). Women who complete treatment during probation or prior to release have reduced risk of recidivism (Grella & Rodriguez, 2011), with many of those programs addressing gender-responsive aspects (i.e., trauma treatment; Edwards et al., 2022). Women considered "high-risk" on probation show reductions in recidivism when their probation officers suggest treatment-seeking (Morash et al., 2019). Unfortunately, high-risk women are less likely to complete treatment programs, which can increase their risk of recidivism (Zarling et al., 2022). One recent study found that women on probation who participated in drug treatment frequently had higher

rates of incarceration at follow-up (Wilfong et al., 2021). However, researchers suggest that those required to participate in drug treatment during probation are more closely supervised which can lead to more technical violations while on probation (Chesney-Lind & Pasko, 2013). A meta-analysis examining justice-involved women's treatment outcomes found that interventions addressing past trauma and comorbid substance use had promising results for improving symptoms (Bartlett et al., 2015). Treatment in community settings is important to continue addressing mental health needs and life stressors that may come up when reintegrating back into communities (Miller, 2021). While treatment offers benefits that extend beyond carceral settings into reentry, the accessibility of those services may not be feasible for justice-involved women, especially those living in a binational region.

Research suggests that mental health treatment for justice-involved women is important for effective rehabilitative outcomes, specifically for women who become involved in the criminal justice system due to gendered pathways (Salisbury & Van Voorhis, 2009). Yet, specific obstacles prevent the ability to effectively address mental health needs among justice-involved populations. Factors that predict non-completion of treatment among justice-involved women are an early age of first arrest and current mental health problems (Grella & Greenwell, 2007). Barriers that hinder completing or accessing mental health treatment during community reentry – such as stigma, affordability, and accessibility – may be unique for justice-involved women (de Heer et al., 2013; Winham et al., 2015). Additionally, many probation departments across the United States do not offer services that address all the unique facets seen among justice-involved women (Chesney-Lind & Pasko, 2013).

When examining minority women, results show that correction officers find it difficult to articulate the unique needs of justice-involved Hispanic women and lack understanding of what

resources may help women with diverse backgrounds (Pasko & Lopez, 2018). This is concerning when considering the prevalence of Hispanic women in the U.S.–México border region (U.S. Census Bureau, 2021) and knowing Hispanic women are more likely to be incarcerated compared to White women (Carson & Golinelli, 2014). Unfortunately, resources for rehabilitative success may not take minority women's diverse background into consideration when offering treatment services (Keyes et al., 2012; Misra et al., 2021). For example, in addition to addressing gender-responsive considerations, research work examining successful mental health outcomes for Hispanic people suggests incorporating aspects of family into the treatment process (Perez & Cruess, 2014).

While research examining gender-responsive treatment outcomes demonstrate their effectiveness on women's recidivism (Gobeil et al., 2016), little work has specifically investigated how racial and ethnic minority women's unique experiences may influence gender-responsive treatment (Lopez & Nuno, 2016). Even further, research has not examined implementation of gender-responsive treatment needs nor continued community mental health treatment seeking among justice-involved women living in the U.S.-México border region.

BARRIERS TO MENTAL HEALTH TREATMENT

Scholars have studied the motives behind help-seeking behavior, or rather the lack thereof. Two categories of impediments to seeking mental health treatment include attitudinal and structural barriers. Attitudinal barriers consist of stigma (Goffman, 1963) and attitudes toward treatment (Meyer et al., 2014; Sareen et al., 2007), which can stem from the public (Bos et al., 2013; Corrigan et al., 2005) or be self-imposed (Brown et al., 2010). Structural barriers encompass affordability (Shen et al., 2016), accessibility (de Heer et al., 2013), availability (Booth & McLaughlin, 2000) and acceptability (Roddy et al., 2019) of treatment. Both

attitudinal and structural barriers impact mental health treatment seeking in unique and sometimes simultaneous ways.

Attitudinal Barriers to Mental Health Treatment

Stigma can be defined as attributes of a person that deem them disqualified from the social norm (Goffman, 1963). Originally, the term *stigma* came from the Ancient Greeks, where physical markings (i.e., cuts, burns) were put on people to identify they should be avoided (Goffman, 1963). Stigmatized attributes can range from racial and ethnic backgrounds to unseen labels, such as mental illness. Stigma works as a function of avoidance, maintaining norms, and exploitation and domination passed on to a group of people by a society (Phelan et al., 2008). Avoidance is a function of stigma whereby it addresses the desire to maintain the health of a society through the evasion of disease that may be passed through physical contact (Phelan et al., 2008). Stigma functions through enforcement of social norms by ostracizing those who deviate from the norm, often proposing the failure of norms is due to character flaws or moral failings (Phelan et al., 2008). Lastly, exploitation and domination are used to control groups that may seem inferior or have less power (Phelan et al., 2008). Stigma can be both explicit and subtle (Bos et al., 2013). For an example of explicit stigma, people may avoid persons with a stigmatizing identity or socially reject them. A more subtle display of stigma could be lack of eye contact or other non-verbal expressions (Hebl et al., 2000).

There are multiple types of stigma. First, social stigma or public stigma is defined as cognitive beliefs and attitudes held by the public (perceivers) towards a group of people (targets) who possess stigmatized attribute(s) (Bos et al., 2013). While public stigma is held by people who are not part of the stigmatized group, it can still impact those with the stigmatized identity. For example, public stigma can impact a person through felt stigma which is when a person

experiences or anticipates experiencing discrimination and negative treatment by the public because of their stigma (Bos et al., 2013). Mental illness is still highly stigmatized (Corrigan, 1988; Curcio & Corboy, 2020; Goffman, 1963; Parcesepe & Cabassa, 2013) despite campaigns to de-stigmatized these disorders (Morgan et al., 2018). At the macro-level, structural stigma focuses more broadly on societal conditions that are stigmatizing. Structural stigma is defined as sociopolitical policies and conditions that diminish opportunities and resources for people in a stigmatized group (Corrigan et al., 2005; Hatzenbuehler, 2016). Research suggests structural stigma and mental illness may relate bidirectionally. For instance, women on probation or parole have more reentry outcomes (i.e., housing, employment, and criminal behavior) negatively impacted by their mental illness compared to that of men (i.e., employment; Bakken & Visher, 2018). Both public stigma and structural stigma are influential to how people with a mental illness experience the world and how these experiences can shape decisions to seek treatment for their mental health problems. Finally, both public stigma and structural stigma impact the stigmatized person in a micro-level stigma, known as self-stigma or internalized stigma (Corrigan & Watson, 2002).

Internalized stigma is defined as the stigmatizing beliefs that people within a stigmatized group have about themselves (Brown et al., 2010; Corrigan & Watson, 2002). Internalized stigma, or self-stigma, is an arguably greater direct threat to stigmatized individuals. The internalized stigma of mental illness can further exacerbate symptoms of mental illness. Psychological distress can occur among people with stigmatizing identities due to the fear of their identity becoming known (Pachankis, 2007). When considering people with mental illness and the stigma surrounding their diagnosis, symptoms of their illness may be further intensified based on their stigmatizing identity (Manos et al., 2009). Being justice-involved carries a stigma

(Moore et al., 2016) that is difficult to navigate without added psychological distress for fear of people discovering their stigmatizing identity. Stigma consciousness – when a person becomes aware of their stigmatized status (Pinel, 1999) – can impact how the stigmatized person perceives discrimination, with those high in stigma consciousness perceiving more discriminating behavior by the public (Pinel & Bosson, 2013). Being aware of discriminating behavior because of high stigma consciousness could have an impact on attitudes towards treatment seeking for people with a mental illness. Understanding the intricate ways that internalized stigma influences help-seeking behavior is important to better assist people with mental illness.

Mental Health Stigma and Treatment Seeking

Several studies have demonstrated that treatment-seeking is influenced by both internalized stigma and perceived stigma by the public (Benz et al., 2021; Brown et al., 2010; Fox et al., 2018; Jennings et al., 2015; Vogel et al., 2007). Internalized stigma can act as a mediator between public stigma and a person's attitudes towards mental health treatment. In community settings, people who attribute causal explanations to mental illness (i.e., genetics, chemical imbalance, stress) show more endorsement for treatment, but still show increased desire to be socially distant from those with mental health problems (Parcesepe & Cabassa, 2013). Looking through the lens of justice-involved people, stigma is often cited as a barrier during incarceration (Meyer et al., 2014; Morgan et al., 2004). Stigma is associated with difficult adjustment among justice-involved people. Perceived stigma – how one believes others see them due to membership in a stigmatized group – predicted worse outcomes for justice-involved people integrating back into communities compared to anticipated stigma (i.e., when one expects discrimination due to your stigmatized identity; Moore et al., 2016). Stigma disproportionately

impacts mental health treatment seeking behavior for people in ethnic minority groups (Clement et al., 2015) and those living in the U.S.–México border region (Eno Louden et al., 2023). Despite community support surrounding seeking treatment for mental health problems, people with mental illness continue to recognize stigma as a prevalent barrier to seeking treatment in general (Brown et al., 2010; Moore et al., 2016) and it continues to be noted for those living on the U.S.–México border (Flynn et al., 2020).

People with mental illness can belong to multiple stigmatized groups. Hartwell (2004) reviewed literature investigating how comorbidity between substance use and mental illness impacted justice-involved people (coined "triple stigma"). People with comorbid substance use and mental illness were more likely to show negative outcomes such as increased probation violations and homelessness (Hartwell, 2004). When examining the effect of triple stigma through the lens of mental illness, race, and criminal history, having self-stigma was associated with worse treatment outcomes (West et al., 2014). Perceived stigma resulting from multiple stigmatizing identities has been shown to influence self-esteem and medication compliance (West et al., 2015). Mental illness acts as a risk factor to self-stigma among justice-involved people (Moore et al., 2018) suggesting that having a mental illness heightens internalized stigma for those involved with the criminal justice system. More recently, scholars raised concerns for justice-involved people with a mental illness during the COVID-19 pandemic suggesting that people may further isolate themselves due to having multiple stigmatizing identities (Chaimowitz et al., 2021). Multiple stigmas can heighten internalized stigma (Jennings et al., 2015) which impacts help-seeking behaviors (Dockery et al., 2015). Unfortunately, these barriers have rarely been examined for justice-involved women with a mental illness living in the U.S.–México border region.

Other Attitudinal Barriers

Barriers to mental health treatment can present differently while incarcerated. Meyer et al. (2014) found that justice-involved people stated they did not participate in treatment because their time being incarcerated was limited and they were not motivated to attend. For some, the effectiveness of treatment is a concern that prevents people from seeking-treatment (i.e., "does treatment even work?"; Meyer et al., 2014; Morgan et al., 2004). Blitz and colleagues (2006) found that formerly justice-involved women thought treatment provided while in the criminal justice system was better than treatment offered in their communities. This suggests that potentially drastic change from carceral to community settings can shift attitudes and avert help-seeking when released. Kaufmann et al. (2014) found that people with substance use frequently endorsed attitudinal barriers related specifically toward disorders (72.1%) or treatment (48.4%), compared to attitudes surrounding stigma (22.7%). For example, negative attitudes surrounding treatment include the belief that no one can help, fear of hospital admittance, fear of the type of treatment, and disdain for answering personal information (Kaufmann et al., 2014; Schuler et al., 2015). Misinformation about disorders that can hinder help-seeking are: 1) that the problems (i.e., the mental illness) will correct itself or get better on its own, 2) seeking treatment means one is not strong enough to handle the problem on their own, and 3) not seeing the problem or symptoms of mental illness as serious enough to warrant treatment (Kaufmann et al., 2014; Sareen et al., 2007; Schuler et al., 2015; Walker et al., 2015). When examining this perspective in the context of justice-involved women, the detrimental effect of believing symptoms will self-improve can lead to ineffective rehabilitation. This attitude is part of the cycle that begets self-medication with substances and can lead back to reoffending (Brown et al., 2021; Edwards et al., 2022).

To better help justice-involved women with a mental illness living in border regions, the first step is to understand what barriers prevent treatment seeking within these areas. Findings are mixed in border regions with some studies indicating positive perceptions of mental health services (Lantican, 1998) and others still noting stigma as a prevalent barrier (El Paso Behavioral Health Consortium, 2014). One study found lower rates of help seeking by those living in a border city compared to a non-border city (Wallisch et al., 2017). However, no work has examined these attitudes toward treatment among justice-involved women in the Paso del Norte border region, highlighting an important gap in the literature and community that needs to be explored.

Structural Barriers to Mental Health Treatment

In healthcare literature, understanding access and barriers to services is an important question that is constantly evolving. For example, an increase in telehealth access has been noted amid the COVID-19 pandemic (Bakken, 2020), which demonstrates the ability for services to adapt in times of need. However, there are still prominent barriers to mental health treatment aside from stigma that continue to dissuade people from seeking treatment. For instance, affordability is a heavily cited barrier for those needing mental health treatment (Byrow et al., 2020; Logan et al., 2004; Walker et al., 2015). There are four dimensions for defining structural barriers to treatment: affordability, accessibility, availability, and acceptability (Penchansky & Thomas, 1981). Another dimension that will be reviewed as a structural barrier to treatment seeking is culture (Brown et al., 2010) and how it may be a relevant barrier among people living on the U.S.-México border. Below these structural barriers are discussed as they apply to mental health treatment seeking among justice-involved women living in border regions, despite the lack of research specifically examining this phenomenon for this population.

Affordability

The dimension of access that relates to affordability hits on a person's financial ability to pay for treatment services (Penchansky & Thomas, 1981). Financial barriers, especially among people with low income, are the most reported barrier for people in the United States (Sareen et al., 2007). Perceptions on the worth of mental health treatment cost can play a role in receiving access to treatment (Penchansky & Thomas, 1981). For example, financial priorities such as rent or food may be a higher budget priority compared to mental health treatment. Cost of mental health services can vary based on insurance coverage. People with a mental illness are more likely to be uninsured (Walker et al., 2015) and cite structural barriers (i.e., cost of treatment) as more detrimental to their help-seeking behavior compared to attitudinal barriers (i.e., stigma; Walker et al., 2015). Justice-involved women who are insured are more likely to remain out of custody (Staton et al., 2019). Unemployment is more common among justice-involved women re-entering communities compared to men (Flower, 2010), however, when financial burden is decreased, reoffending is also decreased (Morash & Kashy, 2022). Yet, women on probation and parole are less likely to have health insurance than those who are not involved in the criminal justice system (Lorvick et al., 2015) which comes at the cost of affording treatment on their own. Spence et al. (2007), found treatment seeking and income to have a negative relationship among people living in a border region. Household income also has a strong negative relationship to stigma among those living in border regions (Eno Louden et al., 2023), which together can further deter help-seeking. Additionally, people living in the U.S.–México border region are at lower odds of having health insurance (Shen et al., 2016), creating lack of treatment access due to affordability (approximately 20.3% of people in El Paso, Texas are unable to see a doctor due to affordability; Healthy Paso del Norte, 2018). However, no research to date has examined

perceptions of affordability of mental health treatment among justice-involved women living in the Paso del Norte border region.

Accessibility

Geographical location can impact how people access treatment services (Penchansky & Thomas, 1981). Hard-to-reach treatment facility locations may be why some people choose to not seek out treatment. Accessibility includes transportation (i.e., having a car), travel time, distance, and cost of travel (Penchansky & Thomas, 1981). For example, women who live in more rural areas often cite traveling distance as a barrier to help-seeking (Booth & McLaughlin, 2000; Logan et al., 2004). People living on the U.S.–México border have less access to doctors (Shen et al., 2016) which can prevent people from seeking treatment. Additionally, Mexican-born women report more transportation related barriers to received care and historically have relied on their family for transportation support (Angel et al, 1996) compared with U.S.-born women (de Heer et al., 2013). Transportation and accessibility as a barrier to treatment may be changing due to an increase in telehealth services during the COVID-19 pandemic (Mishkind et al., 2021). Positive attitudes towards telehealth services have been high among Hispanic individuals (Ghaddar et al., 2020). While telehealth attitudes and access may be growing, many people have cited navigating the vast amount of treatment services available as overwhelming and difficult to understand (Booth & McLaughlin, 2000). Additionally, language has been noted as an influential access barrier, especially when searching for providers who speak languages other than English (Kaufmann et al., 2015; Misra et al., 2021). Unfortunately, information surrounding how justice-involved women in border regions primarily access services is non-existent.

Availability

While healthcare services are arguably more readily available today than previously seen (Mishkind et al., 2021), availability of treatment still exists as a barrier to help-seeking. The types and quantity of services that are required for successful treatment outcomes can be impactful to people who are looking for treatment (Penchansky & Thomas, 1981). For example, people who need specialized care that treat specific needs (i.e., bipolar disorder, schizophrenia, etc.) may encounter more difficulty obtaining appointments. Justice-involved people with mental illness note unique challenges of availability they face when it comes to mental health treatment in the criminal justice system. For example, the lack of available treatment programs is often cited as a problem in carceral settings (Meyer et al., 2014; Morgan et al., 2004). Many people report not knowing where to go for treatment and not having enough time prevents them from help-seeking (Kaufmann et al., 2014; Schuler et al., 2015). In El Paso, Texas, services previously had "minimal" wait times (on average 3 weeks) to access services within the community (Tomaka et al., 2008; McDonough, 2017), while more recent national averages show around three months wait time (Chatterjee, 2023). Recent work has shown a continued emphasis of wait times factoring into receipt of services in the Paso del Norte region (Mallonee et al., 2023). However, telehealth services have increased provider availability since COVID-19 (Healthy Paso del Norte, n.d.) potentially suggesting availability of services are increasing in the border region. Unfortunately, considering that people may not seek out treatment until their mental illness has become unmanageable (Singh & Grange, 2006), even "minimal" wait times may be too long.

Acceptability

Unlike stigma, acceptability is defined as attitudes by clients towards their practitioners and vice versa (Penchansky & Thomas, 1981). Put another way, people who seek treatment have attitudes about how they are accepted by their physicians. The interaction of perceived attitudes can impact treatment. For example, providers may be less inclined to serve certain patients (i.e., those without insurance) which can in turn limit the acceptability of the people that utilize that service (Penchansky & Thomas, 1981). It is not a stretch to then assume that acceptability can work in tandem with both self-stigma and public stigma. Whereby those clients who feel unaccepted by certain practitioners and treatment centers internalize that lack of acceptance into self-stigma. However, acceptability is considered a structural barrier as it relates to a concrete component to facilitating acceptance in treatment – language. Some respondents report that language barriers may prevent people from seeking treatment and feeling accepted by clinicians (Kaufmann et al., 2015; Misra et al., 2021). Language barriers may not be as prevalent in border regions; however, it could pose problems in areas that have fewer treatment providers who are bilingual.

Cultural Competence

The potential role culture plays in presentation of mental illness and treatment acceptance varies. People who identify high in bicultural identity often have better self-reported mental health symptoms (Gonzales, 2018; Nguyen & Benet-Martínez, 2013). Hoppe et al. (1991) found that U.S.-born Mexican American women had higher rates of diagnosed depression compared to México-born women. Identity struggle and acculturation to life in the United States can be difficult for those immigrating to a new country (Paat & Green, 2017). Acculturation combined with perceived lack of cultural competence is cited as a reason for premature termination of

treatment services (Anderson et al., 2019) and can further deter people in minority groups from seeking treatment. U.S.–México border cities present a unique group of people who have access to both countries that people in minority groups living further away from border cities may not have. Yet, research on mental health in the El Paso and Ciudad Juárez region has found that culture can at times act as a barrier to treatment specifically when considering the stigma and lack of mental health education seen in the border region (Tomaka et al., 2008). Treatment of mental illness, especially in a border region, should incorporate culturally unique components as it relates to the population(s) the mental health services are being administered to. Some research suggests the need to incorporate families into the treatment process (Cardemil et al., 2005; Lantican, 1998) as it can be a foundational piece of improvement and support for the people in treatment (Kruse et al, 2002).

Summary

Justice-involved women have largely been subject to mental health treatment programs and probation models based on findings that result in rehabilitative success among men (Belknap, 2007; Chesney-Lind & Pasko, 2013). While research has increased to examine the unique needs of justice-involved women (Brown et al., 2021; Gobeil et al., 2016; Van Voorhis et al., 2010), work focusing on underserved populations of minority women is lacking (Schuck et al., 2004). However, the prevalence of mental illness among justice-involved women of all backgrounds remains (Severson, 2019). The need to access mental health treatment, particularly among women re-entering their communities post-release from carceral settings, is important to rehabilitation (Messina et al., 2014; Saxena et al., 2016; Wanamaker & Brown, 2022). Barriers that hinder mental health treatment seeking can be attitudinal (i.e., stigma, doubt in effectiveness of treatment) or structural (i.e., transportation, insurance coverage). To better understand the

ineffectiveness of treatment, examining the barriers that prevent justice-involved women from seeking mental health treatment in the first place is needed. While work has examined barriers to treatment, limited work has focused on barriers to treatment that are present among justice-involved minority women. Examining what barriers are unique to justice-involved women in the U.S.–México border region is important to accurately address the mental health treatment needs of diverse women in the criminal justice system.

The Present Study

The present study seeks to understand the barriers that justice-involved women face when seeking mental health treatment in the U.S.-México border region. The first aim is to specifically identify barriers to mental health treatment seeking among justice-involved women in the U.S.-México border region near El Paso, Texas. As mentioned previously, there is a lack of research examining experiences of justice-involved Hispanic women and justice-involved women living in the U.S.-México border region (Lopez & Pasko, 2017; Schuck et al., 2004). It is hypothesized that justice-involved women in the U.S.-México border region will experience attitudes as an influential barrier to treatment, like women in other places. However, I expect transportation and affordability to also emerge as influential structural barriers for women living in the border region (de Heer et al., 2013; Tomaka et al., 2008). The second aim is to examine how barriers to mental health treatment contribute to justice-involved women's receipt of services. Specifically, it is predicted that structural barriers will emerge as significant predictors influencing treatment seeking in addition to stigma. The third aim is to examine whether internalized stigma mediates a relationship between endorsed attitudinal barriers and perceived public stigma among justice-involved women in the Paso del Norte U.S.-México border region. Previous research has demonstrated that internalized stigma of mental illness mediated the relationship between

attitudinal barriers to mental health treatment seeking (i.e., “I do not trust mental health professionals”) and perceived public stigma (Brown et al., 2010; Vogel et al., 2007). It is hypothesized there will be a mediation of internalized stigma between attitudinal barriers and public stigma among justice-involved women in a border region.

Chapter 2: Method

Participants

A total of 85 participants completed the interview for the present study. The group of women mostly identified as Hispanic/Latina (87.1%, *n* = 74) with an average age of 36 (*SD* = 10.42). Most women were single (54.1%, *n* = 46), had children (81.2%, *n* = 69), and were unemployed (60%, *n* = 51). Nearly all the women (91.8%, *n* = 78) reported having a mental health diagnosis. Common diagnoses included: Depression (*n* = 68), anxiety (*n* = 46), bipolar (*n* = 40), and post-traumatic stress disorder (*n* = 26), where women often noted comorbidity of diagnoses. Table 1.1 shows a full demographic breakdown. The demographics in the current sample similar to other work examining justice-involved women in the Paso del Norte region (Adair, et al., 2023). Participants were recruited via flyers posted at probation agencies, jail, community centers, social service agencies, shelters, and social media sites (e.g., UTEP Psychology, UTEP Criminal Justice, El Paso Reddit, Kelley Food Bank, Social Workers in El Paso, etc.) in El Paso County, Texas. Snowball sampling was also used where participants could refer other women to the study. Participants could choose to have the interview virtually (e.g., Zoom, *n* = 37) or in person (*n* = 48).

A power analysis was conducted prior to data collection in RStudio using the "WebPower" package suggested 85 participants were needed to achieve a power of 0.80 for the multiple linear regression in the second research aim with four predictors, medium effect size of 0.15, and alpha of 0.05. A post-hoc power analysis in G*Power confirmed that 80% power was achieved with a sample of 85 using four predictors in the model. Considering covariates that were added to the model, another post-hoc power analysis in G*Power showed that 70% power was achieved with a sample of 85 using seven predictors (four predictors, three covariates) in the

linear regression. The results did show that without the covariates, the results were the same, therefore we left the covariates in the analyses to be discussed in Chapter 3.

For the multinominal logistic regressions in aim two, calculating the required sample size is a bit more nuanced. Due to this, caution must be used in how much effect this approach will provide given these guidelines for calculating sample size. Nevertheless, several papers support using heuristic rules to calculate sample size. These guidelines recommend a minimum of 10 cases per independent variable with 20 cases per independent variable preferred (Dixit et al., 2015; Starkweather & Moske, 2011). Using this as a guide, and accounting for the four independent variables that will be used to analyze aim two, the number of participants needed to complete the multinominal logistic regression would range from 40 to 80 people.

Table 1.1

Demographic Information

Variable	*n* (%)
Age	*M* = 36.3 *SD* = 10.42
Hispanic/Latina	74 (87.1%)
Race/Ethnicity	
White	64 (75.3%)
Black or African American	1 (1.2%)
American Indian or Alaskan Native	3 (3.5%)
Native Hawaiian or other Pacific Islander	1 (1.2%)
Other	16 (18.8%)
Marital Status	
Married	9 (10.6%)
Widowed	2 (2.4%)
Separated	6 (7.1%)
Divorced	14 (16.5)
In a committed relationship	8 (9.4%)
Single	46 (54.1%)
Has children	69 (81.2%)
Income	
Below $10,000	47 (53.3%)
$10,000 - $19,999	17 (20%)
$20,000 - $29,999	14 (16.5%)
$30,000 - $39,999	2 (2.4%)
$40,000 - $49,999	2 (2.4%)
$50,000 - $59,999	2 (2.4%)

$60,000 or greater	1 (1.2%)
Employment	
Employed full time	18 (21.2%)
Employed part time	10 (11.8%)
Unemployed, looking for work	38 (44.7%)
Unemployed, disabled	12 (14.1%)
Unemployed, volunteer	1 (1.2%)
Other	6 (7.1%)
Education Level	
7th through 8th	2 (2.4%)
9th through 12th	47 (55.3%)
1-2 years of college	22 (25.9%)
3-4 years of college	4 (4.7%)
College graduate and higher	10 (11.8%)
Generational Status	
1st Generation	6 (7.1%)
2nd Generation	33 (38.8%)
3rd Generation	17 (20%)
4th Generation	14 (16.5%)
5th Generation	15 (17.6%)

Eligibility Screen

Participants were screened for eligibility upon initial contact before an interview was scheduled. Participants were required to be 18 years or older and identify as a woman to be eligible. Participants had to indicate they had recent contact with the criminal justice system in the past 12 months by either having been arrested, convicted, or on probation/parole. In the initial screen for mental health concerns participants were asked, “Do you currently have any mental health concerns or mental health problems including but not limited to anxiety, posttraumatic stress, depression, anger management, mood changes, etc.” and participated respond “yes” or “no”. If they responded no, they were not eligible for the study. However, this question was modified with the IRB to broaden the eligibility criteria to those who may not self-identify with certain diagnostic labels presented in the original question. In the modified screen, participants were asked to indicate if they had mental health concerns with a “yes” response to one of two questions, “Have you had days where you were very sad or anxious?” and “Have you ever thought about speaking with a mental health provider?”. Thirty-four participants were

screened for the study that were not eligible to participate. Common reasons for ineligibility were identifying as a male, contact with criminal justice system had been longer than 12 months, they were not living in El Paso County or surrounding area (i.e., Florida, Georgia, etc.), or they had only been a victim of a crime. Women who were eligible and agreed to an interview were then scheduled for a time, either in-person or virtually, that best fit their schedule.

Measures

Treatment Seeking Behavior (Dependent Variable)

The dependent variables are self-report measures of treatment seeking behavior. The measures were modeled after a treatment adherence instrument used by the MacArthur Research Network on Mandated Community Treatment. In the current study, participants were asked to report their mental health and substance use treatment seeking in three contexts: their past, present, and future.

Past Treatment Seeking

To represent the past treatment seeking behavior, participants were asked two questions surrounding their time in jail/prison (see Appendix B). Participants were asked, "Did you seek out services for *alcohol or drug* problems while you were in jail/prison?" with Yes/No responses. Finally, participants were asked "Did you seek out services for *mental health* problems while you were in jail/prison?" with yes/no responses. Due to the binary outcome of the second and third questions, they were combined to conduct the proposed multinominal logistic regression analyses. Responses were coded as: 0 – did not seek any treatment, 1 – only received treatment for alcohol or drugs, 2 – only received treatment for mental health, and 3 – received treatment for both.

Present Treatment Seeking

The General Help Seeking Questionnaire (GHSQ; Wilson et al., 2005; see Appendix C) was developed to measure help seeking intentions. This scale examines both emotional problems and suicidal thoughts, however the current study only focused on the items assessing the former. Participants are instructed to respond to the prompt, "If you were having *mental health problems*, how likely is it that you would seek help form the following people?" Following this is a list of nine sources (i.e., phone helpline, general practitioner, mental health professional, intimate partner, friend, no one, etc.) for participants to potentially reach out to for help. Participants rank on a 7-point scale (*1 – extremely unlikely* to *7 – extremely likely*) for each source. Reliability with all nine items was unacceptable ($\alpha = 0.45$), therefore a correlation matrix was done with each item on the score total and found that one item was not significantly correlated ("I would not seek help from anyone" ($r = -.19$, $p = .09$)). Once this one item was removed, reliability increased ($\alpha = 0.59$, see Table 1.2 for all corrected item total correlations). The GHSQ has good predictive validity as it has been shown to classify 64.6% of cases (Hammer & Spiker, 2018). Table 1.3 shows the descriptive information for all the scales that were used in the present study.

Table 1.2

General Help Seeking Questionnaire (GHSQ) Corrected Item Correlations

GHSQ Item	Corrected inter-item total correlation	Cronbach's Alpha if item deleted
Intimate partner	0.33**	0.47
Friend (not related)	0.31**	0.46
Parent	0.58**	0.36
Other relative/Family member	0.53**	0.38
Mental health professional	0.56**	0.36
Phone helpline	0.55**	0.37
Doctor/General practitioner	0.54**	0.36
Minister or religious leaders	0.56**	0.37
I would not seek help from anyone	-0.19	0.59

Note. * $p < .05$, ** $p < .01$

Table 1.3

Descriptives of Scaled Measurements

Measure	*M*	*SD*	Likert Scale Range	Current α	Original α
General Help Seeking Questionnaire (GHSQ)	32.76	8.39	1 (Extremely Unlikely) to 7 (Extremely Likely)	.59	.70
Perceptions of Public Stigma (PPS)	37.47	8.39	1 (Strongly Agree) to 5 (Strongly Disagree)	.82	.82
Internalized Stigma of Mental Illness (ISMI)	70.58	18.10	1 (Strongly Disagree) to 5 (Strongly Agree)	.91	.90
Attitudinal Barriers to Treatment	40.91	9.27	1 (Strongly Disagree) to 5 (Strongly Agree)	.76	.73
Structural Barriers to Treatment	36.58	9.18	1 (Strongly Disagree) to 5 (Strongly Agree)	.77	-
Affordability subscale	14.24	4.72		.69	-
Accessibility subscale	10.16	11.61		.66	-
Availability subscale	11.01	3.62		.54	-
Kessler-10 (K10)	29.73	8.14	1 (None of the time) to 5 (All of the time)	.87	.90
Life Events Checklist (LEC-5)	8.99	5.14	0 (No) 1 (Yes)	.82	.87
Two Item Conjoint Screen (TICS)	0.95	0.21	0 (No) 1 (Yes)	.68	-

Note: Original α values come from published validation papers.

Future Treatment Seeking

For future treatment seeking behaviors, participants were asked, “In the next six months do you plan to seek treatment for *alcohol or drug* problems outside of any criminal justice sanctioned required treatment?” and “In the next six months, do you plan to seek treatment for *mental health* problems outside of any criminal justice sanctioned required treatment?” (see Appendix D). Responses were either yes or no. If a respondent stated yes, they were asked in an open-ended response where they planned to seek out services. If a respondent indicated no, they were asked in an open-ended response why they did not plan to seek out services. Due to the nature of the binary response items, and considering the small sample size present, these two questions were combined into one outcome variable with responses being 0 – does not plan to

seek any treatment, 1 – only plans to seek treatment for alcohol or drugs, 2 – only plans to seek treatment for mental health, and 3 – plans to seek treatment for both.

Predictor Variables

Perceptions of Public Stigma

Perceptions of public stigma was measured using a modified version of the Link (1987) Perceived Devaluation Discrimination Scale (see Appendix G). This scale is used to assess the perceived public stigma felt by participants with a stigmatizing identity. The scale has been used in other contexts, such as with Brown et al. (2010) who modified the measure to examine how depression was perceived publicly by African American participants. Brown et al. (2010) found that perceived public stigma was significantly correlated with internalized stigma by participants. The measure in the present study utilized a modified version of the scale, that incorporates both Brown et al. (2010) updated language and Link et al. (1991) use of general mental health in the measure rather than Brown et al.'s (2010) focus on depression only. The original scale created by Link et al. (1991) assessed responses on a 6-point Likert scale (*1 = strongly agree* to *6 = strongly disagree*), however, for the ease of participant understanding across multiple measures with similar scales the current study adjusted the 5-point Likert scale (*1 = strongly disagree* to *5 = strongly agree*) but reverse coded the measure for final analyses. Respondents with higher scores indicate more perceived public stigma. Internal consistency of the scale is good (α = 0.82), similar to previous studies (α = 0.82; Link et al., 1991). All correlations of predictor variables are in Table 1.3.

Internalized Stigma of Mental Illness (ISMI)

To measure internalized stigma, the Internalized Stigma of Mental Illness Scale (ISMI; Ritsher et al., 2003; see Appendix H) was used. The ISMI is a 29-item measure that assess the

experience of a person with mental illness and taps into subscales such as alienation, discrimination experience, stereotype endorsement, social withdrawal, and stigma resistance (Ritsher et al., 2003). The original measure uses a 4-point Likert scale (*1 = strongly disagree* to *4 = strongly agree*), however for the present study, a modified 5-point Likert scale (*1 = strongly disagree* to *5 = strongly agree*) was used for consistency across measures and to provide a neutral option for participants. Higher scores indicate more self-reported internalized stigma. Internal consistency for the ISMI is excellent ($\alpha = 0.91$), similar to previous reliability ($\alpha = 0.90 – 0.93$; Ritsher et al., 2003; Bengochea-Seco et al., 2018). This measure has excellent concurrent validity to other measures examining similar constructs (Ritsher et al., 2003).

Attitudinal Barriers to Mental Health Treatment Seeking

To measure barriers of mental health treatment, a two-pronged approach that examined both attitudinal barriers and structural barriers of mental health treatment seeking was used. Attitudinal barriers were assessed using a modified measure stemming from two measures. First, items from the Attitudes Toward Mental Health Treatment Scale (Brown et al., 2010) were used to measure attitudinal barriers with consideration of cultural influences. Brown et al. (2010) developed the Attitudes Toward Mental Health Treatment Scale to address the criticism that the original scale (see Fisher &Turner, 1970) did not weigh cultural decisions in treatment seeking attitudes. The present study incorporated several items from the Brown et al. (2010) scale (e.g., "I feel confident that I could find a therapist who is understanding and respectful of my ethnicity/culture") to account for cultural factors that may influence treatment seeking in a U.S.-México border region. The second portion of items stem from the Barriers to Treatment Questionnaire (BTQ; Marques et al., 2011). The original BTQ is a 17-item measure that has several subscales, including stigma, shame, and discrimination subscale which were used in the

present study to further evaluate attitudinal barriers (e.g., "I felt ashamed of needing help for my problem(s)"). Participants in the original measure answered the BTQ using a yes/no response option (Marques et al., 2011). The current study used a 5-point Likert scale (*1 = strongly disagree* to *5 = strongly agree*) to determine how much participants endorse the attitudinal barrier to mental health treatment seeking (see Appendix I). Higher scores indicate more reported attitudinal barriers towards seeking treatment. Internal consistency was good ($\alpha = 0.76$) and similar to previous studies ($\alpha = 0.73 – 0.78$; Brown et al., 2010).

Structural Barriers to Mental Health Treatment Seeking

Structural barriers were evaluated through adaptation of a measurement described in Walker et al. (2015) and Marques et al. (2011), where respondents were asked to indicate why their mental health needs were unmet based on a list of structural motives. The list of items used in the present study included statements surrounding affordability, accessibility, and availability. Participants were asked to rate on a 5-point Likert scale (*1 = strongly disagree* to *5 = strongly agree*) how much they agreed or disagreed with each item in their decision to seek out mental health services (see Appendix I). Higher scores indicated more advocation of structural barriers. Reliability for the full scale was good ($\alpha = 0.77$).

Ranked Barriers to Mental Health Treatment Seeking

In addition to the Likert scale responses for both structural and attitudinal barriers, participants were asked an open-ended question of if they had any additional barriers to add that were not already covered in the items from the structural and attitudinal measures. Participants were then asked to rank their top three barriers based on the list of attitudinal and structural measures that were asked. These two questions were used to narrow down the main reasons hindering treatment seeking for the women.

Covariates

Criminal and Mental Health History

Participants were asked questions surrounding their criminal history and mental health history. Criminal history questions asked participants to indicate how old they were when they were first arrested, how many times they have been arrested, and if they are required to seek treatment as part of their release from the criminal justice system. Mental health history questions asked participants if they have ever been given a mental health diagnosis and if so, what are the diagnoses and at what age were they diagnosed (see Appendix E and F).

Kessler Psychological Distress Scale (K10)

To account for the covariate of mental illness, participants answered items on the Kessler Psychological Distress Scale (K10; Kessler et al., 2002; see Appendix J). This is a 10-item self-report measure of psychological distress and uses a 5-point Likert scale to determine the frequency of distress in the past 30 days (*1 = none of the time, 2 = a little of the time, 3 = some of the time, 4 = most of the time, 5 = all of the time*). Scores were totaled to receive an overall score ranging from 10 to 50. Higher scores indicate greater psychological distress. Internal consistency for this measure was good ($\alpha = 0.87$), similar to previous values ($\alpha = 0.90 – 0.93$; Kessler et al., 2002; Vargas Terrez et al., 2011).

Life Events Checklist (LEC-5)

The Life Events Checklist (LEC-5; Weathers et al., 2013; see Appendix K), is used to measure stressful events or experiences that happen to people throughout their lifetime. This measure consists of 12-items with a response scale of (*1 – happened to me, 2 – witnessed it happening, 3 – learned about it happening, 4 – not sure, 5 – does not apply*). Participants could select multiple degrees of exposure to the events, for example stating that it happened to them,

but they also learned about it happening to someone else. This measure was not created for summation, but rather to assess if a person had been exposed to one or more traumatic event(s). The current study evaluated exposure by summing all events that happened, witnessed, or were learned about by a participant to create a total trauma experience score (see Weis et al., 2022). Reliability for the measure was good ($\alpha = 0.82$)

Two-Item Conjoint Screen (TICS)

To measure substance use, the Two-Item Conjoint Screen (TICS; Brown et al., 2001; see Appendix L) was used. TICS is a two-item measure asking participants if they, "have ever drank or used drugs more than they meant to" and "have you felt you wanted or needed to cut down on your drinking or drug use". Participants responded either "yes" or "no". If participants responded yes to either one of the items, it was considered a positive screen for substance use. The two-item TICS screen has good validity as it has been shown to identify nearly 80% of those who display substance dependence or abuse (Brown et al., 2001).

Table 1.3

Correlations of Predictor Variables

Variable	1.	2.	3.	4.	5.	6.	7.
1. Public Stigma	-	-	-	-	-	-	-
2. Internalized Stigma	.33**	-	-	-	-	-	-
3. Attitude Barriers	.25*	.54**	-	-	-	-	-
4. Structural Barriers	.17	.29**	.47**	-	-	-	-
5. K10	-.02	.28**	.22	.10	-	-	-
6. LEC-5	-.01	.02	.12	.23*	.11	-	-
7. TICS	-.03	-.02	.00	-.13	.10	-.06	-

Note: ** $p < .01$, *$p < .05$

Procedure

Prior to recruitment, all measures were translated into Spanish, (if there was not already a translated scale available) for women who prefer to be interviewed in Spanish. The University of

Texas at El Paso offers translation services for a fee. The Translation Services Office provided translation for the demographics, treatment while incarcerated (past treatment), GHSQ (present treatment), future treatment, criminal history, mental health history, perceptions of public stigma, barriers to mental health treatment (structural and attitude), LEC-5, and the TICS measures, as well as the consent form, consent test, payment receipt, and recruitment flyers. The K10 (Vargas Terrez et al., 2011) and ISMI (Bengochea-Seco et al., 2018) had validated Spanish versions that were used. Once all materials were translated, flyers were distributed around El Paso, Texas and Las Cruces, New Mexico. Flyers were modified in March 2023, to remove the mental health eligibility criteria listed on the flyer in order to encourage more participation (see Appendices M through P). Specifically in El Paso, flyers were left with the El Paso County Probation Department, El Paso County Reentry Services, El Paso County Jail, various community centers, social services, bail bonds businesses, homeless shelters, and local shops (i.e., coffee shops, gas stations, etc.). In Las Cruces, flyers were only left with community centers, social services, and shelters. All the locations where flyers were left were given permission by the director, employees, or owner of the establishment.

Potential participants contacted the researcher via telephone or email that was posted on the recruitment flyers. For the Spanish-speaking participants, a separate number was posted to communicate with a fluent Spanish-speaking research assistant, however none of the participants requested to have the interview conducted in Spanish. During the initial phone call, participants received the eligibility screen to determine if they were eligible for the study. If they were, then an interview was scheduled with the participant.

For participants that requested in-person interviews, research assistants asked the participant where they would feel most comfortable completing the interview. Oftentimes, the

research assistant would meet with the participant in a public place, such as a quiet corner of a coffee shop, or at the home of the participant to conduct the interview. Virtual interviews were conducted on Zoom, a web conferencing system licensed by The University of Texas at El Paso. Before beginning the interview, the research assistant read out loud the consent form to each woman. If the participant agreed to participate, they would sign the consent for in-person interviews or verbally agree via audio recording for virtual interviews. A Certificate of Confidentially (CC-OD-22-3165) was obtained from the National Institutes of Health for the study to protect the privacy of the data collected. Next, the participant was required to pass a five-question consent test before moving on to the interview questions. All participants who were interviewed passed the consent test.

Participants were asked to respond to each of the randomized measures described above. If participants did not want to answer a question, the interviewer would move on to the next one. Each interview lasted approximately 45 minutes to one hour. Participants were compensated at the end of the interview with a $50 electronic gift card, using Rewards Genius/Tango Card, for virtual interviews or cash for in-person interviews. Once payment was received, a receipt was issued to the participant. Funding for the project was provided by a Dissertation Grant from the American Academy of Forensic Psychology and the Dodson Research Grant received from The University of Texas at El Paso.

Analytic Approach

Aim #1: Prevalent Barriers to Mental Health Treatment Seeking

Frequencies were used for the first research aim, determining what prevalent barriers to mental health treatment seeking are noted among justice-involved women in the border region. First, frequencies of responses for each item on the attitudinal and structural barriers measure

were conducted. The items that were highly endorsed as barriers that contributed to seeking treatment are discussed in the results section. Next, the ranked barriers were determined by the most frequently open-response barriers to mental health treatment seeking. Despite having the list of items available, many women rephrased or gave more narrative motivations that influenced their decision to not seek services. In order to accurately capture these, conceptual content analysis was used to code the ranked barriers. Conceptual analysis (Carley, 1993; Stemler, 2015) examines text data using pre-determined categories and counting the instances of those coded categories. In this study, participants were asked to rank their top three reasons for not seeking out mental health services. For each ranked response (i.e., Rank 1, Rank 2, Rank 3), coders used the attitude and structural barriers as a categorical guide (i.e., attitudes, affordability, access, and availability) and then summed the frequency of those categories for each rank presented in the text. The Principal Investigator and a research assistant both independently coded the responses. Cohen's Kappa indicated a near perfect agreement ($\kappa = .93$, $p < .001$; see McHugh, 2012).

Aim #2: Extent that Barriers to Mental Health Treatment contribute to Seeking Services

The second research aim was to examine the extent to which justice-involved women in the U.S.-México border region experience barriers of mental health treatment and how those barriers contribute to their receipt of services. To test this hypothesis, several regression analyses were used exploring the four barriers to treatment (i.e., perceived public stigma, internalized stigma, attitudinal barriers, and structural barriers) on the three outcome variables (i.e., past, present, and future treatment seeking) using IBM SPSS Statistics version 29. While the structural barriers do have three subscales to measure affordability, accessibility, and availability, these scales were only assessed in the post-hoc exploratory section, due to power concerns with the

small sample size. As the past and future treatment seeking outcome variables were nominal and the independent variables were continuous, two multinominal logistic regressions were performed for these analyses. Present treatment seeking was analyzed using multiple linear regression as the outcome variable (GHSQ) is continuous.

Aim #3: Mediation of Internalized Stigma on Attitudinal Barriers and Perceived Public Stigma

Version 8 of the *Mplus* software (Muthén & Muthén, 2017) was used to probe the mediation of internalized stigma on attitudinal barriers and perceived public stigma among justice-involved women in the border region. Bias-corrected bootstrapping technique with 10,000 iterations was used as it is an appropriate way for assessing mediations (Fritz & MacKinnon, 2007), however it should be noted that this technique can have larger Type I error rates (MacKinnon et al., 2004). Bootstrapping provides a 95% confidence interval for the mediated model and if a value of zero is not located within the limits of the confidence interval, the conclusion will be there is an indirect effect present. The bootstrapping test was used rather than a structural equation model technique due to the limited sample of justice-involved women located in the Paso del Norte border region. Limitations of cross-sectional mediation are discussed in Chapter 4.

Chapter 3: Results

Aim #1: Prevalent Barriers to Mental Health Treatment Seeking

Attitudinal Barriers

To determine the most endorsed items for both attitudinal and structural barriers, frequencies were run on the 31 items that measured these barriers. It was determined that a score of 51% or greater would indicate majority sample support of an item, therefore this was used to decide which items were frequently endorsed as a barrier to treatment. The most agreed with attitudinal barrier item that women noted was feeling ashamed of their problems (69.4%, *n* = 59). The second was, "feeling ashamed of needing help" (64.7%, *n* = 55), followed by, "I wanted to handle it on my own" (61.1%, *n* = 52). See Table 2.1 for all attitudinal item frequencies.

Table 2.1

Attitudinal Barriers Item Frequencies

Item	Frequency, *n* (%)		
	Strongly Disagree and Disagree	Neither Agree nor Disagree	Strongly Agree and Agree
I felt ashamed of my problem(s).	20 (23.5)	6 (7.1)	**59 (69.4)**
I felt ashamed of needing help for my problem(s).	25 (29.4)	5 (5.9)	**55 (64.7)**
I wanted to handle it on my own.	27 (31.8)	6 (7.1)	**52 (61.1)**
I was scared about being put in a hospital against my will.	36 (42.4)	8 (9.4)	41 (48.2)
In my community, people take care of their emotional problems on their own; they don't seek professional services.	29 (34.2)	17 (20)	39 (45.9)
I worried about what people would think if they knew I was in treatment.	37 (43.5)	10 (11.8)	38 (44.7)
I was afraid of being criticized by my family if I sought help.	48 (56.4)	6 (7.1)	31 (36.6)
I was not comfortable discussing my problems with a mental health professional.	50 (58.8)	9 (10.6)	26 (30.6)
Seeking professional mental health services is a last resort.	55 (64.7)	5 (5.9)	25 (29.4)
I would seek help from my family and friends before seeking help from a mental health professional.	46 (54.1)	17 (20)	22 (25.9)
I do not fully trust mental health professionals.	51 (60)	15 (17.6)	19 (22.3)
Professional mental health treatment would not be helpful for me.	68 (80)	10 (11.8)	7 (8.2)

Mental health services are only effective if your therapist matches your race and/or ethnicity.	82 (96.5)	2 (2.4)	1 (1.2)
I would be comfortable seeing a therapist who is of a different race than I am.	29 (34.1)	7 (8.2)	49 (57.7)
I feel confident that I could find a therapist who is understanding and respect of my ethnicity/culture.	13 (15.3)	12 (14.1)	60 (70.6)

Note. Item(s) in bold were reported at a rate of 51% or more among the sample.

Structural Barriers

Again, a score of 51% or greater was used to determine which items were frequently endorsed among the structural barriers. The only structural item that emerged as being a persistent barrier was putting money towards other necessities (e.g., rent, food, children) over mental health treatment (69.4%, $n = 59$). The next closest item was below the cutoff with 40% of participants endorsing "The cost of mental health treatment is too high for me" ($n = 34$). See Table 2.2 for all structural item frequencies.

Table 2.2

Structural Barrier Item Frequencies

Item	Frequency, *n* (%)		
	Strongly Disagree and Disagree	Neither Agree nor Disagree	Strongly Agree and Agree
I put money towards basic needs over covering my own mental health needs.	19 (22.4)	7 (8.2)	**59 (69.4)**
The cost of mental health treatment is too high for me.	43 (50.6)	8 (9.4)	34 (40)
I do not have insurance.	53 (62.3)	3 (3.5)	29 (34.1)
I find it difficult to find time to scheduled an in-person appointment for treatment.	52 (61.2)	6 (7.1)	27 (31.8)
My insurance does not cover mental health treatment.	48 (56.4)	12 (14.1)	25 (29.4)
The financial cost of traveling to treatment would be too much.	51 (60)	11 (12.9)	23 (27.1)
I do not have transportation options to get to treatment.	61 (71.7)	5 (5.9)	19 (22.3)
I am unaware of telehealth services.	59 (69.4)	7 (8.2)	19 (22.3)
I do not have the capabilities to schedule virtual appointments for treatment.	68 (80)	2 (2.4)	15 (17.7)
I live too far away from services.	61 (72.6)	9 (10.7)	14 (16.6)
I do not have access to Internet for telehealth services.	69 (81.2)	2 (2.4)	14 (16.5)
I do not have access to childcare which impacts my ability to attend appointments.	62 (73)	12 (14.1)	11 (13)

I do not know where to go for services.	71 (83.6)	4 (4.7)	10 (11.7)
I do not know how to begin searching for information about services.	76 (89.4)	1 (1.2)	8 (9.4)
I am unsure I would find a provider that speaks my preferred language.	76 (89.4)	2 (2.4)	7 (8.2)
I am hesitant to use mental health services due to my immigration status.	82 (96.4)	3 (3.5)	0 (0)

Note. Item(s) in bold were reported at a rate of 51% or more among the sample.

Ranked Barriers

To further facilitate the comparison of barriers, the open-ended question was analyzed using conceptual content analysis to determine which barriers emerged for first, second, and third place. For all three places (Rank 1, Rank 2, Rank 3), attitudes still remained the most ranked barrier to seeking out treatment (see Table 2.3). Some examples of responses include, "can't find someone to understand me – hard to express myself and explain what I am trying to say, and I don't feel a therapist would have patience", "my family did not think I needed the help, so I did not seek it myself", and "do it on my own by self-medicating, handle it that way".

The structural barriers varied in their frequency, behind attitudes, among reach rank. After attitudes, in Rank 1, affordability was the second most frequently stated barrier category. Some examples of affordability were: "cost [of treatment]", "can't afford the appointments", "it's expensive", and "no insurance". In Rank 2, again behind attitudes, the availability category was the second most frequently stated barrier. A few examples include, "being a parent and not having enough time to go to treatment" or "can't find the time to go due to work or watching kids". Finally, in Rank 3, affordability is the second most frequently stated barrier category after attitudes.

A Spearman's rank correlation was used to assess the relationship between the ranked barriers. There was a positive correlation between the Rank 1 and Rank 2, $r(76) = .31$, $p = .01$, suggesting a difference between these two ranks. Further inspection shows this may be due to the

change in endorsement of the structural subscales: availability and affordability. There was no significant correlation between Rank 1 and Rank 3 ($r(73) = .21$, $p = .08$) nor between Rank 2 and Rank 3 ($r(72) = .20$, $p = .08$).

Table 2.3

Frequency of Content Coded Ranked Barriers

Code	Frequency of Responses		
	Rank 1	Rank 2	Rank 3
Attitude	38	38	46
Affordability	23	13	11
Accessibility	10	11	9
Availability	9	16	10

Note. Some participants did not provide a response for all rankings (i.e., may have only provided one or two) therefore total responses per ranking will not add to total participant count ($N = 85$).

Overall, results examining the frequency of barriers to mental health treatment, attitudinal barrier items emerged more often than the structural barrier items. Even among the ranked barriers, attitudes were more frequently expressed in comparison to structural barriers. The one structural barrier that was the frequently indicated was affordability.

Aim #2: Extent that Barriers to Mental Health Treatment contribute to Seeking Services

Past Treatment Seeking

A multinominal logistic regression was performed to assess the relationship between past treatment seeking behavior and the four variables measuring barriers to treatment. All the assumptions were met for the multinominal logistic regression. These were tested by examining the linear relationship of the independent variable and logit transformation of the dependent variable using scatterplots of all predictive probability and raw residuals for each outcome pairing and examining correlations for multicollinearity. There was a warning of unexpected singularities in the Hessian matrix provided by IBM SPSS that suggested removing or combining

some predictor variables. This error was a result of the TICS measure having no variability (95.3% had a positive screen, $n = 81$), therefore it was removed, and the analysis rerun.

The fit of the model improved from the intercept-only model when the predictor variables were entered, $\chi^2(18, N = 85) = 31.62$, Nagelkerke $R^2 = 0.34$, $p = .02$ (see Table 3.1 for full output). The reference group was the "no treatment while incarcerated" group. Significant parameter estimates emerged when comparing responses of women who indicated they only received mental health treatment while incarcerated versus no treatment while incarcerated. The significant parameter estimates showed that for every one unit increase in public stigma, the odds of reporting only receiving mental health treatment compared to no treatment while incarcerated decreased by 0.90. This indicates that as public stigma increases, there is a 10% decrease in the odds of reporting mental health treatment compared to no treatment, holding all else constant. For every one unit increase in attitudinal barriers to treatment, the odds of reporting only receiving mental health treatment compared to no treatment while incarcerated decreased by 0.90. Similar to public stigma, as attitudinal barriers increase, there is a 10% decrease in the odds of reporting mental health treatment compared to no treatment, holding all else constant.

When examining the responses for receiving treatment for both mental health and alcohol or drug problems while incarcerated compared to no treatment while incarcerated, results show that for every one unit increase in public stigma the odds of reporting receiving both mental health and substance use treatment decreased by 0.86. Here the findings indicate that as public stigma increases, there is a 14% decrease in the odds of reporting receiving both mental health and substance use treatment compared to no treatment, holding all else constant. For every one unit increase in internalized stigma, the odds of reporting treatment for treatment of both mental health and substance use while incarcerated compared to no treatment was increased by 1.06.

This suggests that as internalized stigma increases, there is a 6% increase in the odds of reporting receiving treatment for both mental health and substance use compared to no treatment, holding all else constant. Finally, for every one unit increase in attitudinal barriers, the odds of reporting treatment for mental health and substance use while incarcerated compared to no treatment was decreased by 0.84. Again, this indicates that as attitude barriers increase, there is a 16% decrease in the odds of reporting receiving treatment for both mental health and substance use while incarcerated compared to no treatment, holding all else constant. Overall, findings show support that stigma and attitudinal barriers have a significant relationship on past treatment seeking for justice-involved women living in a border region.

Table 3.1

Multinominal Logistic Regression on Past Treatment Seeking

Group	Variable	B	S.E. B	Wald χ^2	Odds Ratio	95% CI	
						LL	UL
Only received treatment for *alcohol or drug problems* while incarcerated	Intercept	2.36	2.79	0.72			
	Public Stigma (PPS)	-0.00	0.05	0.00	1.00	0.91	1.09
	Internal Stigma (ISMI)	-0.02	0.03	0.33	0.99	0.94	1.04
	Attitude Barriers	-0.01	0.05	0.01	1.00	0.90	1.10
	Structural Barriers	-0.04	0.05	0.82	0.96	0.87	1.05
	K10	-0.00	0.05	0.01	1.00	0.91	1.09
	LEC-5	-0.06	0.09	0.38	0.95	0.79	1.13
Only received treatment for *mental health problems* while incarcerated	Intercept	6.72	2.25	8.89			
	Public Stigma (PPS)	-0.10	0.04	5.67*	0.90	0.83	0.98
	Internal Stigma (ISMI)	0.04	0.02	3.73	1.05	1.00	1.09
	Attitude Barriers	-0.11	0.05	4.87*	0.90	0.81	0.99
	Structural Barriers	-0.01	0.04	0.08	0.99	0.92	1.07
	K10	-0.04	0.04	0.96	0.96	0.89	1.04
	LEC-5	-0.00	0.06	0.00	1.00	0.89	1.12
Received *both mental health and substance treatment* while incarcerated	Intercept	6.80	2.64	6.66			
	Public Stigma (PPS)	-0.15	0.06	7.28*	0.86	0.77	0.96
	Internal Stigma (ISMI)	0.06	0.03	4.58*	1.06	1.01	1.13
	Attitude Barriers	-0.17	0.06	7.72*	0.84	0.75	0.95
	Structural Barriers	-0.01	0.04	0.03	0.99	0.91	1.08
	K10	0.02	0.05	0.17	1.02	0.93	1.12

LEC-5	0.03	0.07	0.25	1.04	0.90	1.18

Note. Reference Group: Did not receive treatment while incarcerated, *$p < .05$, Overall model χ^2 (18, N = 85) = 31.62, p = .02, -2 log likelihood = 189.07, Cox & Snell R^2 = .31, Nagelkerke R^2 = .34.

Present Treatment Seeking

A multiple linear regression was performed to determine the relationship between the continuous present treatment seeking measure (General Help Seeking Questionnaire (GHSQ)) and the four barriers to treatment (i.e., public stigma, internalized stigma, attitudinal barriers, and structural barriers). All assumptions were met for the multiple linear regression. These were examined through the Durbin-Watson statistic to check for independence of observations, through examining the linear relationship of the predictor variables and dependent variable, and through plotting residual values of the dependent variable in a scatterplot. The results showed a non-significant model, $F(7, 77) = 1.59$, $p = .15$, $R^2 = 0.13$. Findings indicate that barriers to treatment do not have a significant relationship in predicting present treatment seeking among justice-involved women living in a border region. Table 3.2 displays the output for the present treatment seeking outcome.

Table 3.2

Multiple Linear Regression on Present Treatment Seeking

Variable	B	95% CI for B		S.E. B	β	R^2	ΔR^2
		LL	UL				
Model 1 (Covariates)						.04	.00
Constant	28.63	18.00	39.26	5.34			
K10	-0.09	-0.32	0.13	0.11	-0.09		
TICS	7.19	-1.40	15.79	4.32	0.18		
LEC-5	0.01	-0.35	0.37	0.18	0.01		
Model 2						.13	.09
Constant	34.31	19.62	49.01	7.38			
K10	-0.11	-0.34	0.12	0.12	-0.11		
TICS	8.03	-0.47	16.53	4.27	0.20		
LEC-5	0.01	-0.35	0.37	0.18	0.01		
Public Stigma (PPS)	-0.18	-0.41	0.05	0.12	-0.18		

Internal Stigma (ISMI)	0.10	-0.03	0.22	0.06	0.21
Attitude Barriers	-0.27*	-0.51	-0.02	0.13	-0.29*
Structural Barriers	0.13	-0.10	0.36	0.11	0.14

Note. *$p < .05$, Overall model was not significant $F(7, 77) = 1.59$, $p = .15$.

Future Treatment Seeking

A multinominal logistic regression was used to determine if there was a relationship between future treatment seeking and the four barriers to treatment. When running linearity assumptions for future treatment seeking, there was a violation where a non-linear relationship was noted between two of the outcome categories because of too few participants present in this group ($n = 2$, Group 1 – only plans to seek alcohol or drug treatment). These two people were removed from the future treatment analysis and assumptions for linearity were reassessed and met. Similar to past treatment seeking, a warning of unexpected singularities in the Hessian matrix suggested removing or combining some predictor variables. Again, this error was a result of the lack of variability in the TICS measure, therefore it was removed, and the analysis repeated.

The fit of the model improved from the intercept-only model when predictor variables were added, $\chi^2(12, N = 83) = 27.34$, Nagelkerke $R^2 = 0.33$, $p = .01$ (see Table 3.3 for full output). The reference group was the "planning to seek no treatment" group. A significant parameter estimate emerged that for every one unit increase in internalized stigma, planning to seek mental health treatment in the future increases by 1.11 compared to the no treatment group. This finding indicates that for every increase in initialized stigma, there is an 11% increase in odds to seek out mental health treatment in the next six months, holding all else constant. Another significant parameter showed that for every one unit increase in internalized stigma, planning to receive both mental health treatment and substance use treatment in the future increases by 1.10 compared to the no treatment group. Again, the findings show that for every

increase in internalized stigma, there is a 10% increase in odds to seek out both mental health and substance use treatment in the next six months, holding all else constant. Overall, results support that internalized stigma has a significant relationship in predicting future treatment seeking intentions.

Table 3.3

Multinominal Logistic Regression on Future Treatment Seeking

Group	Variable	B	S.E. B	Wald χ^2	Odds Ratio	95% CI	
						LL	UL
Only plans to seek treatment for *mental health problems* in the next 6 months	Intercept	-8.30	3.40	5.96			
	Public Stigma (PPS)	0.09	0.07	1.62	1.09	0.96	1.24
	Internal Stigma (ISMI)	0.10	0.05	4.86*	1.11	1.01	1.21
	Attitude Barriers	-0.03	0.07	0.25	0.97	0.85	1.10
	Structural Barriers	-0.10	0.07	1.92	0.90	0.78	1.04
	K10	0.10	0.07	1.92	1.10	0.96	1.27
	LEC-5	0.33	0.18	3.29	1.38	0.97	1.97
Plans to seek *both mental health and substance treatment* in the next 6 months	Intercept	-4.60	3.11	2.19			
	Public Stigma (PPS)	0.06	0.06	0.78	1.06	0.93	1.20
	Internal Stigma (ISMI)	0.09	0.04	4.66*	1.10	1.01	1.20
	Attitude Barriers	-0.07	0.07	1.03	0.94	0.83	1.06
	Structural Barriers	-0.09	0.07	1.68	0.91	0.80	1.05
	K10	0.07	0.07	0.91	1.07	0.93	1.22
	LEC-5	0.37	0.18	4.35	1.44	1.02	2.04

Note. Reference Group: Does not plan to seek future treatment, *$p < .05$, Overall model χ^2 (12, $N = 83$) = 27.34, $p = .01$, -2 log likelihood = 125.59, Cox & Snell $R^2 = .28$, Nagelkerke $R^2 = .33$.

In summary, findings for aim two show that the predictors of public stigma and attitude barriers decreased odds of self-reported treatment seeking in the past. No predictors emerged as significant for present treatment seeking. Finally, internalized stigma increased odds of self-reported treatment seeking in the past and in future treatment seeking.

Aim #3: Mediation of Internalized Stigma on Attitudinal Barriers and Perceived Public Stigma

The results showed there was a significant indirect effect of internalized stigma on perceptions of public stigma and attitudinal barriers (B = 0.19, p = .01), through path a (i.e., public stigma to internalized stigma) (B = 0.72, p = .002), and path b (i.e., internalized stigma to attitudinal barriers) (B = 0.26, p < .001). The bias corrected 95% CI [0.08, 0.37] excludes zero, therefore internalized stigma is considered a mediator for public stigma on attitudinal barriers. However, the direct path from public stigma to attitudinal barriers (B = 0.09, p = .45) was not significant (see Figure 1).

Figure 1

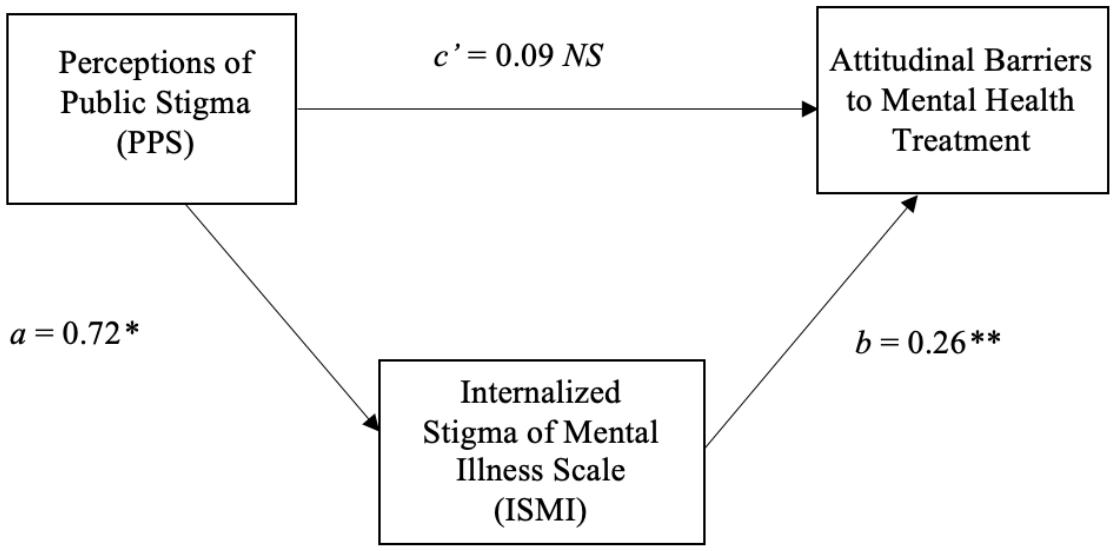

Figure 1: Bias-Corrected Bootstrapping Mediation of Public Stigma on Attitude Barriers.

Note: *p < .01,** p < 0.001

Overall, findings demonstrate a significant indirect path between public stigma and attitudinal barriers with internalized stigma acting as the mediator. Results are discussed in-depth in the next chapter.

Post-Hoc Exploratory Results

Attitudinal Barriers

Cultural attitude barriers were explored outside of the proposed research aims to further understand the role of treatment barriers. When participants were asked if they would be comfortable seeing a therapist of a different race, 57.7% (n = 49) agreed. Over ninety-five percent of participants disagreed when asked if they felt mental health services were only effective when the therapist matched their race and/or ethnicity (n = 82). Most women felt confident in their ability to find a therapist that is understanding of their ethnicity/culture (70.6%, n = 60). Finally, 45.9% (n = 39) agreed that in their community, people take care of emotional problems on their own rather than seek out professional services.

Structural Barriers

There were two specific cultural barriers noted in the structural section. Most participants were not hesitant to seek out services due to their immigration status (96.4%, n = 82) and were confident they would find a provider who spoke their preferred language (89.4%, n = 76).

Structural Subscales with Past, Present, and Future Treatment Seeking

Due to the small sample size, the subscales for the structural barriers were not utilized for assessing the main research aims of the project. Post-hoc exploration showed that when affordability, accessibility, and availability subscales were entered as predictors instead of the structural scale total, there was a significant model compared to the intercept-only model for future treatment seeking, $\chi^2(16, N = 83) = 45.54$, $p < .001$, -2 log likelihood = 107.39, Cox &

Snell = .42, Nagelkerke R^2= 0.50. A significant parameter estimate for internalized stigma remained (*OR* = 1.11, 95% CI [1.00, 1.22], *p* = .04), however an additional significant parameter estimate emerged that for every one unit increase in affordability, the risk of planning to seek both mental health and substance use treatment in the future decreased by 0.63 (*p* = .02) compared to the no treatment group.

Group Comparisons with Past, Present, and Future Treatment Seeking

In order to better understand how mandated treatment impacted seeking treatment, several exploratory regressions were conducted to compare across groups. To complete these analyses, both the past and future treatment seeking were converted into binary outcomes, rather than nominal simplify the interpretation of dependent variables across groups. For the past treatment, a zero represented they did not seek out treatment while incarcerated (*n* = 32) and a one represented they did seek treatment while incarcerated (*n* = 53). Future treatment followed the same recoding, with a zero representing they did not plan to seek treatment in the next six months (*n* = 9) and a one representing they did plan to seek treatment in the next six months (*n* = 76). Present treatment was not changed as it was a continuous variable.

First, I examined the differences between (1) the women who sought out treatment on their own while they were incarcerated (*n* = 34) and (2) the women who were required to go to treatment while incarcerated (*n* = 29). For past treatment, there was a significant logistic regression model noted for the women who sought treatment on their own, $\chi^2(6, N = 34) = 12.73$, *p* = .047, -2 log likelihood = 33.34, Cox & Snell = .31, Nagelkerke R^2= 0.42. However, no parameter estimates were significant. A likely explanation is that this is due to the small sample size. This could also indicate a high correlation among the predictor variables when examining those who did not receive treatment while incarcerated (*n* = 14) versus those who did

receive treatment (n = 20), when viewing the model for those who sought treatment while incarcerated. Present treatment seeking did not have any significant results when examining those who sought treatment while incarcerated ($F(7, 26) = 1.36$, $p = .26$, $R^2 = 0.27$) and those who required treatment ($F(6, 22) = 0.58$, $p = .74$, $R^2 = 0.14$). Finally, for future treatment seeking, a significant logistic regression was noted again for women who sought treatment on their own, $\chi^2(6, N = 34) = 24.63$, $p < .001$, -2 log likelihood = 0.00, Cox & Snell = .52, Nagelkerke $R^2 = 1.00$. Once again, no parameter estimates were significant as sample size was an issue with comparing those who did not receive treatment (n = 4) to those who did receive treatment (n = 30).

Second, I assessed women who were (1) required to go to treatment as part of their mandated sentence (n = 51) compared to those who (2) were not required to attend treatment as part of their sentence (n = 34). Neither past treatment seeking (no treatment required ($\chi^2(6, N = 34) = 8.53$, $p = .20$, -2 log likelihood = 38.61, Cox & Snell = .22, Nagelkerke $R^2 = 0.30$) vs. required treatment ($\chi^2(6, N = 51) = 9.11$, $p = .17$, -2 log likelihood = 52.68, Cox & Snell = .16, Nagelkerke $R^2 = 0.23$)), nor present treatment seeking (no treatment required ($F(7, 26) = 0.97$, $p = .47$, $R^2 = 0.21$) vs required treatment ($F(7, 43) = 1.73$, $p = .13$, $R^2 = 0.22$)) had significant models when the groups were explored. Findings for future treatment showed a significant model when looking at women who were not required to seek treatment as part of their mandated sentence, $\chi^2(6, N = 34) = 24.63$, $p < .001$, -2 log likelihood = 0.00, Cox & Snell = .52, Nagelkerke $R^2 = 1.00$. However, no significant parameter estimates were noted in this model, suggesting sample distribution (no required treatment (n = 4) vs. required treatment (n = 30)) was the reason.

Finally, to understand if the mode of interview (in-person vs zoom) impacted self-reported treatment seeking, another group comparison was assessed in an exploratory set of regressions. There were 48 women who completed the interview in-person and 37 who completed via Zoom. For past treatment seeking, there was a significant logistic regression model noted for women who participated in the interview in-person, $\chi^2(6, N = 48) = 15.69$, $p = .02$, -2 log likelihood = 43.93, Cox & Snell = .28, Nagelkerke $R^2 = 0.30$. However, no parameter estimates were significant. As stated in the other comparison findings, this may be due to the small sample size. Another explanation is that it could indicate a high correlation among the predictor variables when examining those who did not receive treatment while incarcerated ($n = 15$) versus those who did receive treatment ($n = 33$), when viewing the model for those who participated in interviews in-person. Present treatment seeking has a significant linear regression model for women who participated via Zoom, $F(7, 29) = 2.53$, $p = .04$, $R^2 = 0.38$. There were several significant parameter estimates for this model. First, internalized stigma ($\beta = 0.23$, SE = .90, 95% CI [.05, .41], $p = .02$). Second, attitudinal barriers, ($\beta = -0.79$, SE = .23, 95% CI [-1.26, -0.32], $p = .002$). Finally, structural barriers, ($\beta = .43$, SE = .18, 95% CI [.06, .80], $p = .03$). These results suggest that these barriers (internal stigma, attitudes, and structural barriers) are significantly contributing to present treatment seeking for women who participated in the interview via Zoom. Lastly, future treatment seeking had one significant logistic regression model for the women who participated on Zoom, $\chi^2(6, N = 37) = 29.31$, $p < .001$, -2 log likelihood = 0.00, Cox & Snell = .55, Nagelkerke $R^2 = 1.00$. Similar to future treatment seeking findings for the previous comparisons, none of the parameter estimates were significant, which is likely due to the limited sample size.

Mediation Analysis Examining Stigma, Attitudes, and Treatment Seeking Outcomes

A post-hoc examination of internalized stigma, attitudes, and treatment seeking was explored. Present treatment seeking was the only continuous outcome variable able to be assessed using the bias-corrected bootstrap mediation method. The results showed no significant indirect effect of attitudinal barriers on present treatment seeking. The bias corrected 95% CI [-0.14, 0.00] includes zero, therefore attitudinal barriers are not considered a mediator for internalized stigma and present treatment seeking, nor is there a direct path for internalized stigma to present treatment seeking. There was a significant path between internalized stigma and attitudinal barriers (B = 0.28, $p < .001$), similar to what was found in Aim #3.

Figure 2

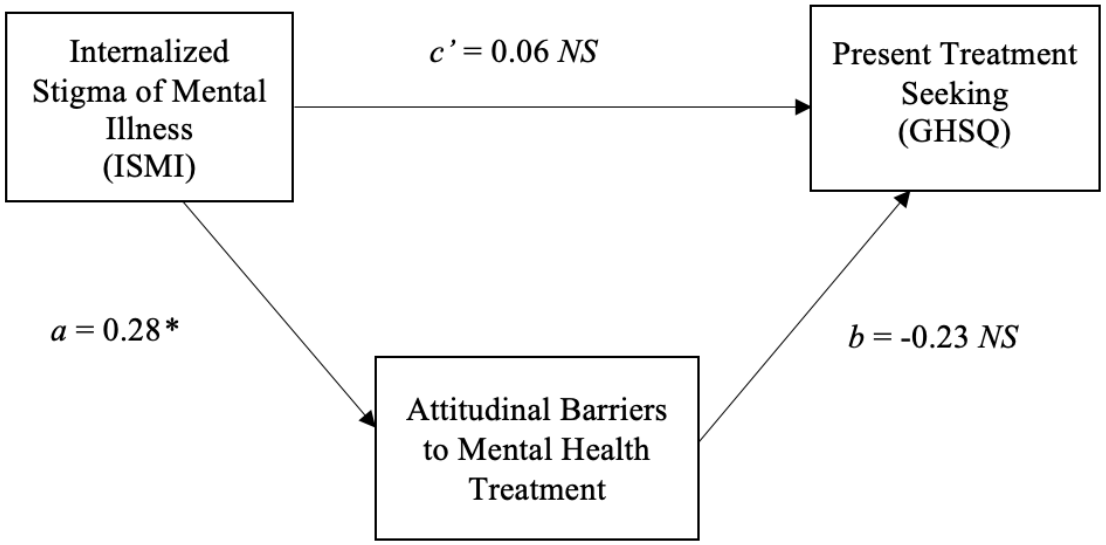

Figure 2: Bias-Corrected Bootstrapping Mediation of Internalized Stigma on Present Treatment Seeking

*Note: *p < .001*

Chapter 4: Discussion

The purpose of this dissertation was to better understand the barriers that justice-involved women living in the Paso del Norte U.S.-México border region face when seeking mental health treatment in their community. Specifically, the project aimed to explore (1) what barriers women frequently identify as hindering their treatment, (2) how the barriers contribute to receipt of services, and (3) whether internalized stigma mediates a relationship between endorsed attitudinal barriers and perceived public stigma for justice-involved women living in a U.S.-México border region. Regarding the first aim, findings show that attitudinal barriers were more frequently supported as barriers to seeking treatment compared to structural barriers. For the second aim, attitudes and public stigma were at decreased odds of treatment seeking in the past, and internalized stigma was associated with increased odds of past treatment seeking and future treatment seeking. Finally, internalized stigma was a significant mediator between public stigma and attitude barriers.

Attitudinal Barriers to Mental Health Treatment

Findings indicate that, compared to structural barriers, attitudinal barriers are more frequently endorsed as motivators to not seek out mental health treatment for justice-involved women living in the Paso del Norte border region. Among these attitudes, feeling ashamed of mental illness, feeling ashamed of needing help, and wanting to handle mental health on their own, were cited most often for the women in this sample. These attitudinal barriers are prevalent in previous research, where negative attitudes have been shown to relate to stigma and impact help-seeking in the general population (Arnaez et al., 2020; Pattyn et al., 2014; Schnyder et al., 2017). Some work shows that alienation (a subscale of internalized stigma) predicts negative attitudes towards seeking treatment (Arnaez et al., 2020), whereas public stigma is associated

with negative ratings of informal help seeking (i.e., hesitant to ask help from friends and family vs professional care; Pattyn et al., 2014). Additionally, attitudes and stigma may stem from negative past experiences with treatment which can further deter treatment seeking among justice-involved women. Previous research shows that fears surrounding treatment while incarcerated are related to less treatment seeking (Shaw & Morgan, 2011) and pressure to engage in treatment is associated with increased internalized stigma for justice-involve women (Moore et al., 2020). Furthermore, some studies note that women seek out treatment services more frequently compared to men during incarceration (Drapalski et al., 2009), studies show women report feeling dehumanized and silenced when in treatment while incarcerated (Fedock et al., 2023). When women feel limited in their ability to express feelings in treatment while incarcerated, this can contribute to stigma and attitudes that further deter treatment seeking.

Not many studies have specifically examined justice-involved women living in a U.S.-México border region, previous research shows attitudes and stigma can influence treatment seeking for justice-involved people (Byrne et al., 2024). Shame (a component of attitude barriers and stigma) has been shown to impact recovery in treatment for justice-involved women (Joseph et al., 2023), thus emphasizing the role attitudes have on treatment seeking for women in the justice system. Additionally, as the current sample of women were majority Latina-identifying, it is important to see what prior research on attitude barriers shows regarding ethnicity. Latina women cite attitude barriers more and are less likely to think treatment would be effective for them compared to Black and White women (Pinedo et al., 2020). Studies examining barriers surrounding mental health treatment in the Paso del Norte region show that both stigma and structural barriers (i.e., affordability) are frequently noted across gender in the region (Mallonee et al., 2023), however no work has directly examined this only among women in the area. Yet,

according to the current findings, attitudes are clearly impacting treatment seeking motivations. Addressing these attitudes may be beneficial to encouraging justice-involved women in the border region to seek out services.

Another component that needs to be discussed given the current sample of justice-involved women living in the border region is the influence of motherhood on help-seeking. Many of the women were mothers, yet motherhood specific attitudinal barriers were not heavily endorsed. Prior research has shown that for women, fear of losing their children is a large concern for not seeking out services (Copeland & Snyder, 2011; Gueta, 2020), however this was not the case for the women in this study. Only three women in the sample (outside of the scaled attitude items) mentioned they were afraid to seek treatment for fear of losing custody of their children. *Familismo* may be a cultural factor alleviating some of this fear within the current group of women. As defined within the Hispanic culture, *familismo* emphasizes family closeness, which goes beyond the nuclear family to extended members (i.e., aunts, uncles, cousins, etc.) (Cauce & Domenech-Rodriguez, 2002). This closeness of family within the justice-involved women in this study could mediate mother-specific barriers that are present in other samples of justice-involved women. Future research should explore this connection of cultural values being a protective factor specifically among justice-involved Latina mothers.

The Role of Attitudinal Barriers in Past, Present, and Future Treatment Seeking

Past Treatment Seeking

Results show that both public stigma and attitudinal barriers were related to the decreased odds of seeking out mental health treatment in the past (i.e., while incarcerated) while internalized stigma was related to the increased odds of seeking out treatment in the past. Findings that attitudinal barriers negatively influenced past treatment seeking is similar to

research examining treatment seeking among justice-involved people. Moore et al. (2018), found that low self-esteem and antisocial characteristics were associated with stigma among justice-involved men. Attitudinal barriers build upon stigma in that they capture real emotions associated with seeking help (i.e., I felt ashamed of needing help, I was afraid of being hospitalized). These emotions and stigmatizing views can serve as motivation to avoid treatment while incarcerated. A meta-analysis (Bryne et al., 2024), found stigma and attitudes (i.e., negative perceptions towards others) were the main contributing factors among people housed in prison to not seek treatment. However, Bryne et al. (2024) acknowledges the lack of women represented in these largely male studies and the need to dedicate research to understanding if this is the same for justice-involved women.

When public stigma is considered in treatment seeking, research examining the general population suggest public stigma of mental illness does not influence treatment seeking attitudes, regardless of gender (Topkaya, 2014). Yet within Latino communities, increased public stigma of mental illness was associated with greater sympathy towards those with mental illness (Gearing et al., 2023) yet Latino people are more willing seeking help compared to White people (Prince et al., 2019), especially Latinas (Mendoza et al., 2015). This is different than what was found in the current group of justice-involved women, which suggests there may be additional public stigma concepts at play.

Among women who are or have been incarcerated, specific gender role stereotypes may factor into reasons to not seek out treatment. Women in the justice system receive labels, such as being “bad” mothers (Travis & Waul, 2003) or “emotional” (McCorkel, 2003), which contributes to their already stigmatized identity of being incarcerated and having a mental illness (West et al., 2014). Women who lose custody of their children because of substance use issues

are more likely to receive stigmatizing views compared to men who lose custody (Stone, 2015). This can become a compounded identity that is made more burdensome when seeking out treatment for mental health problems and relate to feeling stigmatized, which are factors correlated with recidivism among women (Moore et al., 2016).

Results in the study also showed that internalized stigma increased the odds of self-reported treatment seeking while incarcerated. Internalized stigma has been positively correlated with symptom severity (Drapalski et al., 2013; Moore et al., 2018) and this may explain why the present study found internalized stigma preforming in the opposite direction compared to public stigma and attitudes toward treatment seeking. Increased symptom severity is positively associated with seeking out treatment (Fox et al., 2018; Keeling et al., 2020) and increased internalized stigma has been shown to be positively associated with treatment seeking for some groups of people (Martinez de Andino & Weisman de Mamani, 2022). However, Fox et al., (2018) specifically examined this relationship and found that symptom severity acted as a mediator between stigma and help seeking where, for veterans with less severe depressive symptoms, stigma was associated with more help seeking. Studies of the general population suggest that women may experience more internalized stigma of mental illness compared to men (West et al., 2011) whereas others find no difference (Drapalski et al., 2013). Clearly these factors have a more complex relationship than originally hypothesized and should be further explored.

Considering these findings in relation to the border region, it should be noted that in El Paso County, during intake at the jail, the facility staff are instructed to provide services to people who need it. This means that if someone was in treatment prior to being incarcerated, they should be referred to treatment when they enter the facility. However, as research suggests, this

group of people may already have higher internalized stigma but because of their symptom severity and previous treatment history, they seek out treatment at higher rates. Overall, the current study suggests that public stigma, internalized stigma, and attitudinal barriers create obstacles for justice-involved women living in the Paso del Norte border region when deciding to seek out mental health treatment while incarcerated.

Present Treatment Seeking

None of the attitude or stigma barriers were significant predictors for present treatment seeking, which was measured using the General Help Seeking Questionnaire (GHSQ) to gauge willingness to seek out treatment from a range of resources (i.e., partner, doctor, mental health provider, etc.). This was opposite of what was expected; research shows that attitude and stigma barriers are prevalent in the general population (Clement et al., 2015) and in justice involved samples (Tomar et al., 2020; West et al., 2014). This is also unexpected considering the majority Latina sample of the current project and prior research demonstrating that attitude barriers are more commonly noted among Latinas compared to women of other minority groups and White women (Pinedo et al., 2020). One possible explanation for this finding is that the present treatment seeking measure asked participants how likely it was that they would seek help from a list of resources (i.e., partner, mental health professional, phone helpline, etc.) and this measurement may not have tapped into if the women were actively seeking treatment in the present. Even when the present treatment seeking measure was limited to the two items that endorsed only professional help seeking (i.e., doctor or mental health provider), the barriers were still non-significant predictors. Another possibility is that many of the women (50.6%) indicated they were required to go to treatment for alcohol or drugs as part of their criminal justice sanction (i.e., probation requirements, strong suggested for PR Bond, etc.), and therefore barriers

did not emerge as salient as they had already received treatment. However, only 37.6% said they were required to go to mental health treatment as part of their criminal justice sanction, suggesting that coupled with the low reliability of the GHSQ, perhaps the outcome measure did not accurately capture the construct of present treatment seeking.

Future Treatment Seeking

For future treatment seeking, internalized stigma contributed to the increased odds of seeking out both mental health and substance use treatment and mental health treatment alone in the next six months compared to not seeking treatment. This was unexpected. Previous research finds that internalized stigma of mental illness can have an impact on a person's self-efficacy (Bozdağ & Çuhadar, 2022; Corrigan et al., 2009), thus contributing to lack of treatment seeking. However, Bozdağ & Çuhadar (2022) found that increased internalized stigma was positively correlated with motivation to seek treatment. This finding may be due to women internalizing their mental health and substance use problems as their fault, while also recognizing their need to seek out treatment going forward. Other research has found results to suggest this may be the case, particularly for people dealing with substance abuse (Heeren et al., 2008).

Another explanation is that internalized stigma is correlated with mental health symptom severity, thus leading to increased endorsement of help-seeking in the future. As noted in the discussion of the findings from past treatment, research supports the association between internalized stigma and mental health symptom severity (Drapalski et al., 2013; Eno Louden et al., 2023) and the positive association with treatment seeking and symptom severity (Fox et al., 2018; Keeling et al., 2020). For the justice-involved women in the current study, internalized stigma was positively correlated with the Kessler-10 (i.e., psychological distress). This helps to explain why internalized stigma increases as the odds of seeking out treatment are reported.

Prince et al. (2019), found that among those who report more internalized stigma, they were no different in their willingness to seek out help compared to others with lower internalized stigma scores. Tomar et al. (2020), also note a similar relationship between internalizes stigma and symptom severity among a sample of justice-involved people. Both mental health and justice outcomes can be negatively affected by symptom severity and internalized stigma (Skeem et al., 2011). These findings demonstrate an avenue to further explore the interconnected relationship that symptom severity and internalized stigma have on help-seeking behavior.

Mediation of Stigma and Attitudes

The current study found an indirect mediation between perceptions of public stigma and attitudinal barriers with internalized stigma acting as the mediator. Findings of this indirect mediation are similar to previous research showing internalized stigma is a mediator of public stigma and attitudes toward treatment seeking (Brown et al., 2010; Vogel et al., 2007). For justice-involved women living in a border region, stigmatizing views from the public indirectly influences attitudes towards seeking treatment.

There was no direct path between public stigma and attitude barriers, which was unexpected according to prior studies (Brown et al., 2010; Vogel et al., 2007). Research has found internalized stigma plays a larger role compared to public stigma (Arnaez et al., 2020). Perhaps when internalized stigma is present, this association is a stronger influence on attitudes than public stigma alone. This result may also be due to the nature of the attitude items that were geared towards self-reflected treatment barriers (i.e., I wanted to handle it on my own, I was not comfortable discussing my problems with someone) compared to the public stigma questions that captures endorsement of stereotypes for people with mental illness (i.e., mentally ill people tend to be violent). Some research has suggested that acculturation may play a role, where Latino

participants in the U.S. reported fewer public stigmatizing beliefs compared to those in México City (Brewer et al., 2023). The current sample, while not entirely Hispanic, did represent women living in a border region where acculturation may be playing a role in stigma. Additionally, the same study found that people with children were more accepting of mental illness potentially due to awareness or empathy (Brewer et al., 2023), which may also be an influential factor among the current sample of women.

Structural Barriers to Mental Health Treatment

Contrary to what was hypothesized and found in previous literature (de Heer et al., 2013; Tomaka et al., 2008), structural barriers were not frequently noted among the justice-involved women in the current sample. While the subscales within these barriers did emerge in the open-ended ranking question, they still were far behind attitude endorsement in all three ranks. This could be due to a couple of reasons. First, El Paso County Probation connects many justice-involved women with free, or nearly free, mental health and substance abuse services. Having a direct referral to services can mitigate some of the structural barriers, such as not knowing where to go or how to find services. Many women in the study endorsed they did not have problems with transportation, with knowing where to go for services, nor with having difficulty accessing telehealth services. Additionally, prior research shows many people (62.3%) cross into Juarez for health care services (Lapeyrouse et al., 2012), suggesting this may help to alleviate some of the structural barriers such as cost of treatment and lack of insurance.

Second, some research shows that among the general population, stigma barriers often outweigh structural barriers when seeking treatment (Tomczyk et al., 2020). As eligibility for the study was contact with the criminal justice system in the past 12 months, many women in the

study had some recent access to treatment in their past. This could be why few structural barriers items were frequently endorsed among this group.

Despite majority of the justice-involved women in the current study identifying as Latina, cultural barriers (i.e., confidence in finding treatment provider that speaks preferred language, confident I could find a therapist understanding of my ethnicity/culture, hesitant to use services due to my immigration status, etc.) were not frequently cited among the women. Research has shown that Latinas are more likely to describe cultural barriers to seeking substance use treatment compared to women of other racial/ethnic groups (Pinedo et al., 2020). One possible reason for this could be acculturation. Only a few of the women in the study were first generation (i.e., born in México or another country). A large portion of the population (7 out of 10 people) in El Paso, Texas are bilingual (Zajechowski, 2024), which could be why so few women felt this was a barrier when seeking out treatment. Prior research shows that people who are bilingual view treatment more favorably compared to those who are monolingual (Hood, 2023). Research does show that Hispanic people do cite lack of cultural understanding as a reason for not seeking services (Cabassa et al., 2014; Cooper et al., 2003), yet as the Paso del Norte region sits on the U.S.-México border, the service providers in this area are typically part of the Hispanic population and therefore may reduce cultural barriers for justice-involved women in this region.

The Role of Structural Barriers in Past, Present, and Future Treatment Seeking

For the main research aims, structural barriers as a whole were not influential predictors for past, present, or future treatment seeking. These results were surprising as it was predicted that structural barriers would impact justice-involved women's motivations to seek out services. One prior research study found that while structural barriers do exist, internalized stigma displays a strong association with structural barriers (Arnaez et al., 2020), suggesting that

perhaps internalized stigma in the present study overpowered the structural influences on treatment seeking.

One possible explanation for the lack of emerging significance could be due to the overwhelming influence that stigma (Benz et al., 2021; Fox et al., 2018; Mendoza et al., 2015) and attitudes (Meyer et al., 2014; Morgan et al., 2004) have on seeking treatment. Post-hoc results examining group differences found structural barriers significantly contributed to present treatment seeking for women who preferred Zoom over the in-person interview platform. However, these findings should be interpreted with caution due to the reliability of the present treatment seeking measure (see limitations for more information). When the subscales of the structural barriers were explored post-hoc, results showed that affordability did emerge as a significant predictor for future treatment seeking when receiving treatment for both mental health and alcohol or drugs was compared to no treatment seeking. This suggests that when we tease apart structural barriers, affordability is important in seeking treatment for both mental health and substance use, but perhaps not as influential when singular treatment options are in consideration (i.e., only seeking mental health treatment).

Another reason for the lack of endorsed structural barriers when considering past treatment could be structural barriers (i.e., transportation, affordability, etc.) are eliminated while incarcerated. When examining present treatment, some conditions of release from jail/prison require (or strongly encourage) participation in treatment services which may have been why the group of women in the study did not frequently endorse structural barriers being an issue. Finally, for future treatment seeking, cognitive processes, such as future orientation (i.e., thinking about goals in the future) may be why structural barriers did not emerge as salient. One research study showed that justice-involved adults are future-oriented (Vuk & Applegate, 2021)

and this mindset does help with recidivism (Petrich & Sullivan, 2020), however this may not translate to justice-involved women. Research in the general population shows women have more diversity in their future orientation when compared to men (Greene & DeBacker, 2004). Perhaps the women in this study already had connections to resources due to their conditions of release and therefore did not find structural barriers to be influential in future treatment seeking.

Many of the women in the current study were single and had children. Research examining single mothers often cite that these women experience more mental health problems compared to married mothers (Kim & Kim, 2020). Some research suggests that, in the general population, single mothers are more likely to seek treatment compared to married mothers (Cairney et al., 2004). This may be due to the increased stress that surrounds supporting a child while economically disadvantaged as a single mother. While most women in the current study disagreed that childcare needs impacted their ability to attend appointments for mental health treatment, cultural factors (i.e., *familismo*) may be mitigating this barrier for women in the Paso del Norte region.

Implications

Research examining justice-involved women has increased since the 1980s feminist criminological work established a theoretical approach to women's involvement with crime (Chesney-Lind, 2006). Despite the growing body of work, there are still gaps in the literature surrounding justice-involved women. Specifically, one of those gaps is understanding the unique experiences of justice-involved women living in the U.S.-México border region. This dissertation brought to light some of the unique experiences that justice-involved women face seeking treatment services while living in the Paso del Norte border region. Additionally, this project is one of only a few studies that explore how stigma might impact justice-involved women living in

a border region and their motivations to seek mental health treatment. Unexpectedly, internalized stigma had the opposite relationship towards treatment seeking than what was predicted among this population. This provides a unique look into the construct of internalized stigma as it aims to measure how people view mental illness versus how it may relate to seeking out treatment (see Tucker et al., 2013). Despite what was found regarding internalized stigma, many of the other barriers to seeking treatment were similar to other justice-involved studies that examine a border region (i.e., stigma; Booth & McLaughlin, 2000; Eno Louden et al., 2022). No barriers emerged as significant predictors for this sample of women that were unique to the border region (i.e., culture specific barriers; Anderson et al., 2019).

While the population of interest for this project focused on justice-involved women, the insight gained by understanding the barriers to seeking treatment in the Paso del Norte border region provides useful information for improving community mental health treatment services. For example, anti-stigma efforts have been shown to be useful in many communities seeking to improve mental health treatment access (Corrigan, 2012), yet anti-stigma efforts may not be a one-size-fits-all approach specifically in a border region. Specifically, Paso del Norte Health Foundation (2024) granted money to various organizations (e.g., Doña Ana County Health and Human Services, Family Service of EL Paso, Inc.) in an initiative called “Think.Change” to reduce stigma more generally in the region, however there is little information about the effectiveness of these programs on people living in a border region. Based on the results of the current project, incorporating anti-stigma programs that address attitudes towards seeking treatment for justice-involved women in the border region would be beneficial to their rehabilitation in the Paso del Norte community.

The results from this project provide a useful starting point for the criminal justice system in the Paso del Norte border region to see what motivates justice-involved women in their community to seek or not seek mental health services. Largely, stigma and attitudes were the primary barriers for women in the study. Creating a more supportive community that addresses stigma of mental illness is an important part of assisting this population, particularly in a border region. As research has shown, gender-responsive treatment plays a role in reducing recidivism for justice-involved women who enter the criminal justice system through gendered pathways (Day et al., 2015; Saxena et al., 2014) and this is no different for women in a border region. Addressing stigmatizing beliefs in treatment, in addition to mental health symptoms, may help to alleviate these attitudinal barriers for justice-involved women. Finally, this project contributes to the recognition of a group of women that are often overlooked within criminal justice research and feminist criminology (Lopez & Pasko, 2017; Schuck et al., 2004). By giving a voice to the justice-involved women in the Paso del Norte border region it helps understand what areas this community can improve upon to provide more acceptance for those needing access to these resources.

Strengths, Limitations, and Future Directions

Strengths

A strength of this study is that it contributes to the larger literature examining justice-involved women living on the U.S.-México border. Very few studies have explored justice-involved women living in the Paso del Norte border (Adair et al., 2023; Eno Louden & Manchak, 2018) and even fewer have examined the barriers these women face in seeking treatment. This study also offers a unique in-depth examination of the motives behind treatment seeking for a majority sample of justice-involved Latina women living in a border region.

Another strength of this study was conducting the interviews face-to-face, either in-person or virtually, helped to ensure complete understanding of questions and clarification that might not be as easily remedied in online-based survey response methodology.

Similar to previous research work examining stigma and treatment seeking (Bozdağ & Çuhadar, 2022; Mendoza et al., 2015), the present study also found that stigma contributed to help seeking among women. This is the first known project that has addressed barriers to treatment seeking among justice-involved women living in a U.S.-México border region. The findings from this work can be used to inform stigma reduction efforts within the Paso del Norte region to help justice-involved women feel more comfortable seeking treatment for their mental health and substance use needs.

Limitations

There were some limitations with the present study. While the main analyses were adequately powered given the small sample size, any additional predictor variable (i.e., subscales of structural barriers and internalized stigma) added to the models need to be interpreted with caution. Also, there should be caution towards the findings of the mediation as cross-sectional data was used and has shown to generate biased estimates when used in mediation analyses (Maxwell & Cole, 2007). The General Help Seeking Questionnaire (GHSQ) should be mentioned as a limitation as well due to the low alpha score, despite examining the corrected item correlations and removing an item that did not have significance. Low reliability suggests that the GHSQ was not a valid measure, therefore interpretations of present treatment seeking should be examined with caution. Additionally, research has shown there are barriers to treatment seeking among justice-involved people (Meyer et al., 2014; Moore et al., 2016), women (Pinedo et al., 2020), and people living on the U.S.-México border (Mallonee et al.,

2023), suggesting that perhaps the findings in the current study did not accurately measure seeking treatment during the present time.

Using flyers to recruit women for the study may have led to a biased sample, where women who felt stigma or shame surrounding their justice involvement and mental health, may not have reached out to participate. When recruiting via self-selection of the participant, there are underlying factors (i.e., personality, confidence, etc.) that could be present among the women who reach out. While most recruitment calls happened from flyers seen around town, in probation offices, or after being released from jail, some participants were referred by friends who had already participated (i.e., snowball sampling). This may have led the current sample to lack independence. Future research should try to randomize recruitment efforts and perhaps incorporate other modes of disseminating the study (i.e., online survey software) to encourage participation from women who are hesitant to contact researchers. Additionally, for the women who preferred interviews be conducted in a public place (i.e., park, coffee shop, etc.), this might have limited the capacity to which these women were willing to delve into their personal history. While few women refused to answer certain questions, they were told during the consent process that they had the right to skip any questions they did not feel comfortable answering.

The current study did not specifically account for if the women needed treatment. However, the psychological distress measure (i.e., K10) did show that the mean score (M = 29.73, SD = 8.14) was at the cut off between exhibiting moderate (scores ranging from 25-29) to severe distress (scores 30 or higher; see Kessler et al., 2003) suggesting most women in the study would benefit from treatment. Previous treatment seeking outside of the justice system, nor satisfaction of treatment, were not assessed in the current study. These limitations should be accounted for in future studies to determine if these may be additional factors influencing

treatment seeking. Finally, while this work was informative to understanding barriers for justice-involved women living in the Paso del Norte border region, it may only be unique to the cultural experiences in this area. Future research should examine other U.S.-México border cities to determine if similar findings emerge in other culturally salient geographical areas.

Future Directions

To further understand barriers to treatment for justice-involved women, several future directions should be explored. First, compiling a larger sample across multiple border cities would help to generalize the findings of specific barriers women face when seeking treatment services in these areas. Additionally, a larger sample would yield concrete exploration into the structural subscales such as affordability. This was a significant subscale in our post-hoc exploratory analyses but should be further investigated to confirm significance. The Internalized Stigma of Mental Illness (ISMI) also has subscales that capture alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. Some research has shown that the alienation subscale within the ISMI is a more prominent predictor of barrier endorsement than the stereotype or stigma resistance subscales (Arnaez et al., 2020). Future research should continue to tease apart these scales within justice-involved women to better understand what areas to target for reducing stigma surrounding treatment and identify what structural barriers, if any, may be present.

Longitudinal studies are ideal for determining treatment outcomes (Caruana et al., 2015), especially when conducting mediation analyses (Maxwell & Cole, 2007). The current study utilized cross-sectional, self-report of intentions to help seek in the future, however prospective studies aimed to determine if treatment was sought out and what motives may have prevented (or encouraged) treatment seeking should incorporate longitudinal follow ups with participants.

Mental health treatment outcomes (Grella & Rodriguez, 2011) and stigma (Tomczyk et al., 2020) have been longitudinally studied, however, incorporating this approach in a justice-involved sample of women living in U.S.-México border regions would fill a gap in the current research literature.

Lastly, culture should be further examined as it may be a protective factor for some structural barrier (i.e., childcare), while also a risk factor for stigma. As mentioned previously, *familismo* is defined as family closeness (Cauce & Domenech-Rodriguez, 2002), and could help justice-involved single mothers to seek out mental health services while their family members provide childcare. Examining the role that a close nuclear family has for justice-involved single mothers in the border region is a way to further explore if culture is acting as a protective factor among this group of women. However, culture may also be a risk factor for stigma where research in the Paso del Norte border has found those who endorse more collectivistic ideals have more internalized stigma (Eno Louden et al., 2023). Future research should examine if this is the case among justice-involved women in the Paso del Norte region as it may be helpful when implementing anti-stigma programming within the community.

Conclusion

This project was to explore barriers that justice-involved women living in the U.S.-México border region face when seeking out mental health treatment services in the community. First, the study aimed to determine what barriers women frequently cited as hindering their treatment. Findings show that justice-involved women living in the border region endorsed attitudinal barriers, such as feeling ashamed and wanting to handle the problems on their own, however only one structural barrier was frequently endorsed where women indicated they put their money towards other needs over treatment. Second, the project examined how the barriers

contributed to the receipt of services, specifically for the past, present, and future. Past treatment results showed public stigma and attitudinal barriers emerged as decreasing the odds of treatment seeking. Present treatment results did not display either attitudinal or structural barriers as contributing to seeking treatment, while future treatment found that internalized stigma played an interesting role in increasing the odds of seeking treatment compared to no treatment. Finally, the project wanted to investigate if internalized stigma mediated the relationship between public stigma and attitudinal barriers. The current study did find support of internalized stigma acting as a mediator.

Overall, these findings can be used to inform future public policy for an understudied group of women involved in the criminal justice system - those living in the Paso del Norte region on the U.S.-México border. Stigma of mental illness and attitudes towards treatment were prominent factors contributing to the receipt of mental health treatment among women. This suggests that while women in the border region may have access to services and can find the time to attend appointments, the main barriers influencing treatment are related to the perceptions of others, internal mental health stigma, and feeling ashamed of their mental health. Agencies working with justice-involved women living on the border should take these findings into consideration when introducing service options or in their approach to encourage accessing these services upon reentry. Previous research has shown that justice-involved women with peer-mentoring support often have better treatment outcomes (McLeod et al., 2020) and having a peer may help to reduce some of the maladaptive attitudes surrounding help seeking for women. This study helped to provide a look into a group of women that are often overlooked by larger research and with this work we can better assist these women as they navigate treatment services in their border community.

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Appendix A

Demographics

1. What is your age in years? _____

2. Are you of Hispanic or Latino/a origin? (ethnicity)
   - ☐ Yes
   - ☐ No

3. How would you describe yourself? (race)
   - ☐ White
   - ☐ Black or African American
   - ☐ American Indian or Alaskan Native
   - ☐ East Asian or Asian American
   - ☐ Middle Eastern or Arab American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ Other: (Please Specify) _____

4. With whom do you live? (check all that apply)
   - ☐ With parents
   - ☐ With spouse/partner
   - ☐ With children
   - ☐ With other family members
   - ☐ With other non-related persons
   - ☐ No one, live alone

5. What is your current marital status?
   - ☐ Married
   - ☐ Widowed
   - ☐ Separated
   - ☐ Divorced
   - ☐ In a committed relationship
   - ☐ Single

6. Are you pregnant or have you given birth in the past year?
   - ☐ Yes
   - ☐ No

7. Do you have children?
   - ☐ Yes
   - ☐ No
   a. How many children do you have? _____

8. What is your current employment status?
   - ☐ Employed full time

☐ Employed part time
☐ Unemployed, looking for work
☐ Unemployed, disabled
☐ Unemployed, volunteer
☐ Unemployed, retired
☐ Other/specify

9. What type of work do you do?

_____
_____
_____
_____

10. Do you qualify for benefits such as Medicaid, SSI, or SSDI?
    ☐ Yes
    ☐ No

11. What is your current income bracket?
    ☐ Below $10,000
    ☐ $10,000 – $19,999
    ☐ $20,000 – $29,999
    ☐ $30,000 – $39,999
    ☐ $40,000 – $49,999
    ☐ $50,000 – $59,999
    ☐ $60,000 or greater

12. What was the last grade you completed in school?
    ☐ Elementary through 6th
    ☐ 7th through 8th
    ☐ 9th through 12th
    ☐ 1-2 years of college
    ☐ 3-4 years of college
    ☐ College graduate and higher

13. Which is your generational status?
    ☐ 1st generation = You were born in México or other country
    ☐ 2nd generation = You were born in USA, either parent born in México or other country
    ☐ 3rd generation = You were born in USA, both parents born in USA and all grandparents born in México or other country
    ☐ 4th generation = You and your parents born in USA and at least one grandparent born in México or other country with remainder born in the USA
    ☐ 5th generation = You and your parents born in the USA and all grandparents born in the USA

Appendix B

Treatment Seeking while Incarcerated

1. When you were in jail/prison, did you seek out mental health treatment on your own or were you required to speak with mental health services?

   ☐ Sought on my own
   ☐ Required
   ☐ Both

2. Did you receive treatment for **alcohol or drug problems** while in jail/prison?

   ☐ Yes
   If yes, what kind?
   _____
   _____
   _____ (List: Individual therapy, group therapy, medication management)

   ☐ No

3. Did you receive treatment for **mental health problems** while in jail/prison?

   ☐ Yes
   If yes, what kind?
   _____
   _____
   _____ (List: Individual therapy, group therapy, medication management)

   ☐ No

Appendix C

General Help-Seeking Questionnaire (GHSQ)[3]

(Instructions) If you were having mental health problems, how likely is it that you would seek help from the following people using the following scale?

	1 Extremely unlikely	**2**	**3 Unlikely**	**4**	**5 Likely**	**6**	**7 Extremely likely**
Intimate partner (e.g., girlfriend, boyfriend, husband, wife, etc.)							
Friend (not related to you)							
Parent							
Other relative/family member							
Mental health professional (e.g., psychologist, social worker, counselor)							
Phone helpline							
Doctor/General Practitioner							
Minister or religious leader (e.g., Priest, Rabbi, Chaplain)							
I would not seek help from anyone							
I would seek help from another not listed above. (Insert if provided) _____							

[3] Wilson, C. J., Deane, F. P., Ciarrochi, J. V., & Rickwood, D. (2005). Measuring help seeking intentions: properties of the general help seeking questionnaire.

Appendix D

Future Treatment Seeking

In the next 6 months, do you plan to seek treatment for **alcohol or drug problems** outside of any criminal justice sanction required treatment?

☐ Yes

If yes, where are you planning to seek treatment services?

_____
_____
_____

☐ No

If no, why do you not plan to seek treatment?

_____
_____
_____

In the next 6 months, do you plan to seek **mental health treatment** outside of any criminal justice sanction required treatment?

☐ Yes

If yes, where are you planning to seek treatment services?

_____
_____
_____

☐ No

If no, why do you not plan to seek treatment?

_____
_____
_____

Appendix E

Criminal History

1. How old were you when you were first arrested for a crime? _____

2. How many times total have you been arrested? _____

3. For your **most recent arrest**, what crime(s) were you charged with?
   _____
   _____
   _____
   _____
   _____

4. What is the **most serious crime** you were arrested or convicted for?
   _____
   _____
   _____
   _____
   _____

5. Have you ever been picked up by the police (but not charged)?
   - ☐ Yes
   - ☐ No

6. Have you ever been assigned to a diversion program?
   - ☐ Yes
     If yes, what was the diversion program?
     _____
     _____
     _____
   - ☐ No

7. Are you currently required to go to treatment for **alcohol or drug problems** as part of probation, pretrial release, or other criminal justice sanction?
   - ☐ Yes
     If yes, what type of treatment?
     _____
     _____
     _____
   - ☐ No

8. Are you currently required to go to treatment for **mental health problems** as part of probation, pretrial release, or other criminal justice sanction?
   - ☐ Yes

If yes, what type of treatment?

_____

_____

_____

☐ No

Appendix F

Mental Health Diagnosis History

1. Have you ever been given a mental health diagnosis?

☐ Yes

If yes, what diagnosis(es) have you received and what age did you receive them? *[List each of the participant's diagnoses and corresponding ages]*

☐ No

Appendix G

Perceptions of Public Stigma[4]

Please indicate how much you agree or disagree with each of the following statements.

	1 Strongly Disagree	**2 Disagree**	**3 Neither agree nor disagree**	**4 Agree**	**5 Strongly Agree**
Most people would accept a person who has had a mental illness as a friend.					
Most people believe that a person who has been hospitalized for a mental illness is just as intelligent as the average person.					
Most people believe that a person who has a mental illness is just as trustworthy as the average citizen.					
Most people would accept a person who has fully recovered from being a mental health patient as a teacher of young children in a public school.					
Most people believe that entering a mental hospital is a sign of personal failure. (RC)					
Most people would not hire someone who has a mental illness to take care of their children, even if he or she had been well for some time. (RC)					
Most people think less of a person who has been in a mental hospital. (RC)					
Most employers will hire someone who has a mental illness if he or she is qualified for the job.					
Most employers will pass over the application of someone who has a mental illness in favor of another applicant. (RC)					
Most people in my community would treat someone who has a mental illness just as they would treat anyone else.					

[4] (Link, 1987; Brown et al., 2010)

Most young women would be reluctant to date a man who has been hospitalized for a mental illness. (RC)					
Once they know a person was in a mental hospital, most people will take his or her opinions less seriously. (RC)					

Appendix H

Internalized Stigma of Mental Illness Scale (ISMI)[5]

For this next set of questions, we will be asking about mental illness. When I use the term 'mental illness' I am referring to any type of emotional stress, anxiety, worry or feeling down. Please indicate how much you agree or disagree with each of the following statements.

	1 Strongly Disagree	**2 Disagree**	**3 Neither agree nor disagree**	**4 Agree**	**5 Strongly Agree**
I feel out of place in the world because I have a mental illness					
Having a mental illness has spoiled my life					
People without mental illness could not possibly understand me					
I am embarrassed or ashamed that I have a mental illness					
I am disappointed in myself for having a mental illness					
I feel inferior to others who don't have a mental illness					
Stereotypes about the mentally ill apply to me					
People can tell that I have a mental illness by the way I look					
Mentally ill people tend to be violent					
Because I have a mental illness, I need others to make most decisions for me					
People with mental illness cannot live a good, rewarding life					
Mentally ill people shouldn't get married					
I can't contribute anything to society because I have a mental illness					
People discriminate against me because I have a mental illness					
Others think that I can't achieve much in life because I have a mental illness					
People ignore me or take me less seriously just because I have a mental illness					
People often patronize me, or treat me like a child, just because I have a mental illness					

[5] (Ritsher et al., 2003)

Nobody would be interested in getting close to me because I have a mental illness					
I don't talk about myself much because I don't want to burden others with my mental illness					
I don't socialize as much as I used to because my mental illness might make me look or behave 'weird'					
Negative stereotypes about mental illness keep me isolated from the 'normal' World					
I stay away from social situations in order to protect my family or friends from embarrassment					
Being around people who don't have a mental illness makes me feel out of place or inadequate					
I avoid getting close to people who don't have a mental illness to avoid rejection					
I feel comfortable being seen in public with an obviously mentally ill person (RC)					
In general, I am able to live life the way I want to (RC)					
I can have a good, fulfilling life, despite my mental illness (RC)					
People with mental illness make important contributions to society (RC)					
Living with mental illness has made me a tough survivor (RC)					

Appendix I

Barriers of Mental Health Treatment[6]

Please indicate how much you agree or disagree with each of the following statements in your decision to seek mental health treatment services.

	1 Strongly Disagree	**2 Disagree**	**3 Neither agree nor disagree**	**4 Agree**	**5 Strongly Agree**
The cost of mental health treatment is too high for me to seek out those services.					
My insurance does not cover mental health treatment.					
I do not have insurance.					
I put my money towards basic needs (examples: rent, food, children, etc.) over covering my own mental health treatment needs.					
I do not know where to go for mental health services.					
I do not know how to begin searching for information about mental health treatment services.					
I do not have transportation options to get to mental health treatment.					
I live too far away from mental health services.					
The financial cost of traveling to mental health treatment would be too much.					
I find it difficult to find the time to schedule an in-person appointment for mental health treatment.					
I do not have the capabilities (example: access to computer or internet) to schedule virtual appointments for mental health treatment.					
I do not have access to childcare which impacts my ability to attend mental health appointments.					
I am hesitant to use mental health services due to my immigration status.					
I am unsure I would find a treatment provider that speaks my preferred language.					
I am unaware of telehealth services for mental health treatment.					

[6] (Walker et al., 2015; Marques et al., 2011; Brown et al., 2010)

I do not have access to Internet for telehealth services.					
In my community, people take care of their emotional problems on their own; they don't seek professional mental health services.					
I would seek help from my family and friends, before seeking help from a mental health professional.					
I wanted to handle it on my own.					
I felt ashamed of my problem(s).					
I felt ashamed of needing help for my problem(s).					
I worried about what people would think if they knew I was in treatment.					
I was afraid of being criticized by my family if I sought help.					
I was not comfortable discussing my problems with a mental health professional.					
I do not fully trust mental health professionals.					
I was scared about being put in a hospital against my will.					
I feel confident that I could find a therapist who is understanding and respectful of my ethnicity/culture. (RC)					
Seeking professional mental health services is a last resort.					
Professional mental health treatment would not be helpful for me.					
Mental health services are only effective if your therapist matches your race and/or ethnicity.					
I would be comfortable seeing a therapist who is of a different race than I am. (RC)					

Additional Barrier Questions

1. *Are there any other barriers that you feel may have prevented you from seeking treatment that have not been asked?*

_____
_____
_____
_____
_____
_____
_____

Using the above scales, please rank order (1 through 3) the top three reasons why you do not seek mental health treatment.

Appendix J

Kessler Psychological Distress Scale (K10)[7]

For the following questions, please think about how often you have experienced these feelings **during the last 30 days,** using the following scale.

"During the last 30 days…"	**1 None of the time**	**2 A little of the time**	**3 Some of the time**	**4 Most of the time**	**5 All of the time**
…about how often did you feel tired out for no good reason?					
…about how often did you feel nervous?					
…about how often did you feel so nervous that nothing could calm you down?					
…about how often did you feel hopeless?					
…about how often did you feel restless or fidgety?					
…about how often did you feel so restless you could not sit still?					
…about how often did you feel depressed?					
…about how often did you feel that everything was an effort?					
…about how often did you feel so sad that nothing could cheer you up?					
… about how often did you feel worthless?					

[7] (Kessler et al., 2002)

Appendix K

Life Events Checklist (LEC-5) Standard[6]

Listed are a number of difficult or stressful things that sometimes happen to people. For each, please indicate if: 1) it happened to you personally, 2) you witnessed it happen to someone else; 3) you learned about it happening to a close family member or close friend; 4) you are not sure if it applies to you, 5) it does not apply to you.

Event	**Happened to me**	**Witnessed it**	**Learned about it**	**Not sure**	**Does not apply**
Physical assault (for example, being attacked, hit, slapped, kicked, or beaten up)					
Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, etc.)					
Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
Other unwanted or uncomfortable sexual experience					
Combat or exposure to a war zone (in the military or as a civilian)					
Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
Life-threatening illness or injury					
Severe human suffering					
Sudden violent death (for example, homicide, suicide)					
Sudden accidental death					
Serious injury, harm, or death you caused to someone else					
Any other stressful event or experience					

[6] (Gray et al., 2004)

Appendix L

Two-Item Conjoint Screen (TICS) for Alcohol and Other Drug Problems[8]

For the following questions, answer yes or no.

1. Have you ever drunk or used drugs more than you meant to?
   - ☐ Yes
   - ☐ No

2. Have you felt you wanted or needed to cut down on your drinking or drug use?
   - ☐ Yes
   - ☐ No

[8] (Brown et al., 2001)

Appendix M


UTEP PSYCHOLOGY DEPARTMENT
PARTICIPATE IN A RESEARCH INTERVIEW!
Earn a $30 gift card!
Eligible participants can exchange the gift card for cash
Details
Interview takes 45 minutes - 1 hour
Interview can be held via Zoom, telephone, or in person
Eligibility
Participants must identify as a woman.
Participants must be 18 years or older.
Participants must have been involved with the criminal justice system in the past 12 months.
(For example: arrested, convicted, paroled.)
Participants must have mental health problems or concerns.
(For example: depression, PTSD, anger management, mood problems.)
Contact us!
Call us at
(915) - 247-6344
Or email us at
rradair@miners.utep.edu
Approved on: January 26, 2023
Expires on: July 28, 2023
Study Number: [1919900-5]

Appendix N

UTEP DEPARTAMENTO DE PSICOLOGIA

PARTICIPA EN UNA ENTREVISTA DE INVESTIGACION!

Gana una tarjeta de regalo de $30!

Algunos participantes pueden ser elegibles para recibir efectivo

Detalles

- La entrevista durara 45 minutos a 1 hora
- La entrevista puede realizarse a través de Zoom, telefono, o en persona

Elegibilidad

- Las participantes deben identificarse como mujeres.
- Las participantes deben ser mayores de 18 años.
- Las participantes deben haber tenido involucramiento con el sistema de justicia penal reciente en los ultimos 12 meses
  - (Por ejemplo: arrestada, convicta, libertad condicional.)
- Las participantes deben tener problemas o preocupaciones de salud mental
  - (Por ejemplo, depresion, trastorno de estrés postraumático, problemas [illegible].)

Contactanos!

Llama al
(915) - 247-5931
O mandanos un correo a
rradair@miners.utep.edu

Approved on: January 26, 2023
Expires on: July 28, 2023
Study Number: [1919900-5]

Appendix O


UTEP PSYCHOLOGY DEPARTMENT
PARTICIPATE IN A RESEARCH INTERVIEW!
Earn a $50 gift card!
Eligible participants can exchange the gift card for cash
Details
Interview takes 45 minutes - 1 hour
Interview can be held via Zoom, telephone, or in person
Eligibility
Participants must identify as a woman.
Participants must be 18 years or older.
Participants must have been involved with the criminal justice system in the past 12 months.
(For example: arrested, convicted, paroled.)
Contact us!
Call us at
(915) - 247-6344
Or email us at
rradair@miners.utep.edu
Approved on: December 1, 2023
Expires on: July 12, 2024
Study Number: [1919900-12]

Appendix P

UTEP DEPARTAMENTO DE PSICOLOGIA

PARTICIPA EN UNA ENTREVISTA DE INVESTIGACION!

Gana una tarjeta de regalo de $50!

Algunos participantes pueden ser elegibles para recibir efectivo

Detalles

- La entrevista durara 45 minutos a 1 hora
- La entrevista puede realizarse a través de Zoom, telefono, o en persona

Elegibilidad

- Las participantes deben identificarse como mujeres.
- Las participantes deben ser mayores de 18 años.
- Las participantes deben haber tenido involucramiento con el sistema de justicia penal reciente en los ultimos 12 meses
  - (Por ejemplo: arrestada, convicta, libertad condicional.)

Contactanos!

Llama al
(915) - 247-5931
O mandanos un correo a
rradair@miners.utep.edu

Approved on: December 1, 2023
Expires on: July 12, 2024
Study Number: [1919900-12]

Vita

Rebekah Adair-Russell is a doctoral candidate at The University of Texas at El Paso pursuing her Ph.D. in Psychology with a concentration in the legal area. She received her bachelor's degree in psychology from Georgia Southwestern State University in 2014. She received her master's degree in psychology from University of West Georgia in 2016, where her thesis research focused on examining empathy and public perceptions of justice-involved people. Her research interests led her to work with Dr. Jennifer Eno Louden in the Mental Health and Criminal Justice Lab, where she began to concentrate her work on women in the justice system and the unique experiences they face. She has published research on her work in *Psychology, Crime, and Law*, with additional future manuscripts under review. During her time as a doctoral student, Rebekah served as a student reviewer for *Law and Human Behavior*, was an elected student committee member for American Psychology and Law Society, and appointed the Legal Area Student Representative at The University of Texas at El Paso. She hopes to continue her work contributing to research that addresses the needs of women in the criminal justice system.