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Access to Mental Health Services Following a Use-of-Force Encounter With Police

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Walden University
2024

Abstract

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MPA, Saint Louis University, 2012

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Dissertation Submitted in Partial Fulfillment

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Abstract

African American males are more likely to be involved in a use-of-force encounter with police yet less likely than their non-Black counterparts to seek mental health services afterwards. Little is known about the perceptions this population has about the ease/difficulty they encounter when attempting to access care following the event. The purpose of this qualitative study was to examine the perceptions of 11 African American males in north Saint Louis County, Missouri, about the facilitators of and/or barriers to accessing mental health care services after experiencing a use-of-force encounter with police. Participants were chosen using a purposeful sampling strategy. Data for the study were collected using a semistructured interview protocol. Benet's polarities of democracy theory was used as the theoretical framework to examine and analyze the participant responses. Study findings strongly suggested that legislators in Missouri have opportunities to effect positive social change in the lives of their citizens through policy changes that include but are not limited to: expanding the state Medicaid program to provide coverage for more citizens, allocating additional funds to build mental health care facilities within underserved communities, and to pay for staff to run those facilities. Additional policy changes could provide for: an increase in access to reliable, public transportation, creation of civilian oversight review boards, and the creation/ dissemination of public health information programs. By implementing or revising current public policy programs in Missouri, legislators could help alleviate the oppression African American males in Saint Louis County are currently experiencing and create positive social change.

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Dedication

I dedicate this work to my creator who saw fit to make me in His own image, my parents, who gave me life, specifically to my Mother, who has been with me during every single phase of this life, my children, Justin, Sandi, and Karisma, my siblings, and to all the others who stood by me and rooted for me during this journey. There is no way I could have done this without all of you. And last but certainly not least, to my husband, John, who held my hand, wiped my tears away, encouraged me when I felt like I was failing, and supported me on every leaning side, you are my rock.

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Chapter 1: Introduction to the Study

Introduction

Throughout the recorded history of the United States, African Americans have been the victims of use-of-force encounters with law enforcement. The encounters that make the mainstream news are typically those where the victim has died. There are thousands of these encounters that happen across this country each year where the victim does not die but they suffer harm (Sheats et al., 2018) Young African American men are two and one-half times more likely to be the victim of a use-of-force encounter than their White counterparts (Planey et al., 2019). According to McLeod et al., (2019), African Americans seek mental health services at a significantly lower rate than other demographics. The higher rate of use-of-force encounters coupled with the lower rate of mental health seeking activities leaves a large segment of the population at risk for post traumatic disorders and behaviors.

There is an intersection that occurs for victims of these encounters where although they may recover from any physical injuries, the resulting mental trauma often goes undiagnosed and untreated. Despite being more likely to be involved in a use-of-force encounter, African American males are less likely to seek/receive mental health assistance after said encounter (Bohanon, 2020). If African American men are more likely to be the victim of a use-of-force event while simultaneously being less likely to seek/gain access to professional mental health services, there could potentially be a large segment of this already disenfranchised group who is unable fully function within or contribute to the community in which they live.

It was important to conduct this study because an opportunity could emerge to understand the perceptions of African American males as to why they did not access mental health services after the use-of-force encounter with police. Understanding their perceptions could help public policy makers identify and revise current programs and policies that do not facilitate and/or or pose as barriers to access to professional mental health care services. It is important that all members of a community work together for the benefit of the whole organization (Shafritz et al., 2016). If a community member is infirmed in their mind, their contribution could be limited, thereby negatively impacting the effectiveness of the overall system.

In this chapter, I provided background data relative to the number of use-of-force encounters African American men have been the victims of in the last 50 years. The data are intersected with empirical literature that highlights the disparities between persons of color who do not seek and/or do not receive mental health services with those who do. After the background, I introduce the research problem this study examined. Although there are empirical data on African American males and police officer use of force, there is a lack of literature that has explored the perceptions of African American males ages 18 – 45 from north Saint Louis County, Missouri, concerning the facilitators of and/or barriers to obtaining mental health services following that encounter. I then discuss the research question designed to address the problem and the conceptual and theoretical frameworks that provided the blueprint for the inquiry and the lens through which the problem was explored.

Following the discussion of the frameworks, I provide definitions for terms that have been operationalized to enhance the concepts discussed. Chapter 1 proceeds with a discussion of my philosophical assumptions, the scope, delimitations, and the limitations of this inquiry. Chapter 1 concludes with a discourse on the significance of this study and its potential to contribute to transformational social change.

Background

African American males are disproportionately impacted by police violence as they are two and one-half times more likely to be the victim of police brutality than their White peers (Planey et al., 2019). Researchers have suggested that African American men are more likely to be the victim of use-of-force acts because law enforcement officers have been trained to view them as inherently evil and overly aggressive (DeVylder et al., 2020). Officers may see African American men as a threat to the general population and take whatever "preventative steps" they deem necessary to control and/or eliminate that threat. This mindset is supported and perpetuated by racist media influences, a long-standing culture of structured racism (Alang et al., 2017), and politically charged rhetoric.

There are data to suggest that African American males have suffered greatly because of programs like stop and frisk, three strikes law, and unfair discretionary sentencing policies (Adedoyin et al., 2019; Hutto et al., 2016). These public policies were intended to address rampant crime in inner cities, but an unintended consequence was the "over policing" of impoverished Black and Brown communities (Aymer, 2016). Public policies like these increase the likelihood of a police encounter and a subsequent use-of-

force violation for African American men. These frequent encounters could lead to several negative mental health outcomes for this population like social retardation, mental health trauma, and declines in care utilization (Williams et al., 2019).

Studies have shown that African American males are more disproportionately exposed to harassment and violence than other races and as a result are subjected to greater mental and physical risk (Sheats et al., 2018). African Americans make up only 13.4% of the United States population (U.S. Census, 2019), but in the decade from 2010 to 2020, they made up more than 16% of the number of individuals who identify as suffering from a mental illness (Eproson, 2021). Studies have been done that have addressed the effect fatal encounters with police have on family and community members, but specific data regarding the impact of nonlethal encounters on the mental health of survivors are not readily available.

According to the American Psychiatric Association (APA; 2017) only about 1/3 of African Americans who need mental health treatment receive it. Failure to receive treatment can result in the person suffering long term negative effects of depression, thoughts of suicide, and posttraumatic stress disorder (Avent Harris et al., 2019). The negative impacts are not limited to mental well-being but could affect physical health as well. According to Watson-Singleton et al. (2018), persistent depression, stress, worry, and thoughts of suicide could lead to heart disease, high blood pressure, increased risk of heart attack, and hypertension.

My research was specifically focused on exploring the perceptions of African American men who are at the intersection of being a victim of use-of-force encounter and

not receiving professional mental health services. Exploring the perceptions of African American men, ages 18 - 45, who reside in north Saint Louis County, Missouri, may provide some insight for public administrators in Missouri on how best to develop/revise mental health programs/policies. Examining their perceptions through the lens of polarities of democracy could be the catalyst for shift in policy development and implementation.

The specific gap in the literature this study addressed was the perceptions of African American males who have experienced a use-of-force encounter with police with regards to the facilitators of and/or barriers to accessing mental health services through the lens of the polarities of democracy theory. The participants for this study resided in the greater Saint Louis County, Missouri municipalities. It was important to conduct this study because the results could inform public policy makers in Missouri regarding any facilitators of and/or barriers to access to current mental health programs. Armed with this knowledge, public policy makers could begin to identify opportunities to change, sunset, or create new programs based upon end user utilization.

Problem Statement

The problem this study addressed was although African American males are 2 1/2 times more likely to be the victim of a use-of-force encounter with police than their white counterparts (Planey et al., 2019), they are less likely to seek professional mental health services for the resulting trauma (Bohannon, 2017; Campbell & Winchester, 2020). This study examined the perception African American males, ages 18 to 45, who reside in north Saint Louis County, Missouri, regarding the facilitators of and/or barriers to access

to mental health care services after a use-of-force encounter with police. There are some data that suggest failure to treat the trauma in adolescents could lead to long term, negative mental health outcomes like social retardation, aggressive physical outburst, and depression (Graham et al., 2020; Staggers-Hakim, 2016). However, there were no data available regarding the intersection of use-of-force police encounters and mental trauma for adult African American males in north Saint Louis County, Missouri. Secondarily, no studies have been conducted regarding the perceptions of African American males in this geographic area examined through the lens of polarities of democracy.

There are current efforts underway to address the continued use-of-force violations, including the introduction of new legislation by members of Congress (from Clay, Harris, and Pelosi), revising new police officer training manuals (Saint Louis County and Municipal Police Academy Manual, 2024, p. 4-11), and submitting legal challenges to the doctrine of qualified immunity (Nemeth, 2019). However, these efforts are geared towards stemming the rate of use-of-force encounters and do not address the possible resulting mental health trauma.

Despite federal, regional, and local efforts to retrain officers and abate the use-of-force encounters, African American males continue to be physically assaulted/killed by police officers at an alarming rate (Tate et al., 2020). Even if these efforts were successful, use-of-force encounters represent only one of the possible reasons African American males would need to access professional mental health services. Mental health trauma can be caused by a myriad of factors, not just physical assault. Regardless of the actual precipitating event, the resulting trauma and need for mental health care are the

typical outcomes (DeVylder et al., 2020; Graham et at., 2020). There are also efforts underway to expand access to mental health services for low-income families that reside in about one-half of the counties in the state of Missouri. Additionally, according to Bohanon (2020), there is an industry-wide push to offer professional mental health services through tele-medicine and telehealth. This effort may increase mental health care use if transportation were the limiting factor, but it does not address other possible barriers to access like racism, lack of education, or limited family support.

Purpose Statement

The purpose of this study was to explore how African American males, ages 18 – 45, from north Saint Louis County, Missouri, who have experienced use of force at the hands of police, perceive the facilitators of and/or barriers to obtaining mental health services following the encounter. The intent of this study was to explore how these men perceive the challenges to and/or ease with which they were able to access mental health care services after the use-of-force experience.

Combining aspects of a narrative research paradigm with elements of a phenomenology approach, this general qualitative research design allowed this population to share their lived experiences using rich, thick, descriptions to convey what they went through and how the experience affected them (see Ravitch & Carl, 2016). From a public policy perspective, the themes that emerged from these stories could inform policy makers in Missouri about what is working and/or what is missing in current public health care programs at the local, county, and state level.

Research Question

What are the perceptions of African American males in north Saint Louis County, Missouri, about the facilitators of and/or barriers to accessing mental health care services after experiencing a use-of-force encounter with police?

Conceptual and Theoretical Framework

The theoretical framework I used for the study was polarities of democracy (see Benet, 2006, 2013, 2022). This theory has five polarity pairs or 10 poles that are in a constant state of tension. Benet (2022) labeled those polarity poles as freedom and authority, justice and due process, diversity and equality, human rights and communal obligations, and participation and representation. The foundation of this theory is that for effective social change to be achieved and maintained to any degree, society must work together to manage the tension between the polarity perspectives.

When the tension is managed effectively, the positive aspects of the paired polarities can be maximized while the negative aspects of paired polarities are minimized. Tension between those who champion traditional values and those who advocate for reform is not uncommon, but society works best when everyone's needs are considered and all members are contributing to the end goals (Shafritz et al., 2016). Sufficing strategies can be employed that involve both/and thinking rather than seeking solutions that use either/or thinking. There need not be a group of winners and losers, but compromises must be made in order to achieve a democratic society that benefit all of its members.

I used the polarities of democracy theory to frame this study with a focus on the specific human rights and communal obligations polarity pair to address the research question. From a public policy standpoint, if access to mental health care is unavailable, severely limited, or cost prohibitive because of current policies, a pathway did emerge from this study that addressed those possible barriers.

I used Johnson's (1992) polarity management theory as the conceptual framework for this study. In this theory, Johnson stated that polarities occur when problems surface that are unsolvable. The problems are unsolvable because they are ongoing and because each side of the issue has both negative and positive aspects. These types of problems are best suited for polarity management where "both and thinking" is required not "either/or" thinking. Approaching the problem from a both/and perspective leads to maximizing the positives of both poles while minimizing the negative aspects of both poles. Successfully leveraging the poles to achieve the best of both perspectives is the aim of polarity management (Johnson, 1992). A more thorough explanation of the connections between the framework and the key elements of the study is provided in Chapter 2.

Nature of the Study

This qualitative inquiry used a generic design (see Kostere & Kostere, 2021). The iterative process of collecting data, analyzing the data, and drawing conclusions as themes emerged guided the direction of the study from inception to conclusion. The participants were selected using Patton's (2015) snowball purposeful sampling model. The population sampled was African American males between the ages of 18 and 45 from the underserved, minority communities in north Saint Louis County, Missouri. The

participants were recruited by placing an announcement of the study on the public bulletin boards in the community centers, barber shops, and convenience stores in the local area. The study was also announced on social media pages, which were started by members of the targeted municipalities not the official government pages. Participants were also recruited by word of mouth via individuals previously identified during prior coursework who met the study criteria.

Participants were chosen from this geographical area because anecdotal evidence has surfaced since the riots in Ferguson, Missouri, indicating a high probability of locating participants who have been the victim of use of force at the hands of police or know someone who has. The perception that this group had about the facilitators of and/or barriers to access to mental health care services after the encounter was the concept being investigated in this study. The sample size of the participant population pool was expected to be between 10 to 20 participants. This number was flexible, and it did change when saturation was met during the interview phase and no new themes came forth (see Hagaman & Wutich, 2017).

Individual interviews were conducted in person, via Zoom, WebEx, Microsoft Teams, or telephone, to gather the data for this study. Interview questions were semistructured using an interview guide that I developed based upon guidance provided by the dissertation committee members and by Rubin and Rubin (2012). Interviews were audio recorded, and I took notes during the interview sessions. After the interviews were completed, I transcribed the audio recordings first manually and then by using a commercial transcription software. Following transcription of the interview sessions, and

a thorough review of my notes, the statements from the interviews were coded into categories and themes emerged.

Definitions

Communal obligation: A responsibility arising out of an agreement or a treaty.

Excessive use of force: An act committed by law enforcement that goes beyond. physical force. It could include emotional and sexual violence as well as verbal assault and psychological intimidation (Alang et al., 2017).

Human right: A right that is believed to belong justifiably to every person.

Racial trauma: Psychological injury caused by the experience of a racially-motivated incident that overwhelms the individual's amplitude to cope that either results in physical harm or threatens the persons integrity (Bryant-Davis, 2007).

Racist policies: A system of structural racism that operates to sustain White supremacy (Alang et al., 2017).

Use of force: Level of force that is reasonable for the current situation or circumstance that de-escalates a conflict, ensures the safety of the officer, and brings the incident under control (St. Louis County Police Training Manual, 2017).

White supremacy: An institutionally perpetuated and ever-evolving system of exploitation and domination that consolidates and maintains power and resources among White people. This system promotes the ideology of Whiteness as a standard and the belief that White people are superior to other races (Center for the Study of Social Policy, 2019).

Assumptions

A qualitative study of this nature must consider the personal ontological, epistemological, axiological, and methodological assumptions of the researcher (see Creswell, 2013). Assumptions are positions the researcher accepts as true, without proof, during the research process. There are several assumptions that I made during this study. First, I assumed that a participant pool size of 20 would be significant enough to produce sufficient, objective results driven data. Second, I assumed that the participants selected for the study would be honest about meeting the study criteria. Third, I assumed that the participants would offer truthful responses to interview questions about their lived experiences with use-of-force violations and seeking mental health care.

Ontological Assumptions

From the ontological perspective, the assumptions I made revolved around the sustainability of the current democratic governance structure in the United States. While it is true that the United States is a republic, the people govern and are governed as a democracy. The people agree to hand over control to the government in exchange for certain protections and programs. The citizens trust the government to take care of their needs, and the government trusts the citizens to behave in a manner congruent with the laws it passes. This relationship has existed since the inception of sovereignty; however, the more the United States evolves, the less sustainable this agreement becomes.

As the United States evolves, there are some groups who choose to embrace change and other groups who fight to keep things the same. One way to manage the natural tension that arises between these positions is to adopt the “both/and” approach to

dilemma management that Johnson (1992) talked about. If citizens begin to consider what works best for all and institutes plans and programs from that perspective, public policy makers may be able to avoid creating the "us vs. them" atmosphere. Examining the thought process via honest and open debate could lead to a shift in focus. Compromises will need to be made, but affecting the greatest good should be the starting point of the conversation, not who wins or loses.

Individual needs, as Maslow (1943) defined them, are met through forms of social interactions, spiritual connections, and like-mindedness. However, failure to consider how actions impact others in the community and subsequent failure to adjust perspectives and actions could lead to a collapse of the democracy. I assumed it would be possible to stave off this collapse by examining the relationship between the government and the people and attempting to leverage the best outcomes from both perspectives. Leveraging the tensions between those who advocate for the promise of democracy and those who champion for the status quo can lead to maximizing the positive aspects for both. It is the effective management of this tension, through the lens of the 10 values identified by Benet (2006, 2012), that could help U.S. citizens overcome oppression and achieve democracy.

Epistemological Assumptions

The first assumption I made was that the perception is the reality. How people view, internalize, and make sense of their surroundings create the reality in which they live. The participants in this study were asked to tell their own individual stories about their encounters with police and their experiences with access to health care. Their

perceptions regarding the barriers to and facilitators of access to healthcare form their interpretative reality. Their perceptions are neither right nor wrong; they are simply how they see the world and understand their place in it. In a civilized society, the social construct works best when each person performs the role they are expected to. Survival depends upon how well people play their individual parts (Benet, 2006).

The second epistemological assumption is rooted in the credibility and transferability of the responses the participants provided to the interview questions asked. I assumed that the participants would honestly share their lived experiences about how easy or difficult it was for them to obtain/access mental health care after a use-of-force encounter with police. If the participants are honest about their experiences and if the voice of the researcher remains in the background, the themes that emerge from the analysis of the interview responses should be justifiable, trustworthy, and credible (Lincoln & Guba, 1985).

Axiological Assumptions

The axiological assumption of this study was undergirded by the community's understanding of its obligation to do what is right for its citizens. If healthcare is a human right as Ford (2020) and the framers of the Universal Declaration of Human Rights (1948) posited, then perhaps the community is obligated to provide it, and not just for some of the residents, but for all, regardless of race, gender, ethnicity, education, or socioeconomic standing. In addition to being considered the ethics of a study, axiology also examines the aesthetics of research combining what is considered right and good with the ideas of symmetry and beauty (Hartman, 2011). Achieving democracy, which is

the ultimate end goal of the 10 values Benet (2022) discussed in his theory, may require governing bodies to change their current decision-making approach to include what is right and just for those it governs, not just what is expedient or least expensive. For the purposes of this inquiry, I assumed that Johnson's (1992)'s theory of leveraging the tension between the polarities would overcome oppression for the population segment I had chosen as participants.

Methodological Assumptions

Methodological assumptions made in this study were based upon the narratives the participants shared. A generic qualitative study design offered the best approach to explore the lived experiences of the participants (see Ravitch & Carl, 2016). Their stories, in their own words about what they went through when attempting to access mental health services, provided the best lens to analyze the data through. I assumed my role as the research instrument was to allow the participant's voices to be heard and not to interject my voice into the narrative (see Shenton, 2004).

How the participants feel about their experiences and what they chose to share about those experiences is what this study captured. The themes that emerged from the analysis of their interviews could inform policy makers in Missouri how best to improve mental healthcare accessibility. Benet's (2006) polarities of democracy theory, specifically the polarity pair of human rights and communal obligations, could serve as a guidepost for new policy development and implementation.

Scope and Delimitations

The scope of this study was narrowed to a population who met very specific criteria. Only African American males who resided in the geographical area of north Saint Louis County, Missouri, between the ages of 18 and 45, and who had been the victims of a use-of -force incident were included in this study. The rationale for limiting the population to these individuals was because it is their perception of their experiences that addressed the research question, filling a gap in the current literature. While I expected the participants to provide truthful responses to the interview questions, their responses were based upon their personal perception of their constructed reality within their own geographic area.

Nonetheless, the participant's thick, rich, descriptions of their experiences, as defined by Ravitch and Carl (2016), could lead to emerging themes about possible barriers and/or potential facilitators to obtaining/accessing mental health care services. These themes have the potential to inform the decision-making process of Missouri legislators and public policy makers. It is important for policy makers to expand their vantage point to include not only policy intentions but policy outcomes as well.

Despite the small sample size and geographic delimiters, this study has the potential to inform the public policy makers in state, county, and municipal governments due to the potential transferability of the findings. According to the U.S. Census Bureau, in 2017, African American males made up roughly 48% of the African American population at 21 million. Considering the racial undertones that exist in police departments across the United States, there is a possibility that the population targeted in

this study could be found in other states. In that case, the results from this study may have some transferable outcomes for other inquiries involving similarly situated individuals.

Limitations

A fundamental basis of this qualitative research study was the use of a generic approach. The very nature of a qualitive study was limited because analysis of the data represents the perceptions of a specific target population in a particular geographical area. Any recommendations were limited because the findings were not generalizable to other populations or circumstances.

An additional limitation of this study was possible researcher bias. Being of the same ethnicity as the target population, I am aware that confirmation bias may be present at both the data gathering and analysis stages. Thus, I used reflexive journaling and dialogic engagement to control bias (see Ravitch & Carl, 2016). Providing the participants with a copy of their responses and my subsequent analysis also ensured their stories were being represented in an authentic manner (see Lincoln & Guba, 1985), further limiting the potential for my personal biases to shade the results and recommendations.

Significance

Analyzing the thematic data that emerged from the interview responses provided insight into how the participants perceived the barriers to and/or facilitators of access to mental health care services. This study gave the self-described victim a platform to tell their story first-hand, and it invited the readers to formulate their own opinions (see Ravitch & Carl, 2016) of what the participant said. This opinion could inform public

policy makers in state, county, and local governments of the effectiveness of current mental health programs and policies. Regardless of the intent of such offerings, if they do not produce the desired results, they may not be considered successful. The Missouri State legislature spends hundreds of millions of dollars per year on public health programs (State of Missouri, Office of Administration, 2022 Budget Summary, p. 5). If the program offerings are not producing the desired effects for the intended audience/participants, revising, or restructuring them may be in order. Identifying waste in resources, capital, or human could help governments streamline programs and perhaps free up money for additional services.

Mentally healthy citizens contribute to the overall success of society in its organizational context where individual roles and associations come together to support overarching activities and outcomes (Shafritz et al., 2016). The findings of this study could lead to positive social change by allowing young African American males impacted by a use-of-force incident to receive the mental health services they need rather than allowing the trauma to go undiagnosed and/or treated. Healthcare, mental and physical, should be seen as a human right (Benet, 2006).

Outcomes of this study could show that citizens governed by organized groups of policy makers, administrators, government leaders, and other authorities may be entitled to equitable access to health care regardless of their circumstance. Those who govern should work to provide citizens with basic human rights, not only because they have an obligation to do so but because ethically it is the right thing to do (Kagan, 2018). Democratic forms of governance work best by acknowledging the needs of the people

and then taking steps to address those needs. This study could lead administrators to pay closer attention to the disparities in mental health care access when developing new policies (Alang et al., 2017).

Summary

The purpose of this research was to highlight the possible barriers to and/or facilitators of mental health care access from the perspective of Africa American males who have been the victims of use-of-force acts. African American males are 2 ½ times more likely to be the victims of assault at the hand of police officers (Planey et al., 2019). As a result, this segment of the population is more likely to suffer from undiagnosed and untreated mental health infirmities. It is important for policy makers in Missouri to understand what the barriers to and facilitators of access to mental health care are as African American males perceive them. Failure to consider their vantage point could lead to a host of unintended consequences if new programs and policies are rolled out that do not address the issue. This could lead to further marginalization of African American men.

Organizations work best when their members are contributing to the overall success and defined objectives of the system (Shafritz et al., 2016). Local neighborhoods are the foundation upon which larger communities and societies are built. It is important for those who govern to provide for the human rights of all citizens, and human rights should be equitable access to health care (Ford, 2020). Using Benet's (2006) polarities of democracy theory as the lens to view, learn, and analyze the perspectives of those

impacted by the lack of equity of access, I provide policy makers with the information they needed to address the issue.

In Chapter 2, I provide an extensive review of the germane literature as it relates to the intersection of the barriers to and facilitators of access to mental health care and use-of-force encounters when viewed through the lens of the polarities of democracy model. Through the literature review, I find support for the need to complete this research inquiry.

Chapter 2: Literature Review

Introduction

African American males are 2 ½ times more likely to experience a use-of-force encounter at the hands of police than their White counterparts (Planey et al., 2019). Despite being more likely to have this experience, African American males are less likely to access mental health services to address the resulting emotional trauma (Bohannon, 2017). Throughout the history of the United States, African Americans have faced barriers when it comes to accessing mental health care services. These barriers include but are not limited to racist medical policies, a long-standing caste system, and socioeconomic inequities (Planey et al., 2019; Taylor & Kuo, 2019; Watson, 2014). There are some facilitators to access education and strong support networks (Lindsey et al., 2013), but there are far more barriers. The purpose of this study was to explore the perceptions African American males have regarding the facilitators of and/or barriers to access to mental health care. Exploring their perceptions could provide information to policy makers in Missouri about the effectiveness of current mental health programs.

Public administrators, policy makers, advocacy groups, and some churches have begun to work collaboratively to ameliorate the barriers and enhance the facilitators to access, but more work needs to be done (Brand, 2019; Campbell & Littlejohn, 2018). It should be the priority of any governing body to provide for the needs of those being governed (O'Sullivan et al., 2017). This applies to all citizens, not just those in the upper 1%. In a democratic society, just and fair treatment,including equitable access, should be the standard, not the exception (Brand, 2019; O'Sullivan, 2017).

Some practitioners and politicians may disagree that healthcare is a human right. However, other researchers, such as Ford (2020) and Alang et al. (2017), asserted that health care is a fundamental right and should be available and accessible to all who need it, regardless of race, gender, ethnicity, religion, or socioeconomic status. Healthcare in the United States is an important ingredient to the recipe in that democratic system. The Bill of Rights states in part that each citizen has the right to life, liberty, and the pursuit of happiness. Maintaining a healthy mind, body, and spirit are key elements to having a good life. From this perspective, one could argue that the democratic form of governance has an obligation to provide an undergirding network that supports these rights. Somewhere in the governing system, some individuals and groups have recognized this obligation, as evidenced by government sponsored programs such as Medicare, Medicaid, and the Affordable Health Care Plan.

In this chapter, I provide background on why access to health care poses a problem for members of underserved communities. The United States has a long and sordid history of denying rights to its nonmajority citizens. Historical accounts from as early as the 1600s have detailed how African Americans were denied the right to vote, the right to property ownership, the right to gainful employment, and the right to proper healthcare as a pattern of normalcy (Alexander, 2020). These rights are unalienable to citizens of the United States; however, those in charge made it a practice to deny access to these rights for anyone they saw fit long after the economic institution of slavery ended (DeGruy, 2017). This legacy of disparity continues today as segments of the governance

structure in America still treats those of African descent poorly regularly violating their constitutional rights (Alexander, 2020).

Also included in this chapter are the terms used during the salient literature search, the conceptual and theoretical frameworks, and a comprehensive review of the literature found to be relevant to my search terms. In this section, I review, analyze, and connect the work other researchers have conducted that speak to the lived experiences of the target group. The problem this study explored highlights the probable facilitators of and possible barriers to access to mental health care young African American males encounter after a use-of-force encounter with police officers. Studies have shown that African American males are disproportionately impacted by use-of-force encounters (Adedoyin et al., 2019; Alang et al., (2017)). They are 2 1/2 times more likely to be the victim of these encounters than their White counter parts, yet in most cases have less/limited access to mental health care options/treatments (Planey et al., 2019).

Literature Search Strategy

I completed an extensive review of the literature using academic databases, including Political Science Complete, Thoreau Advanced, ProQuest Central, PsycARTICLES, and Criminal Justice, to locate and review relevant, peer-reviewed articles. Additionally, I reviewed excerpts from books authored by some of the leading academics in the field of racism, racial trauma, racial histories, and the American political landscape. I also searched for additional peer reviewed articles on Google Scholar. To narrow my search and find the articles that were most salient, I used the following keywords: *barriers to and facilitators of mental health care access, African American*

males, racism in health care, racial politics, use of force, and *polarities of democracy*. Other terms related to my search strategy included *emotional trauma, help seeking attitudes, police brutality, White supremacy,* and *post-traumatic stress*.

Most of the works cited in this study were published between 2015 and 2022. However, there are some articles that fell outside this range that were included for racial context and historical perspective. The seminal works that provided the conceptual and theoretical frameworks are also well beyond the 5-year period but were necessary to provide the foundation and lens for this inquiry.

Theoretical Foundation

This study explored the perceptions that African American males have about the barriers to and/or facilitators of access to mental health care after a use-of-force event. Their experiences were examined through the lens of Benet's (2006) polarities of democracy theory. This theory provided the theoretical framework upon which the study was conducted, results were analyzed, and suggestions for new policies were developed. Johnson's (1992) polarity management theory served as the conceptual framework for this study. The conceptual framework is discussed first because Benet's polarities of democracy theory used Johnson's polarity management theory as its conceptual framework. To grasp Benet's polarities of democracy theory, an explanation of Johnson's theory is provided.

Conceptual Framework: Johnson's Polarity Management Theory

Johnson (1992) stated that polarities represent conflicting positions that cannot be resolved. The problems are unsolvable partly because they are on-going and partly

because the opposing sides are interdependent. He likened the polarities to the idea of breathing. Exhaling breath from the body has benefits and so does inhaling. However, the two positions must work together to produce the desired result. Johnson posited that these interdependent poles, when working together, bring about the best outcome for both poles. The product of effective pole management is not the result of either/or thinking but emerges when both poles are given due consideration in the equation through both/and thinking. Johnson's model recognizes that both solvable and unsolvable problems exist in the workplace and in society. Solvable problems use either/or thinking while unsolvable problems require a both/and approach. He presented the idea of polarity management in the form of a four-quadrant matrix where the upper quadrants represent the positive aspects of the polarity, and the lower quadrants symbolize where the negative aspects can be found.

Johnson (1992) spoke of tradition bearers and crusaders that make up the populations of the four-quadrant model. Tradition bearers are those who recognize and fight for the benefits of those at the top of the pole, the people in power. This group works to keep focus on the current status of the pole and does not want things to change for fear of losing power, influence, and resources for current group members. While the terms "tradition bearers" and "crusaders" are no longer being used by Johnson, the power/privileged position versus those who are being oppressed remain relevant. Those who hold the power and the privilege tend to have an either/or way of approaching crisis management. According to Benet (2012), those with power and privilege tend to believe that for another group to gain something, they will have to lose something. In addition,

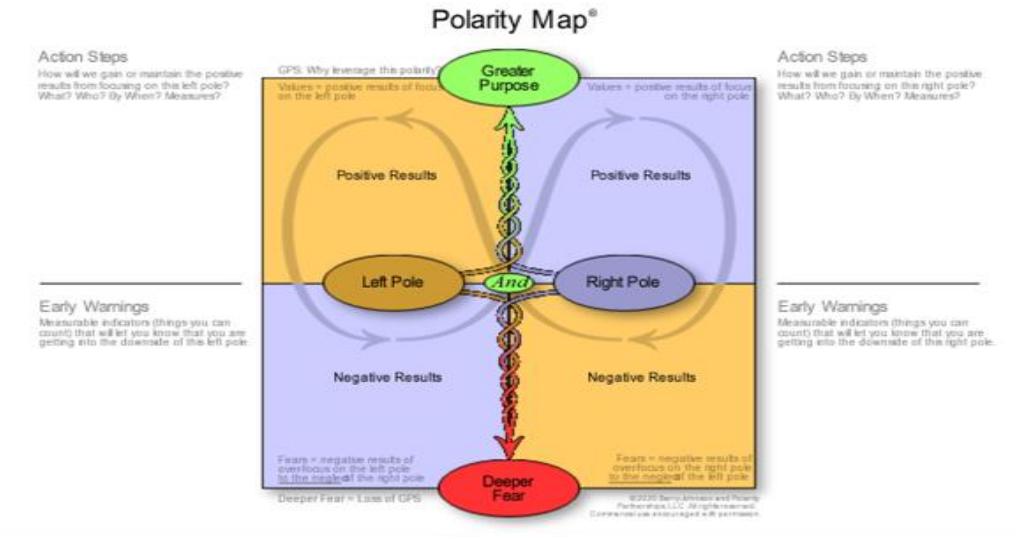
while this may be true, it does not mean that they will lose all their power and position but rather they will have to learn to share it. Until those in power adopt a power with ideology, effective tension management will remain out of reach.

Those who advocate for change tend to focus on the benefits those in power have and believe they should have those benefits as well. The latter group feels they are being ignored and rally efforts to close the benefit gap between what those in power have and what they do not have. The key to bringing these groups together is appealing to a sense of cooperation (Johnson, 1992). This requires a conscious move from either/or thinking to both/and thinking. Johnson (1992) presented the idea of polarity management in the form of a four-quadrant matrix where the upper quadrants represent the positive aspects of the polarity, and the lower quadrants represent the negative aspects.

Figure 1 represents a generic polarity map of Johnson's (1992) overall polarity concept and infinity loop. The upper left quadrant reflects the positive aspects of the left pole, and the upper right represents the positive aspects of the right pole. The lower left quadrant depicts the possible negative aspects of the left pole, and the lower right quadrant portrays the negative aspects of the right pole. The upper quadrants are where action steps can be taken to achieve higher purpose, and the lower quadrants show the early warning signs that personify people's deepest fears. Benet (2006) posited that democracy can be achieved and oppression overcome when society works to properly leverage the tension between the poles. When the tension is not properly leveraged, societal outcomes move through an infinity loop where the benefits are not being maximized and the adverse impacts are not being minimized.

Figure 1

Generic Polarity Map



Note. Image reproduced with permission of Polarity Partnerships LLC and the Polarities of Democracy Institute.

Theoretical Framework: Benet's Polarities of Democracy

Polarity management focuses on how problems are managed and how solutions are developed. Building upon the idea of polarity management, Benet (2006) constructed a 10 pole, five polarity-pair model, that when managed properly can lead to overcoming oppression by establishing democracy. Benet posited that democracy is foundational to achieving equitable, sustainable, and just communities.

The goal of the polarities of democracy model is not to balance the poles but to manage the tension between the poles so that positive aspects are maximized for all while negative aspects are minimized. Effective management of the tension between the polarity pairs looks like an infinity loop where the majority of the effort is extended in the

upper quadrants where maximum benefits are gained. Ineffective pole management also looks like an infinity loop, but in this case most of the effort is spent focusing on the negative outcomes of the two lower quadrants. Power, influence, effort, and attention move repeatedly between all four quadrants in both effective and ineffective management styles (Johnson, 1992).

In his theory, Benet (2006) identified 10 values that make up the poles of the five polarity pairs that, when leveraged effectively, can lead to communities overcoming oppression. The polarity pairs were developed from Benet's study of five broad arenas of literature covering organizational development theory, occupational health and safety, workplace democracy, democratic theory, and economics. He tested his theory using democracy models developed by Blake and Mouton (1985), Butts (1988), Ellerman (1990), and Karasek and Theorell (1990). Benet's polarities of democracy theory with its five pair polarity structure posits that oppression, the greatest fear, can be overcome when all parties work together to achieve human agency, the highest purpose. Under this theory, there are no winners and losers but benefit for all as compromises are reached. The polarities Benet has identified as necessary to overcoming oppression are; freedom and authority, justice and due process, diversity and equality, human rights and communal obligations, and participation and representation. The polarities that form the foundation of the theory are listed in Figure 2 below.

Figure 2

The Polarities of Democracy Theory as an Either/or Solution to Oppression

Note. Image reproduced with permission of the Polarities of Democracy Institute.

Each polarity pair represents a unique value of society that consists of both positive and potentially negative aspects in all four quadrants. Those in the power position fight to maintain the positive aspects of their pole, not seeing the negatives of their position, while the oppressed/those who advocate for change focus on attaining the benefits they are currently being denied in their current position. The tension that results from this unsolvable conflict is what Johnson's (1992) work aimed to manage using both/and thinking. Polarities of democracy builds upon this premise using this both/and approach to challenge the status quo of socioeconomic, health standards, justice concerns, and individual rights to overcome oppression. Democracy can be achieved if those in power adopt a "power with" approach to problem management versus the current "power over" structure. However, regardless of whether a "power with" ideology is adopted, those in power must be willing to accept the fact that compromises must be made to

move the dilemma out of crisis status. While it is true the problem cannot be solved due to its very nature, it can be managed through a paradigm shift in the power dynamic.

Polarity management as posited by both Johnson (1992) and Benet (2006) does not talk about winners and losers but how effective management of the polarities can lead to maximizing the positive aspects of the polarities for all. Benet's polarities of democracy theory applies the polarity management theory introduced by Johnson to the 10 specific values he identified. The effective management of these 10 values could move society towards sustainable democracy for all by creating a shared power paradigm that overcomes oppression.

The poles are interdependent values that have both upsides and downsides. The first polarity pair Benet (2006) presented is freedom and authority. Butts (1988) provided a lengthy definition of freedom that includes individual rights to live life free from the capricious constraint of outsiders. Butts stated that people should be free to learn, believe, express themselves, and make decisions for themselves without coercion or undue influence from the public. Using this definition of freedom, some of the upsides of this pole could include dignity, equality, justice, and self-fulfillment.

Possible downsides of the freedom pole, in a workplace setting, were illuminated by Taylor (1947). Taylor believed that giving workers too much autonomy would make them lazy, combative to authority, irresponsible, and dishonest in their deportment. There are more modern theorists who disagree with Taylor, such as Blake and Mouton (1985) and McGregor (1960); however, the downsides Taylor noted can color the perception of those who enjoy the upsides of the pole, making them less amenable to compromise.

The positive and negative aspects of this polarity are not limited to workplace settings. Members of organized societies see equality, justice, and dignity as positive aspects of the freedom pole while simultaneously viewing laziness, lack of accountability, and dishonesty as negative aspects of the same pole. When viewed from the authority pole position, the positive aspects include personal responsibility and focusing on communal good. The negative aspects of the authority pole could include an increase in illegitimate power and loss of human agency. The aspects mentioned here represent one singular possible perspective. Each polarity identified by Benet (2006) could have an infinite number of positive and negative aspects, and some of the polarities could even share some of the same aspects. The fluidity of aspects across polarities highlights the interdependence of the poles. Because of the interconnectedness of poles, failure to effectively manage one or more of polarities will have a measurable impact on the others (Benet, 2012).

Benet (2006, 2012) provided an extensive list of possible upsides and downsides of each of the five polarities he identified in his theory. Because the outputs are quite numerous, the synthesis that follows represents one of almost limitless possible outcomes. Benet analyzed the polarities to determine if they were valid, and to support his position that the polarities, when properly managed, can lead to overcoming oppression. The analysis included asking two over-arching questions put forth by Johnson (1992): (a) Is the problem/issue ongoing and (b) are the poles truly interdependent?

Benet (2006) conducted a logical analysis on each of the five polarities in the polarities of democracy theory. Specific questions were asked i.e., are the poles interdependent, is the goal to remain in the upper quadrants as long as possible, are the polarity pairs consistent with Johnson's (1992) definition, and does insulation, duration and fear affect how the groups of each pole affect their actions when challenged. Each polarity was found to have the required characteristics and traits first identified by Johnson. The entire polarities of democracy theory served as the theoretical framework for this study. However, the fourth polarity pair, Human Rights and Communal obligations is the specific polarity this study focused on. Because of the interdependence of the polarities, I expected evidence of the impact the pairs have on each other to emerge as the literature review progresses.

Literature Review

In the literature review, I discuss the themes that emerged from the research conducted on studies related to a combination of the following research terms: *African American males, emotional trauma, barriers to and facilitators of mental health care access, African American culture, racial politics,* and *post-traumatic stress* among other closely related topics. Possible barriers to access are presented first and included, historical medical racism, racism in the media, cultural beliefs/social mores, elder advice/racial discordance, stigma from external entities and socio-economic limitations. This section of the chapter concludes with a discussion of the perceived facilitators to access that included, having a support network, education, and financial resources.

Possible Barriers

Historical Medical Racism

Racism is woven into the fabric of the United States. Even before its inception as a sovereign nation the ruling class treated persons of color as less than human (Roberts & Rizzo, 2021). Racism pre-dates the establishment of the republic. It has been around so long it has become part and parcel of national policies, public relations, media influences, police strategies, and health care (Combs, 2018; Hannah-Jones, 2019). Ford (2020) defines racism as "The state sanctioned and/or extra-legal production and exploitation of group-differentiated vulnerability to premature death." The pattern of racism towards African Americans in this country is evident in the penal system, public governance, economic infrastructure and in the medical community. Examples of racism in the medical arena include; the Tuskegee experiment, where three hundred ninety-nine African American men with syphilis were not treated for the disease, abhorrent medical experiments conducted on African American women, by the father of gynecology, J. Marion Sims, and medical students being taught that African Americans do not feel pain to the same degree as European's and should not receive the same kind of pain management treatment or medication (Cooper Owens and Fett, 2019;Villarosa, 2021).

These are not the only examples of how historical medical racism has prevented African Americans from receiving appropriate medical care/treatment. The literature is replete with examples of state policies that targeted African Americans for commitment to mental hospitals for no other reason than "racial inferiority" (Babcock, 1895; Curry, 1981; Dubois, 1899; Grob, 1994; Lowe, 2006). While there may be some academics and

policy makers who take the position that there is no direct link between racism and negative mental health outcomes there are several studies that indicate a strong and direct correlation between the two (Bor, et al., 2018; Roberts & Rizzo, 2021; Williams et al., 2007).

The history of African Americans being mistreated by the medical community is long and sordid. A cursory purview of American history recounts the brutalizing, and murdering of enslaved people as early as the 1600's. If the enslaved person survived the beating, he/she was provided with only minimal medical attention if any at all (Savitt, 2005). Medical care was not provided out of concern but to salvage the slave owner's investment. In the event the enslaved person survived the physical assault, the mental trauma was never addressed (DeGruy, 2017).

The physical assault of African American people started with slavery, continued into Jim Crow period, on into the civil rights era, and runs consecutively into modern day society. Partnered with these abuses were/are barriers to access of mental/physical health care. And when access is granted, the care received is often sub-standard because the goal was not to treat the injured party but to confirm his/her inferiority (Bronson & Nuriddin, 2014). For hundreds of years African Americans have suffered at the hands of members of the ruling class who enslaved them.

Historical racism in the medical community does not exist in a vacuum. It is supported and perpetuated by racist public relations and media. Blackness has been purposely weaponized by and in the media (Alang et al., 2017). African Americans are not only viewed as less than human they are also often portrayed as barbaric animals in

need of constant oversight and corralling (Ford, 2020). And as they are being villainized by the racist media, their physical, mental, and emotional needs are ignored.

Racism in the Media

African American males have been repeatedly portrayed in the media as being violent and non-compliant with the rules of police authority. A cursory review of movies like Birth of a Nation (Griffith, 1915) or books like The Resurrection of Nat Turner (Ewell-Foster, 2011) help explain how this narrative came into existence. The narrative has been replayed on a continuous loop on the news, in print, and on the radio for decades. News producers, it seems, go through great lengths to convince their viewers that African American victims of police brutality are criminals and thugs who got what they deserved (DeVylder, et al., 2020). And if it turns out that they were innocent of that crime, the secondary narrative was, their death, however tragic, was warranted because it prevented them from committing future crimes.

This narrative has been told and presented as fact for so long it has normalized police brutality against African American males. Racism within the media has worked to convince the public that African Americans, specifically African American males must be controlled, and state sanctioned police violence is an acceptable method of that control (DeVylder et al., 2020). It is this narrative that acts as a barrier to African American males seeking help from the medical community. The rebroadcasting of the “big, bad, Black man” storyline reinforces the mindset that no one will believe African American males are actual victims. And even when they are allowed to be referred to as victims, racists reporting within the media shared everything socially undesirable about them to

prevent viewers from feeling empathy for them. It is this racist portrayal of African Americans as that undergirds the idea that white people need to be protected from Black people because the latter are inherently dangerous and need to be controlled (Adedoyin et al., 2019; Roberts & Rizzo, 2021).

What is often reported includes what the person was doing when the assault occurred, the poor neighborhood he lives in, his employment status (if unemployed), his marital status (if unmarried), his criminal past, and his drug use history. There are several reasons why information is presented in this way including but not limited to; ignorance of the reporter, an attempt to perpetuate the narrative that all African Americans are inherently violent, to confirm the media's bias, and to allow for the acceptance that the officer was not punished for his/her actions because the victim deserved it (Dukes & Gathier, 2017). It is easier for the public to vilify the victim and to see the officer as a hero if mainstream media purposely removes all shades of gray/doubt when reporting on these incidents.

The message African American males receive from meso-level police policies and news media organizations is, they are at fault. No matter what the facts of the encounter may be, no matter how many violations the officer may have committed, the story was spun to vilify the victim and hail the perpetrator. And when the victim attempted to avail himself of physical or mental health services he was often met with indifference and made to feel like he wass responsible for his trauma (Rich, n.d.; Menifield et al., 2018).

Black lives are devalued so commonly that each time a new policy goes into effect to further marginalize them society barely notices (Alang et al., 2017). The belief

in the rightness of white and the wrongness of Black is disseminated at macro, mezzo, and micro levels. The mindset is ubiquitous and can be found thriving everywhere in the United States. White supremacy is more than a belief of some it has become a mantra to many. The mental anguish African American males suffer at the hands of police, which is supported by the media, and sanctioned by the legal system is akin to racial terror (Petersen & Ward, 2015). The propagation of this subjugation keeps entire minority communities living in constant fear and suffering from an unending cycle of mental trauma. This might suggest that a failure to properly leverage the Diversity and Equality polarity pair as well as the Freedom and Authority polarity pair is occurring external to the locus of control of the community members.

African Americans are portrayed as brutal animals in the media. The purposeful misrepresentation of African American males fails to consider the positive aspects of Diversity and Equality polarity, i.e., treating everyone with human dignity and respect, while simultaneously exaggerating the negative aspects i.e., acceptance of an unfair caste system. Failure to manage the tension between the Freedom and Authority polarity undergirds this narrative by focusing on the need to protect the general public from the harm African American males perpetrate on society as a positive aspect, and at the same downplays one of the negative aspects which is allowing those with the power to unjustly influence the public to retain their power.

This type of subhuman treatment provides fertile soil for discontent and cultural mistrust to grow. Terrell and Terrell (1984) define cultural mistrust as a propensity for African Americans to mistrust white people in social and interpersonal settings. Being

attacked by a white person, being vilified by white, racist public relations, being disregarded by a white medical provider certainly lead to cultural mistrust in the African American community (Planey, et al., 2019).

This circumspection spreads with ease as the brutalization/murder of African American men gets filmed and the world watches as the perpetrators go free time and time again. The filming and subsequent public viewing of police use-of-force events may have started with Rodney King thirty years ago but there appears to be no end in sight. In today's voyeuristic environment most of us are walking around with cell phones poised to record the next news-worthy event including assaults, abuses, and even murders. Frank Jude was assaulted in 2004, Eric Gardner was killed in 2014, Dajeeria Becton was beaten in 2015, Philando Castile was shot and killed in 2016, Terrence Crutcher was shot and killed in 2017, George Floyd was murdered in 2020, Daunte Wright was shot and killed by Officer Kim Potter in 2021, and the list goes on.

There is no shortage of African American men being beaten/killed on film. Violent acts perpetrated by the police against minorities is used as a form of control and intimidation and are often spun, by racism in the media, as necessary acts. The way these events are reported in the media serves to ensure white America that Black people, specifically Black men, are being kept in their "socially accepted place" (Aymer, 2016). The beatings that African American men suffer at the hands of law enforcement leaves them traumatized and in fear for their lives from the time of the event onward (Gilmore, 2020). The frequency with which the beatings occur and are broadcast creates an environment of fear and need for self-preservation within their own community (Smith-

Lee & Robinson, 2019). Carrying this kind of stress and worry day in and day out can lead to a myriad of negative physical and mental health related outcomes.

Community Beliefs/Social Mores

Cultural norms function as a governing framework in African American communities. One cultural norm is members are taught not to seek mental health assistance. African Americans are told they must be strong, they must have faith, they must call upon their ancestors for help (Taylor & Kuo, 2019). A person of color who desires to seek professional mental health service is often discouraged from doing so because he/she only need to rely on self, immediate family members, and or close friends for help (Bauer, et al., 2020). African Americans, particularly African American males, have been conditioned to believe they must be strong in all circumstances and situations. They cannot show any weakness, especially mental weakness, because they come from a long line of survivors and that weakness would be an insult to their ancestors. They have been told that they are strong enough to endure any hardship without the assistance of anyone but themselves (Bauer et al., 2020).

The stigma a victim of a use-of-force encounter would face if he/she sought professional mental assistance would be daunting. The individual could be shunned by his/her family, church, and community at large if word got out. He/she could be labeled as weak, faithless, untrustworthy and a possible threat to his/her own community (Alvidrez et al., 2008). As a result of this stigma African American men would rather suffer in silence or develop coping mechanisms to avoid being shamed. The victims do not have the required skills, knowledge, or ability to manage the mental trauma on their

own which could lead to an exacerbation of negative health outcomes (DeVylder et al., 2020). Without direction or an intervening source to redirect this approach the stigma remained throughout the victim's lifetime, and he/she passed the stigma on to subsequent generations (Alvidrez et al., 2008)

Self-reliance is seen as a sign of competence, strength, and resilient faith in the Black community. According to Gaskin et al. (2007) 84.5% of African Americans they surveyed indicated they depended upon themselves when it came to their mental well-being. These participants did not seek professional help because they had been taught mental illness could be overcome if they were strong enough. African American culture instills in its members from a very early age that Black people do not suffer mental illness, they are not cursed by mental infirmity because they are anchored to God. And for anyone who does suffer from a mental illness, it is because he/she has sinned against God or has a lack of faith (Alvidrez et al., 2008).

These cultural taboos are revered in the African American community and rise to the level of guideposts for acceptable, normative behavior. Failure to adhere to the accepted traditions of relying on an all knowing, all wise deity to deliver you from whatever may ail a member could lead to social, spiritual, emotional, and even physical exile (Alvidrez et al., 2008). Community members often choose to suffer in silence rather than seek necessary treatment which leads to them moving through their environments with undiagnosed/untreated mental illness. The sentiment that African Americans have an almost super-human ability to overcome any physical or mental health obstacle is a

learned concept. This belief is shared in the home from a very early age, and it is reinforced by the church, a staple in the Black community (Conner et al.,2010).

Elder Advice/Racial Discordance

Stigma is not the not the only cultural barrier to accessing mental health care services in the Black community. Members who suffer from mental illness are often dissuaded from seeking help because their elders tend to distrust the quality and efficacy of medical providers from different ethnicities (Gaskin et al., 2007). Seeking the advice of elders is considered a sign of respect in the Black community and it pays homage to their authority. Following the instructions of the elders is a requirement not an option (Harris, 1998). As such, when a community elder tells a younger member that white doctors cannot treat him/her properly because he/she does not know how to treat Black people the younger member listens. This outcome could suggest a failure to manage the tension between the Diversity and Equality polarity by the elder. He /she has been focused on preserving the Communal Obligations pole for so long that the positives of the Diversity and Equality pair have been downplayed/discounted.

The belief that only Black doctors know how to effectively treat Black patients dates to a pre-civil war period and stems from a history of medical mistrust (Taylor & Kuo, 2019). But even before then the tradition of seeking help from the tribal medicine man was handed down to generation after generation from African culture. This is another example of where a cultural tradition possibly stems from a failure to properly manage the tension of the polarity pair Freedom and Authority. While African Americans may no longer seek a medicine man/woman to cure them, they will intentionally seek out

a familiar, trusted, Black physician for assistance (Townes et al., 2009). If a Black doctor cannot be located the member may choose to go the local pastor for "healing prayers" or just learn to live with the ailment. There may not be any empirical evidence that prayers have a positive impact on treating mental/physical illness but the belief that prayers are necessary persists in the African American community (Breland-Noble et al., 2011; Lindsey et al.,2013).

Stigma From External Entities

When school systems, external social groups, employers, police departments etc, encounter these individuals they often mislabel them as being a threat to society. The mislabeling could lead to the affected person being suspended, ostracized, terminated, or even worse killed. African Americans see the impact of negative stereotyping of mental illness being played out in the media on an almost 24-7 loop. This continual exposure tends to coincide with a higher rate of PTSD presenting among them (Smith Lee & Robinson, 2019). The desire to seek/access professional help is eroded when a mentally ill person comes to accept the only option to keeping community ties, staying employed, or avoiding police interaction is to keep the illness a secret (DeVylder et al., 2020). Given that Fripp and Carlson (2017) posit even if the individual can overcome the external stigma and is willing to face the threat of being labeled a criminal by outsiders, he/she still may not receive the support needed from within his/her own community.

The cultural belief that the community would not support a member could signify a failure to properly manage the tension between the Freedom and Authority polarity pair and/or the Diversity and Equality polarity pair. As with all the polarity pairs, Johnson

(1992) argues that focusing on one pole for too long may lead to the negative aspects of both poles being maximized. In the case of the Freedom and Authority polarity, solely focusing on the positive aspects of the Freedom pole may eventually lead to an amplification of the negative aspects of both Freedom and Authority polarity i.e., group think and authoritarianism. These are not the only possible aspects of ineffective polarity management, that list is almost endless.

The same type of possible aspects could be expected if too much time, effort, and resources are expended on maintaining the positive aspects with little to no attention spent on addressing the negative aspects regarding all of the polarities in Benet's (2006) theory. The polarities are interdependent and function best when they are acted on with the understanding that the values function as an operating system like inhaling and exhaling. Management of the Freedom – Authority polarity will have an impact on the Communal Obligations – Human Rights polarity which will in turn cause some type of movement in the Diversity – Equality polarity and so on. When the values are effectively managed the system works as intended, creating an atmosphere where the best possible aspects for all come forth.

Socio/Economic Limitations

Historical racism and cultural taboos to include medical mistrust and racial discordance are two broad barriers to African American males accessing mental healthcare. Socio-economic factors such as employers who do not offer healthcare coverage, facilities being geographically out of range, and lack of financial resources round out the top three in the barrier category. If the infirmed person manages to

overcome the first two barriers, he/she may still face obstacles i.e., not having enough time or method of transport to get to a medical appointment, not having enough resources to cover missed hours and having no reliable childcare (Gaskin et al., 2007).

The costs of medical care have increased year over year in the United States for the last several decades. In 2020 the costs of medical care rose by $4.1 trillion dollars overall, an average of $12,530 per person compared to 2019 (Centers for Medicare & Medicaid Services, 2020). Mounting medical debt is one of the leading reasons why families file for bankruptcy even with some type of medical coverage (Himmelstein et al., 2019). Surprisingly, 72% of those who filed bankruptcy due to mounting medical debt did have some form of medical insurance coverage. Having medical coverage offers no assurance against financial crisis but it can function as buffer to sudden financial ruin.

According to Beard (2007), from 1996 to 2006 African American households have carried more medical debt than any other racial group, with nearly 45% reporting they cannot manage the medical debt they currently have. There is no room in the budget to add more debt even if more medical care is needed. Treatment of mental trauma is cost-prohibitive for these families. Even with private or state sponsored insurance "patient responsibility" costs put households at risk for not being able to purchase food, clothing, medicine, and other essentials (Beard, 2007). There seems to be no real change in this trend with Lichtenstein and Weber, (2016); Morrison et al., (2020) reporting similar study results.

Being employed sometimes works against the employee when it comes to obtaining health coverage from a state or federal sponsored program. Recipients of state

assistance programs must be at/under four and a half times under the poverty level to qualify for state health insurance benefits (Missouri Department of Social Services, 2019). Working for an employer that only pays minimum wage often disqualifies an individual from receiving state benefits. Tens of thousands of Missourians fall in the uncovered gap between not making enough to purchase medical coverage but making too much money to get government assistance (Missouri Department of Social Services, 2019). If access to health care is a human right, this gap of coverage might suggest the tension between the polarity pole of Human Rights and Communal Obligations is not being properly managed. It also suggests that the tension between the Participation – Representation polarity pair is not being properly leveraged as the capacity for some members to fully contribute to their communities is weakened by those elected to represent them.

African American males in underserved communities tend to be unemployed or they work for companies that do not provide health insurance. The uninsured/underinsured rely on local clinics or community health centers for medical care because of free or reduced fee options (Gaskin et al., 2007). Clinics located in underserved communities do not have the resources needed to provide mental health care. A growing number of African Americans, specifically African American males, in urban communities cannot access mental health services because they simply do not have the financial means to do so (Watson, 2014). Even in the best-case scenario where the employer provides insurance coverage, and patient co-pays would not be cost prohibitive, the person needing care may still forgo getting treatment because he would have to miss

hours at work. Financial resources are already strained and taking time off work to seek mental health assistance is just too costly (Alang et al., 2017).

One of the tenants of good governance is those in power work to meet the needs of the citizens they represent. They write, debate, and promulgate rules and policies that govern everything from public health to prison reform, to bridge and road repair. The laws are designed to support the well-being of citizens as well as the productivity of businesses (Weible & Sabatier, 2018). If health care is a human right, as some have argued, it should be provided for by the government. And public policy should make access to healthcare easier and more affordable for all citizens (Alang, et al., (2017).

Lack of reliable transportation serves as another socio-economic barrier to accessing mental health care for use-of-force victims. Clinics and out-patient facilities that operate within marginalized communities typically do not have psychiatrists and/or psychologists on staff. And if they do, the hours that these clinicians are there are quite limited (Taylor & Kuo, 2019). Accessing the right doctor, at the right location and time can be an almost insurmountable task. Living below the poverty line often means you must rely on friends and family or public transportation to get to work, run necessary errands, get the children to school/childcare etc. If you do not have ready and reliable transportation to see a mental health care provider, who may be fifteen to twenty miles away from your home, chances are you will not travel there to get the treatment needed (Bejleri et al.,2017).

Gaining access to mental health services can be quite difficult for African Americans. Racism, cultural misgivings, and financial limitations are just a few markers

that function as barriers to access. Sub factors i.e., racist media portrayals, socio-economics obstacles, medical mistrust, and racial discordance make the barrier wall appear much taller (Watson, 2014). These barriers are quite formidable but there are some facilitators of access to care that can make the pathway to care a little easier to navigate. Several studies highlight supportive social networks, public health education, and solid financial standing as facilitators to access to mental health care (Bryant-Davis et al., 2017; Lindsey et al., 2010; Snowden, 2012).

Society is an organization, a living, breathing, ever-changing system that produces the best outcomes when each of its citizens is contributing to its success (Shafritz et al., 2016). When citizens are healthy, they can be productive, and they can positively contribute to the success and life cycle of their local, state, and regional communities. Ford (2020) argues that in a healthy and sustainable community, providing mental healthcare for citizens should be viewed as a communal obligation. One way for the governance structure to meet that obligation, if Ford is correct, is to facilitate access to that care. They could do this by developing policies/programs that undergird support networks, enhance mental health care education, and improve the socio-economic standing of those at the bottom of the system.

Potential Facilitators

Community Support Network

African Americans with strong community ties are often bound by unspoken rules and regulations of the embedded sub-culture (Watson, 2014). Deference to the elders in the community was listed as a barrier to access but, deference to the elders can function

as a facilitator as well. Elders who believe suffering from mental illness does not signify a lack of faith can guide someone who is suffering from a mental infirmity to an access path (Lindsey et al., 2010). Other members in the community can band with the elders in solidarity to show support for a change in cultural attitudes and beliefs. Any concerns a community member may have about seeking mental health care can be ameliorated if he/she feels understood and supported by circles of emotional emancipation (Bryant-Davis et al., 2017).

Individuals and families respond to mental health needs within the context of what is considered acceptable in their communities and local churches. Communal networks impact adult beliefs and actions in much the same way as peer group pressure affects adolescents (Cauce et al., 2002). Within the network there are members who have experienced both negative and positive events in the mental health care forum. If these groups approach access to mental health care with a positive and supportive attitude they can guide the individual's help-seeking beliefs in a positive direction (Cauce et al., 2002).

If the members who have had positive mental treatment experiences shared those encounters with the person undergoing a crisis there is a chance, he/she sought access to care rather than rely on the self-healing techniques he/she has been taught (Avent Harris et al., 2019; Byrant-Davis et al., 2017). The sharing of positive experiences is exceptionally helpful in changing attitudes if the person providing guidance used to believe that self-healing was the only acceptable treatment. The individual sharing his/her experience gives the person in crisis permission to seek help regardless of the opposition. One of the persons interviewed by Taylor and Kuo (2019, p. 330), put it this way: "Screw

what everybody else thinks. You gotta think this [is] for yourself. You want to get better for yourself …you just can't worry about what other people think."

Through the development of internal community relationships or via newly established external relationships, community members undergoing mental infirmity can begin to reprogram their beliefs. They can move away from the long-held traditions of faith-healing and self-reliance ideologies to a more logical, medically sound approach to treatment. Support networks are crucial to the process of unfreezing old beliefs, learning new approaches, and then refreezing new thought processing systems (Lewin, 1948).

This does not mean that faith takes a back seat to treating mental illness, on the contrary. Members who have moved beyond the captive mindset of relying solely on faith incorporate those beliefs into their new approach. They use scriptures to help those needing care understand their faith is not being denied, it is being activated (Avent Harris et al., 2019). Incorporation of scripture makes the transition from the "I am going to rely solely on my faith" approach to combining faith with seeking professional help more palatable. Acceptance is achieved by highlighting the prominent figures within the bible who solicited help when needed. Moses got help from Aaron, Ananias was there to help guide Paul, even Jesus himself had Luke to look after him. Deconstructing the belief that mental illness is a sin may help the person suffering move beyond the shame of seeking professional help (Avent Harris et al., 2020).

This new way of thinking about mental health does not happen overnight. Community members must be open to the possibility that other treatment options may be more effective. In addition, they must have some willingness to challenge the stigma their

community has about mental illness. The two-step process of getting the facts and downplaying the superstition is vitally important to overcoming traditional beliefs especially within the African American community. The scientific data on its own is not enough to change hearts and minds. It must be disseminated in a respectful manner by an empathic member, a member who has the deference of the community, a network actor (Thatcher, 1998; Weible & Sabatier, 2018).

The network actor is trusted to bring "outside" information into the community, and he/she is trusted to speak on behalf of the community. The actor leaves the local environment and educates him/herself about mental health services, programs, providers etc. He/she then returns and shares the information with those in need. The actor does not assume the role of savior but one of teacher. African American communities do not want to be saved. They want to be treated fairly and they want to be treated equitably (Snowden, 2012).

Education

Education is a key component to increasing access to mental health programs for African American communities. Knowing where to go, who to contact, what information to bring, and what services are offered is essential to gaining access to providers and facilities. Public health programs lean towards providing information about providers that treat physical infirmities. However, information about mental health providers, particularly those that treat adult patients in underserved communities is either scarcely available or is not disseminated with equity. The longer a person goes without receiving mental health care the more exacerbated his/her illness may become. Purposely hoarding

information and resources regarding mental health providers/services is a by-product of a well-maintained system of white supremacy and subordination of all others in public policy administration (McCandless & Blesset, 2022). I agree with Guy and McClandless (2020) in their assertion that governing body should acknowledge this inequity and work to ameliorate this discriminatory treatment.

Gathering and sharing information about mental health providers is just one aspect of mental health education. Providing mental health assistance seekers with factual data about treatment options, information on case studies, and provider reviews helps to combat the stigma associated with seeking/accessing care (Alvidrez, Snowden, & Kaiser, 2008). Supplanting superstition with coping strategies can help mentally ill persons overcome the shame and guilt they feel about their illness. Educating them about the psychological tools at their disposal i.e., putting their needs before others, controlling the kind and flow of information they intake, and advocating for others raises awareness and helps abate self-stigma (Alvidrez et al., 2008).

Acknowledging and addressing concerns African Americans have about racial discordance can help facilitate access to mental health care. Medical mistrust exists within the African American community largely in part due to non-Black providers, downplaying ethnic differences, disbelieving patient symptoms, and a lesser sense of agency about their care (Malat et al., 2009). Public health facilities that acknowledge the importance of racial concordance ameliorate the fears African Americans have about receiving a lower standard of care due to their ethnicity. Choosing a doctor is an important first step is accessing health care. Having the option of choosing a doctor who

looks, believes, and speaks like his/her patient not only facilitates access for African Americans it also enhances the chances for compliance with treatment plans (Saha, 2007).

Financial Resources

Having a favorable economic standing rounds out the top three facilitators of access to mental health care in the African American community. While limited social/financial resources function as a barrier to access to mental health care, having sufficient economic resources i.e., gainful/flexible employment, better than basic group health insurance, and dual income households operate as facilitators of access to health care (Borba et al., 2011). Rising health care costs are placing Americans in financially unstable conditions. Choices between paying for shelter, food, clothing, and health care are becoming harder and harder to make as household income remains flat and living expenses grow. African Americans living in marginalized communities feel the weight of medical debt at a rate much higher than non-white households (Beard, 2007). Having medical insurance that offers sufficient coverage for mental health services can facilitate access to care.

African Americans who have insurance through their employers are at a definite advantage. These group sponsored health plans tend to hold cost steady for their employees due to economies of scale of the private sector. In addition to affordable costs, these group coverage plans typically offer some form of Employee Assistance Plans or EAPs. The EAPs are specifically designed to furnish employees access to covered mental health care providers and services. Without this insurance benefit, a large percentage of

individuals who suffer from a mental illness would be less likely to seek professional help due to the excessive costs (Huber et al., 2019). Insurance alone may not allay all the costs associated with receiving professional mental health services.

More and more families are discovering that having dual incomes provides a needed financial safety net. A potential downside of having both parents work outside the home is that there is no one in the home to attend to the social, emotional, and psychological needs of the children. Left to their own devices, the children could be more likely to develop selfish attitudes or possibly succumb to negative, conforming peer pressure. These are not the only negative aspects that could result from a failure to manage the Human Rights – Communal Obligations polarity; they represent one possible scenario among countless options.

Having multiple streams of income can function as a facilitator to obtaining healthcare in much the same way that insurance coverage does. Money buys the family's options, and it allows them to take some control over their health care and mental well-being. The households that have multiple streams of income do not have to make the choice between buying food/clothing and seeing a mental health professional because there is enough money in the budget to cover all the household expenses (Borba, et al., 2011).

The downside of having both parents working, or to have one parent working two jobs is that it reduces the amount of time available for leisure activities, spending time with children, and/or for interacting with other members of the community. The dual income household may help to alleviate the economic disparity associated with the

Diversity and Equality polarity pair, but it can simultaneously create more tension within the Communal Obligations and Human Rights polarity pair. Having more disposable income can stimulate an atmosphere of financial safety, but it can also foster attitudes of self-interest and required self-reliance. The belief that each of us is responsible for his/her own lot in life does not promote a culture of shared, mutually beneficial commitments. Lack of cultural continuity is a negative outcome and represents how the polarity pairs are interdependent (Benet, 2006).

Summary

In this chapter, I discussed both the conceptual and theoretical frameworks that provide the perceptual lens for this study. I also reviewed what current literary studies report are some of the barriers to and facilitators of mental health care seeking behaviors of African Americans are across the United States. Furthermore, I discussed how those barriers impact the well-being and stabilization efforts of those who live within the African American community. What is known in the discipline is the utilization of mental health care services is much lower than their white counterparts (Bohanon, 2020). What is not known is how the perceptions of the former group impact their ability to access mental health services following a use-of-force encounter with police.

Additionally, I provided evidence that there is a gap in the current literature that warrants further inquiry into the perception that African American males have about the barriers to and facilitators of access to mental health services. An extensive review of the literature denotes a lack of data regarding the perceptions of African American males, who are at the intersection of having been victimized and facing challenges with

accessing mental health care after the event. In the next chapter, I discuss the research design used to conduct this inquiry. The elements of the design include the methodology, data collection method, and analysis of the data.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the perceptions that African American males have about the barriers to and/or facilitators of access to mental health care after a use-of-force encounter with police. In Chapter 2, I discussed how their perceptions were examined through the lens of Benet's (2006) polarities of democracy theoretical framework. The entire theory provides the framework; however, this study primarily focused on the polarity of human rights and communal obligations. From this vantage point, I hoped to uncover how the perception African American males have about access to mental health care could possibly inform public policy makers in Missouri as to the efficacy of those programs. Chapter 2 concluded with a presentation of the themes that emerged from the literature review related to the facilitators of and the barriers to access to mental health services.

This chapter includes a description of the research study design and rationale, role of the researcher, chosen methodology, criteria used for participant sample selection, data collection method, analysis, and synthesis of data collected, and the ethics surrounding data collection and analysis. This chapter also includes information on how informed consent was explained and obtained and how trustworthiness of the data was secured. This study took a general qualitative approach, and although I considered the perception of the participants with regards to the same topic, barriers to and facilitators of access to mental health care after a violent police encounter, each participant has their own set of unique, situational perceptions to similar incidents.

The research question that guided this study was aimed at exploring and understanding those individual perceptions the participants have about access to mental health care. African American males ages 18 to 45 years from north Saint Louis County, Missouri, who have had a violent encounter with law enforcement were the key demographic for this study. Their perceptions of the barriers they encountered or facilitators that assisted them provided the data needed to address the research question and to inform policy makers on revisions and/or additions needed to current programs or policies.

Research Design and Rationale

Research Question

What are the perceptions of African American males in north Saint Louis County, Missouri, about the facilitators of and/or barriers to accessing mental health care services after experiencing a use-of-force encounter with police?

Central Concept

The central concept of this study was that by exploring the perceptions of African American males regarding the facilitators of and barriers to access to mental health care after a use-of-force event, those perceptions could be shared with public policy makers in Missouri. How African American perceive their surroundings creates their reality. If public policy makers have access to how the end users of public mental health programs view those programs, an opportunity could emerge to improve upon their efficacy and/or utilization.

Through the lens of Benet's (2006) polarities of democracy theory, I gathered information from my study participants that could inform public administrators on how best to provide mental health care for the underserved, minority populations in north Saint Louis County, Missouri. If health care is a human right, as Ford (2020) believed, and if fair and equitable policies are necessary to good public governance, as McCandless and Blessett (2022) posited, then by providing access to mental health care for African American males following a use-of-force encounter with police helps manage the tension between the human right and communal obligation polarity. It is the effective management of the polarities identified by Benet that can lead to overcoming oppression and to achieving democracy.

Research Tradition

The research design I used for this inquiry was a general, qualitative approach (see Kostere & Kostere, 2021). This design afforded me the opportunity to hear the participants tell their stories using their own words. The rich, thick descriptions they offered about their encounters with police allowed for their stories to be told and their genuine perceptions to come through (see Ravitch & Carl, 2016). The objective of this type of research inquiry was to use the participant responses to help scholars and practitioners address social issues (see Merriam & Tisdell, 2015).

Role of the Researcher

As the researcher, my role was to serve as the research instrument for gathering and analyzing the data necessary to address the research question. My role was to identify participants who met the selection criteria, set up interviews with those individuals,

transcribe those interviews, and then synthesize and summarize those findings. The questions asked during the interview sessions were developed using the interview guide developed in accordance with guidance provided by my committee chair as well as the procedural guidance furnished by Rubin and Rubin (2012).

I have a few close friends who met the criteria specified for the participant pool. My personal connection to those individuals was one of the reasons I chose mental health care access as a study topic. However, because of my familiarity with these individuals, they were not included in the participant pool. I did not want my perspective of their stories to impair my objectivity during the data collection and analysis phases.

The purpose of this study was to explore the perceptions of African American males from north Saint Louis County, Missouri, regarding the barriers to and/or facilitators of access to mental health care, not my perceptions. My intent was to keep my opinions and biases in check through reflexive journaling, member checks, and peer debriefing (see Lincoln & Guba, 1985).

Methodology

I used a general qualitative approach (see Kostere & Kostere, 2021) to conduct this study. I considered a phenomenological approach but that would have required each participant to have experienced the same phenomenon at the same time under the same circumstances (see Moustakas, 1994). A case study approach would not have provided the data necessary to answer the research question because the results would have been presented through the lens of individuals outside of the chosen participant demographics and geographical area (see Yin, 2013). A grounded theory approach would have been

difficult to quantify and would have left too much interpretation up to the researcher and not the participants (see Corbin & Strauss, 2014). All things being considered equal, the general qualitative approach was the study design best suited for this research inquiry. In this section of the study, the following topics are covered: participation selection logic, procedures for recruitment and data collection, instrumentation, data analysis plan, questions of trustworthiness, and ethical procedures.

Participation Selection Logic

Population

The individuals best suited to provide the answer to the research question were those who had direct knowledge about the facilitators of and/or the barriers to access to mental health services. African American males between the ages of 18 to 45 who resided in the selected geographical areas were the only ones who could speak intelligently about their experiences. It is their perception of those experiences that this study was focused on.

Sampling Strategy

The sampling strategy I used to locate participants for this study was Patton's (2015) purposeful snowballing strategy. This strategy was chosen because it was the most effective way to find participants who met the selection criteria. There were two individuals who I identified as meeting the criteria, but they were not included in the study due to my personal relationship with them. These individuals had knowledge of other possible participants and agreed to reach out to them about the study. Snowball

purposeful sampling (see Patton, 2015) was used to expand the pool of possible participants through word of mouth.

Participant Criteria

The participants to be chosen for this study met certain criteria. They were all African American males who experienced a use-of-force event at the hands of police. The participants were between the ages of 18 – 45 years of age. The use-of-force encounter they experienced occurred in the north Saint Louis County, Missouri. Additionally, the participants attempted to access mental health services within a 3-year time period after the event. The participants selected for this study were telephone screened to ensure they met the criteria before any interviews were scheduled.

Number of Participants/Rationale

The number of participants to be included in this inquiry was 11. Based upon the literature review I conducted, the number of participants included in the most relevant studies ranged from as few as five to as many as 100. I expected 10 to 20 participants would be sufficient to achieve saturation as defined by Guest et al. (2006) and Hagaman and Wutich (2017). Eleven final participants fit within the expectation.

Procedures for Identifying, Contacting, and Recruiting

There were two individuals who I identified as meeting the criteria but were included in the study due to my personal relationship with them. These individuals had knowledge of other possible participants and agreed to reach out to them. Snowball purposeful sampling (see Patton, 2015) was used to expand the pool of possible participants through word of mouth. Once those individuals were identified and agreed to

speak with me, I contacted them and went over the conditions of their participation in the study.

Procedures for Recruitment and Data Collection

I used the selection process Patton (2015) referred to as snowball purposeful sampling to identify/locate participants for this study. The study was publicized on the billboards of local markets, churches, barbershops, and community centers within the boundaries of north Saint Louis County, Missouri. Additionally, I placed the announcement of the study on the Walden University approved social media pages. Using Patton's purposeful sampling method as a guide, I asked the individuals who I excluded from the study because of personal connection to contact other individuals who had a similar use-of-force experience. I used gift cards to incentivize participant participation. I expanded the age range up to 45 years, and I enlarged the proposed geographical area to include all the sovereign municipalities in north Saint Louis County.

Individuals who responded to the public announcement received a personal invitation to participate in the study via email or regular mail. The invitation included my personal contact information, a more complete description of the study, along with an explanation of how the collected data would be used. The invitation included an informed consent document that each participant was required to sign and return to me before an interview was scheduled. In addition to the informed consent document, each study participant received, in advance, a copy of the interview questions, if requested.

The goal was to secure at least 20 individuals who were willing to participate in the interviews/group sessions. I assumed this number would be sufficient to achieve what

Guest et al. (2006) and Hagaman and Wutich (2017) referred to as saturation. Saturation is defined as the point in the data collection/analysis stages where no new categories or themes are coming forth. The participants selected were screened not only for the race, age, and geographical location criteria but also for their willingness to share their stories with candor and transparency. Meeting the standards for credibility and dependability allowed for trustworthiness in the data analysis to be gained (see Lincoln & Guba, 1985).

Instrumentation

As the researcher who conducted this study, I functioned as the primary data collection instrument. As the primary research instrument, I took great care to ensure that my voice/perspective did not drown out the voice of the actual storyteller. I conducted interviews with each participant using an established interview protocol. This protocol was not published instrument but was developed by myself in conjunction with my dissertation chair. The protocol was designed to answer the research question, and it confirmed my study's relevance to the polarities of democracy theory (see Benet, 2006). Interview sessions were audio taped with the permission of the participants.

The questions asked during the 45-minute interview sessions were open ended and reflective, allowing for the participants to provide rich, thick descriptions (see Ravitch & Carl, 2016) of their experiences when they attempted to gain access mental health services following a use-of-force event. The responses the participants provided painted an illustrative picture of their experiences and drew the reader in to understanding the participants perception clearly hearing his voice not mine (see Shenton, 2004). The

proposed interview questions were appropriate for the current study, but modifications were made as needed once interviews commenced.

Data Analysis Plan

After the interviews were completed, I began the transcription process. However, before the actual transcription process began, I assigned each participant an alpha-numeric code, which served two purposes. The code preserved the anonymity of the participant and protected his identity from being discovered by anyone seeking to find out who he was or where he lived. In addition to protecting the participant's identity, the codes allowed me to easily report the captured categories and themes that emerged during the data analysis process.

Because this was a qualitative inquiry, I used Saldañ a's (2016) coding process to develop categories and themes. The first step was to go through the interview transcripts and look for shared ideas, thoughts, and concepts among the participants. This is what Saldaña referred to as precoding. At this step, I circled and/or underlined any responses that stood out to me that I decided to revisit later. I did not expect the responses to be identical, but I did expect to see some overlap among the answers. After the precoding phase, I went through the responses again using the first cycle coding method. Saldaña identified seven subcategories to be used during this first cycle coding pass, including but not limited to grammatical, literary and language, elemental, exploratory, affective, procedural, and theming. Interview responses were grouped together based upon how they best fit into one of these categories.

After the first cycle coding was complete, I went back over the participant responses further grouping the identified categories into patterns, areas of focus, axial, theoretical, elaborative, and longitudinal similarities (Saldaña, 2016). This second cycle coding is where possible themes emerged regarding the participant's perceptions of the facilitators of and/or barriers to access to mental health care. After the manual coding was complete, I used a coding software solution, Atlas ti., to further categorize the data. Using a software application to develop and organize the themes allowed for the voice of the participant to be heard keeping any researcher bias from influencing the results (see Shufutinsky, 2020).

The themes that emerged during data collection did not exactly match those noted from the literature review, but there was some overlap. I was not surprised to find finances emerged as both a possible barrier and a probable facilitator, just as Planey et al. (2019) noted, as did education. Participants in this study had some of the same experiences with cultural taboos in the African American community as Avent Harris et al. (2020) and Bauer et al. (2020) discussed in their studies. Others expressed how their faith played a prominent role in their ability/willingness to access mental health services following the use-of-force encounter. This revelation dovetailed with Fripp and Carlson's (2017) study regarding the importance of having a spiritual connection made in the lives of their study participants. These were mere assumptions at the beginning of the study, but they did emerge as key themes once the data were analyzed.

Issues of Trustworthiness

This was a qualitative study and as such concepts like reliability and validity were not appropriate terms to use when describing the data analysis. However, trustworthiness, a concept developed by Lincoln and Guba (1985) was an appropriate descriptor. Trustworthiness is comprised of four key concepts including dependability, confirmability, transferability, and credibility. The dependability of this study hinged on how I, as the research instrument, identified the participants, collected the data, analyzed the results, and presented the findings. I controlled researcher bias through reflexive journaling (Turner, 2020). This control allowed the themes to emerge, objectively, through the application of Saldaήa's (2016) coding process. As a result, dependability was achieved. Additionally, while peer debriefing is typically used to bolster the credibility of a qualitative inquiry, this technique was used to increase dependability. I asked my colleagues/mentors to read the interview transcripts to review how I captured the emerging themes. This helped ensure the data analysis was objective thereby increasing the level of dependability of the results (Cope, 2014).

I did not expect confirmability, which encompasses the idea of capturing an objective audit trail, to be an issue, and it was not. Each participant received a formal invitation to participate in the study via email and his permission was garnered via the required informed consent document. These documents will be maintained by myself and are a part of the permanent research study file. The alpha-numeric code assigned to each participant to maintain his anonymity was kept in a secure location throughout this study.

This number was not included in any electronic record as part of a larger effort to ensure the participant's privacy.

The legend which identifies each participant is a part of the permanent research file and will be produced as part of the audit trail if/when university officials request it. All notes, transcripts, methodology approach, analysis, and findings were collected, organized, and maintained in a strict and secure manner (Thomas & Magilvy, 2011). Backups were made of all electronic information and exact copies were produced of hard copy material, so total loss of data did not occur.

Transferability, or rich, thick descriptions (Ravitch & Carl, 2016) of the participants' experiences could have posed a problem if the participants failed to provide factual and truthful responses to the interview questions. The perceptions of the participants of the barriers to and/or facilitators of access to mental health care was the question this study sought to explore. If they failed to provide honest and transparent accounts or if they decided to give answers, they believed I was seeking rather than answers that were truthful, the emerging data would have been flawed. I trusted the participants to be honest and forthright in retelling their stories.

The last element of trustworthiness, credibility, was not an issue considering the data gathering methods. During the individual interview sessions, I objectively and persistently observed the participants, paying close attention to what was said, as well as what was not verbalized. Member checking, which is defined as a validation technique used by researchers to explore the credibility of results (Birt et al., 2016), was used before analysis to ensure alignment of transcripts with participant responses. I circled back to the

participants, when needed, to check for the veracity of their shared experiences. I did this to ensure that I accurately captured what was said. The few discrepancies that were noted were resolved before the data was analyzed.

Triangulation was considered as a possible obstacle because there were no other data sources to compare the study results to. However, prolonged engagement and persistent observation were utilized and proved to be robust enough to bolster credibility (Lincoln & Guba, 1985; Shenton, 2004). As the primary research instrument, I controlled personal bias and remained objective. This practice allowed the themes to naturally emerge, increased the level of integrity, and enhanced the trustworthiness of the overall inquiry (Birt et al., 2016).

Ethical Procedures

Closely following the guidance and direction provided by Walden University's Institutional Review Board (IRB) abated any ethical concerns regarding the protection of the participants. I rigorously followed the established federal guidelines that govern the ethical practices and standards for conducting qualitative research of this nature. No participants were considered for this study until the IRB approval was granted to move forward. The approval number granted by the IRB is 09-28-2023-0605459. No participant's involvement in this study was be coerced in any way. The informed consent document ensured that participants knew their participation was completely voluntary and they could withdraw from the study at any time. Participants received an informed consent document to sign via email/mail after they were screened.

Strict adherence to the IRB standards was followed not only to ensure participants knew that they controlled every aspect of their involvement but also to protect their privacy. IRB guidelines require that participant's identity remain unknown to everyone but me. Their identities were protected from anyone or entity seeking to locate them because of their participation. I chose to not include personal friends who met the participant selection criteria, in this study, because I wanted to protect them from identified and from possibly targeted. Providing full disclosure about my relationship with them might have been sufficient to overcome bias, but in the long run including their stories in the data collection could have negatively impacted the rigor and trustworthiness of the study results (Shufutinsky, 2020).

The alpha-numeric code that was used to identify the participants was kept in a secure, physical location or password protected electronic file, and will not be disclosed to any party without a legitimate need to have access to that information. The data collected, study findings, recommendations and conclusions will be maintained for up to five years pending study completion.

Summary

In this chapter I, provided an overview of the methodological approach for this study. I introduced the topic of the study; the perception African American males have regarding their access to mental health care and discussed how the research question aims to explore those perceptions. I conducted individual interviews to gather rich, thick, descriptive stories (see Ravitch & Carl, 2016) from the participants that recreated the experiences that informs their perceptions. I allowed the participants to tell their own

stories in their own words because this is the most effective way to gather unbiased, objective data (see Rubin & Rubin, 2012).

It was important to explore and understand the perceptions of African American males regarding the barriers to and facilitators of access to mental health because their perception creates their reality. How they understand their environment and their role in it could increase their involvement and individual productivity (Hogg & Rinella, 2018; Shafritz, et al., 2016). Public policy makers and administrators could take the data obtained from this study and use it to create or expand upon policies that govern how health care is administered in underserved, marginalized communities.

As part of the overall methodology approach the procedures for participation selection process, data collection, and data analysis plan were plotted out. Potential participants were targeted using local supermarkets, barbershops, and church bulletin boards. Study participants were selected using Patton's (2015) purposeful snowball sampling method. Data was collected from the participants using a qualitative interview approach (Rubin & Rubin, 2012) and it was analyzed using Saldaŋa's (2016) descriptive coding and thematic development guidance.

Issues of trustworthiness were managed using guidance and direction provided by Lincoln and Guba (1985) and Shufutinsky (2020). I discussed my role as a researcher which included holding the position of the primary data collector. As the primary research instrument, I controlled bias during the data collection and analysis phases by using reflexive journaling, mentor guidance, member checks, and pro-longed engagement (Brit et al., 2016; Lincoln & Guba, 1985). Strict adherence to the procedures set by

Walden University's IRB ensured ethical concerns were addressed by protecting the participants human rights, identity, and privacy.

In this chapter, I presented my research design and rationale to include the research question, central concepts, and research tradition. I also discussed what my role as the researcher should be and addressed concerns related to researcher bias. I concluded this chapter by introducing my methodological approach and by acknowledging possible ethical issues that could have arisen. In Chapter 4, I report on the study findings. I discuss the study setting, participant demographics, and the interview process. I then present information on the data collection and data analysis approaches. The issues of study trustworthiness noted in Chapter 3 are addressed and the study results are presented.

Chapter 4: Results

Introduction

The purpose of this qualitative inquiry was to explore the perceptions that African American males in north Saint Louis County, Missouri, have about their ability to access mental health care services following a use-of-force encounter with police officers. I used Benet's (2006, 2012) polarities of democracy theory as a lens to view and examine those perceptions. I also incorporated Johnson's (1992) polarity management theory in conjunction with Benet to bring into focus the perceptions African American males have about the facilitators of and/or barriers to accessing professional mental health care services within the democratic, representative governance structure of north Saint Louis County, Missouri.

In this chapter, I discuss the participant selection and interview processes I used in line with the semistructured protocol I developed (see Appendix A). Information on the coding process and how the themes were developed is also provided. Following a review of the themes and ethical concerns that emerged during the study, I conclude the chapter with a summary of the results of the data analysis.

Research Question

What are the perceptions of Africa American males in north Saint Louis County, Missouri, about the facilitators of and/or barriers to accessing mental health care services after experiencing a use-of-force encounter with police?

Setting

The qualitative nature of the study coupled with the information that emerged from the literature review helped me to identify a suitable segment of participants for the study. I used Patton's (2015) purposeful snowball sampling method to locate and secure 11 participants who met the specific study criteria. I interviewed African American males who were between the ages of 19 and 45. The individuals lived in north Saint Louis County, Missouri, personally experienced a use-of-force event, and attempted to or were, in their opinion, prevented from accessing professional mental health services following that encounter.

I used a social media posting as well as a study announcement flyer to inform the targeted population about the study. Six individuals responded directly to me after reading the flyer. Another six individuals were referred to me from the original respondents, following Patton's (2015) purposeful snowball sampling strategy.

Each participant was interviewed via telephone or in a face-to-face setting. Their responses to the interview questions listed in Appendix B were audio recorded. The interviews were conducted in a way that allowed the participants to speak openly and honestly about what they experienced. They were allowed to share as much or as little as they wished in a safe and respectful atmosphere. Creating this safe space for them helped to create an atmosphere of trust which is necessary for quality interviewing (see Rubin & Rubin, 2012). The interview times ranged from 20 minutes to 56 minutes in length. Their responses centered on their individual encounters with police, including what led up to the event, what was occurring during the event, and how they felt once the event was

over. The thick, rich descriptions they offered about the encounter provided the data needed to address the research question, per the guidance provided by Ravitch and Carl (2016).

Demographics

All of the participants who responded to this research inquiry were African American males. They ranged in age from 19 to 45 years old. The 11 participants resided in eight of the 80 plus municipalities in north Saint Louis County. Each participant experienced a self-described use-of-force encounter with police and either sought professional mental health assistance after the event or felt he was prevented from doing so. I assigned a randomly generated alpha-numeric code to each participant to maintain his privacy. Demographics of the participants are included in Table 1.

Table 1

Participant Demographic Data

Participant ID	Age	Participant number	Municipality	Sought care
AD4572	41	1	Berkeley	N
BH8317	34	2	Florissant	Y
CB1462	42	3	Berkeley	N
DE2156	35	4	Hazelwood	N
EA8463	45	5	Jennings	Y
FY4631	42	6	Unincorporated St. Louis County	N
GZ2546	36	7	Hazelwood	N
HB7346	39	8	Ferguson	Y
IJ4200	19	9	Dellwood	N
JP8420	23	10	Florissant	N
KW1943	29	11	St. Ann	N

Police officers and mental health professionals play a very important role in the overall inquiry, but they were not interviewed as a part of this study. The research question centered on the perception African American males had about the facilitators of and/or barriers to access to professional mental health services after a use-of-force police encounter. The police officers were involved in the precipitating event, and the mental health professionals were needed to address the resulting trauma, but neither group was qualified to speak about the perceptions of the participants themselves and were, therefore, excluded from the study.

Data Collection

Participants for the study were selected based on a prequalifying conversation in response to the study flyer. The 11 individuals chosen to participate were selected using Patton's (2015) purposeful snowball strategy. Once study eligibility had been determined and the participant was selected for the study, an IRB approved informed consent document was emailed to him, and an interview was scheduled. Interviews took place between October 5th, 2023, through December 16th, 2023. Data pertaining to occupation, marital status, and religious affiliation were not collected as part of this inquiry, although there was some discussion of these topics during the interviews. Saturation appeared to be reached after seven interviews were completed around Day 44. However, another four interviews were conducted after that to bolster that presumption.

Interviews

Following the participant responding to the informed consent document via email/mail, an interview was scheduled. Participants were provided with three to four

options for an interview time and chose one that worked best with his availability. A 1-hour block of time was allowed for each interview session. Interviews were conducted via phone and face to face. Interview sessions were audio recorded with the participant's consent. At the start of each interview, the participants were reminded that their participation was completely voluntary and that they could stop the interview at any time with no consequences. I confirmed that each participant understood that his privacy would be maintained and that when the study was shared publicly, his interview responses would be reported in aggregate using the random alpha-numeric identifier I had assigned. Participants were also told that some of their individual quotes would be included but the identity of the individual making the quote would remain confidential.

I followed the semistructured interview questions listed in Appendix B as closely as possible to assure consistency but to also allow for flexibility as the interviews progressed. The semistructured interview questionnaire provides a roadmap that ensures a quality interview can be secured (Rubin & Rubin, 2012). However, the protocol remained pliable enough to allow the participant to share rich, thick descriptions of his experience where his perceptions can be heard clearly (see Ravitch & Carl, 2016) helping to downplay researcher bias and voice (see Shufutinsky, 2020).

Each face-to-face interview was conducted in a private office setting where no one could hear who I was speaking to or what I was speaking about. Interviews were audio-recorded continuously, and no start or stop actions was taken, as none were requested by the participants. I took notes during each interview session. These notes afforded me the opportunity to go back and ask follow-up questions when needed. The

notes also helped me keep the interview on track when the participants went down paths of discourse that were outside the scope of my research inquiry in line with guidance provided by Rubin and Rubin (2012). The notes were very helpful during and after the interviews as they provided a means of triangulation, as recommended by Lincoln and Guba (1985).

At the end of each interview, the participant was thanked for his participation, and he was given information about the purpose of the study and the plan for dissemination of the results. Each participant agreed that he would be open to a follow-up contact after the interviews were transcribed to ensure that his responses were captured correctly, if needed. Circling back to the participants at this stage aligns with the advice provided by Shenton (2004) to bolster credibility. This process was completed for those participants who requested it.

Data Analysis

Coding Process and Theme Identification

The first step in the data analysis process began with transcribing the interviews. The interviews ranged from 26 minutes in length to 55 minutes. Transcribing the audio files took several hours over a period of nearly 3 weeks. I started the process by first listening to audio for clarity and quality. The files were then individually loaded into the Microsoft Word voice dictation option. The resulting transcripts captured about 70% of what was on the audio files. The next step included listening to the audio files again and comparing the transcripts in real time. Each file had to be replayed several times to fill in

any blanks and/or edit anything that was incorrect or incomplete. Once all the transcripts were complete, I began the process of what Saldaήa (2016) referred to as precoding.

Precoding involved reading through the transcripts and looking for shared ideas or thoughts among the participants. As I read through the transcripts, I looked for responses to the interview questions that expressed the same or similar concepts or outlooks. I did not expect the wording to be exact, but I was able to find a relatively large number of responses that expressed common feelings, thoughts, and/or statements. During the first pass, I looked for categories that could be considered barriers that prevented the participants from seeking/obtaining professional mental health care after the identified use-of-force event. I highlighted those shared ideas to assist in theme development. I completed the same process a second time looking for ideas or thoughts that could be viewed as facilitators to seeking/obtaining professional health care. Those statements were also highlighted. Each transcript was precoded using Saldana's (2016) guidance.

After precoding was completed, I started another round of data analysis using the categories Saldaήa (2016) identified at this first cycle coding stage. Saldaήa included grammatical, literary and language, elemental, exploratory, affective, procedural, and theming as subcategories to look for when coding qualitative data. The responses and direct quotes that were highlighted at the precoding stage were then grouped into one or more of the aforementioned subcategories. It is worth noting that I did not find any large variances in grammatical, elemental, affective or language categories. Although the participants ranged in age from 19 to 45 and were from different municipalities and

different backgrounds, they used a lot of the same language and jargon and ascribed very similar meanings to a range of different emotions.

The third step in the coding process is called second cycle coding (Saldaήa, 2016). This is where possible themes emerge regarding the participants perceptions about the facilitators of and/or barriers to accessing/obtaining professional mental health services following the use-of-force encounter. The shared concepts from precoding coupled with the subcategory development from the first cycle coding process allowed for the emergence of overarching themes once this third step was completed.

After the manual coding was done, I then uploaded the transcripts into the Atlas.ti coding software application. I used the Atlas.ti application to look for the codes I had identified during the manual coding phases. I critically reviewed interview responses again looking for shared ideas, concepts, feelings, or statements. Direct quotes were highlighted and matched as close as possible to the existing codes. There were three new codes that were developed during this phase that I had not captured during the manual process. The Atlas.ti software created and stored the electronic list of codes, and it kept a running total of the number of times a response was captured and coded. The software was not able to code based upon intuitive language, but I was able to use my interview notes and observations to provide context to longer more complex replies.

Theme Emergence

The Atlas.ti software generated an electronic list of eight emerging themes based on nearly 200 direct quotes and interpretive interview responses. Tables 2 and 3represent the theme, associated codes, frequency, and number of participants who raised the

concern. Despite the participants being of varied age and background understanding of concepts like support, racism, equality, trauma, and spirituality were very similar.

Table 2

Barrier Themes to Accessing Professional Mental Health Care Servies

Themes	Associated codes	Frequency mentioned	# of participants who raised the concern
Racism	Blacks are not treated fairly; non-Blacks are given the benefit of the doubt Blacks are always presumed to be dishonest	27	9/11
Lack of education	Trauma not recognized, did not know where to go or how to get access to mental health care, no resource to provide guidance/assistance	19	7/11
Lack of finances	Not enough money saved, no available financial resource, unemployed or underemployed	15	8/11
Lack of transportation	No car, no/limited access to public transportation, no reliable resource with transportation	11	6/11
Stigma	Seeking mental health care frowned upon in the African American family/community/church	8	7/11

Table 3

Facilitator Themes to Accessing Professional Mental Health Care Services

Theme	Associated codes	Frequency mentioned	# of participants who raised the concern
Support system	Network of family members/friends provide guidance, emotional/psychological support, and encouragement	16	9/11
Sufficient finances	Employed at a job that offered paid time off/ EAP services, had enough money om hand, or saved, had access to a resource that had money	10	7/11
Sufficient education	Had sufficient knowledge to understand what happened, knew where to go to get help and how to access the mental health treatment system or had a resource who had this knowledge	7	5/11

Evidence of Trustworthiness

Trustworthiness is a serious consideration for any qualitative research inquiry because the possibility exists for researcher bias and data manipulation, even if unintended. There is a method in place developed by Lincoln and Guba (1985) that can help the researcher to establish trustworthiness for his/her study. Credibility, transferability, dependability, and confirmability are the accepted measures that

researchers can implement to address any trust issues that may arise during and after the data collection and analysis phases. I addressed the concern of trustworthiness by following Lincoln and Guba's advice and by using elements to boost rigor as defined by Shufutinsky (2020). In the paragraphs below, I discuss how credibility, transferability, dependability, and confirmability were achieved.

Credibility

During the interview process, I allowed the participants to tell their stories in their own words. I was careful not to lead them in their responses or attempt to rephrase questions to get them to say what I wanted them to say. I created an atmosphere of respect during the process, which allowed their stories to be told with authenticity, as suggested by Rubin and Rubin (2012). Follow-up questions were asked during the interview if the responses were unclear or incomplete. However, there were at least three instances where I had to follow up with a participant to get clarity on an interview response during the transcription phase. This process, which Birt et al. (2016) referred to as member checking, was used to enhance the credibility of data collection phase.

Transferability

Establishing a good rapport before and during the interview session-built trust and gave the participants permission to tell their stories using the thick, rich, detail needed to fully examine their position and perception. Ravitch and Carl (2016) write that creating trust and building report allows the needed details to come forth, demonstrating transferability of the data. Participants appeared to provide honest responses to the questions asked. They were not challenged or made to feel that what they were sharing

was untrue or not factual. Shenton (2004) advises allowing study participants to tell their own stories, using their own words. The use of the semi-structured protocol allowed the participants to recount the events as they saw fit and kept the voice of the researcher in the background. Objective analysis was achieved by following Saldaɲa's (2016) coding process, allowing themes to emerge rather than reading something into a response that was not actually there.

Dependability

Dependability as discussed in chapter three is rooted in the idea of controlling researcher bias at all stages of the study. As the primary research instrument, it is easy for personal opinions and experiences to color the manner in which participants were selected for the study, how the data was collected and analyzed as well as how the findings are presented. The first step in achieving dependability of the study approach and reporting of the findings was to recognize that bias exists. I am an African American female and I have my own opinions about what African Americans go through when we encounter police officers. I acknowledged and attempted to control this bias by engaging in regular reflexive journaling as described by Turner (2020). I used the journals during data analysis in conjunction with interview notes to assure that I captured what the participants actually said and not what I thought they meant based on my own experiences. This approach helped me to address the last trustworthiness component, confirmability.

Confirmability

Confirmability encompasses the concept of securing an objective and verifiable audit trail. From beginning to end the steps associated with this inquiry have been well documented. The IRB approved study flyer and social media announcement were secured and are a part of the permanent record at the university. The participant study selection is supported by Patton's (2015) purposeful sampling snowball method and the IRB approved consent from was emailed or given to each participant before any interviews were conducted to ensure his voluntary participation and understanding of the study. Participants were assigned a random alpha-numeric code to secure their privacy. Any verifiable information that could lead to the identity of the participant was kept in a confidential logbook in a secure, locked office. All records will be kept for five years in a strict, organized, and secure manner as described by Thomas and Magilvy (2011).

Study Results

The results presented below are a synopsis of the recorded interview responses the participants provided to the questions listed in Appendix B. The primary goal of the data collection and subsequent analysis was to fully explore the perceptions the participants had regarding the facilitators of and/or barriers to accessing professional mental health services following a use-of-force event with police. A secondary goal of the analysis was to examine those same perceptions through the lens of Benet's (2006, 2012) polarities of democracy theory. By viewing the data through the lens of this theory the subsequent analysis provided some additional support for the underlying tenet, that by effectively managing the tension between the polarities democracy could be achieved. Polarities of

democracy expands upon Johnson's (1992) polarity management theory that on-going issues that have no solution can still be managed thereby creating a situation where win-win scenarios can be crafted for the betterment of all.

Analysis of the data was completed using a combination of manual coding and software coding through the Atlas.ti platform. Each transcript was subjected to several rounds of review where similar phrases, ideas, concepts, feelings, and outlooks were grouped into categories. Inductive reasoning and intuitive guidance allowed for overarching themes to gradually come into focus. At the end of the data analysis process, 9 themes emerged. These themes represent what the participants had to say about their experience with the mental health care system and how those perceptions impacted their decision to seek care immediately after the incident. There was some additional data captured that indicated how they perceived their ability to presently access mental health care.

The first five themes that were discussed deal with the barriers the participants said they faced when considering accessing or accessing mental health services. Direct quotes and researcher interpretations are provided beneath each identified barrier. The barrier themes that emerged were racism, lack of education, lack of finances, lack of transportation and stigma. The frequency with which each barrier was mentioned by or correlated with a participant response is listed in a figure at the beginning of the discussion of each theme in this section. The aggregate data is reported in table number one on page 79.

Following the presentation of the barrier themes and corresponding code frequency, the facilitator themes of attempting to access mental health care services was discussed. The facilitator themes that emerged were having a good support system, having sufficient finances, and having sufficient education. Included in table number two of facilitator themes is data related to the number of times the theme was mentioned and the total number of participants who referenced the issue. The data derived from the analysis and reported in both tables one and two was the result of a combination of single source responses in individual categories and in some cases single source responses in multiple categories.

Barriers to Access

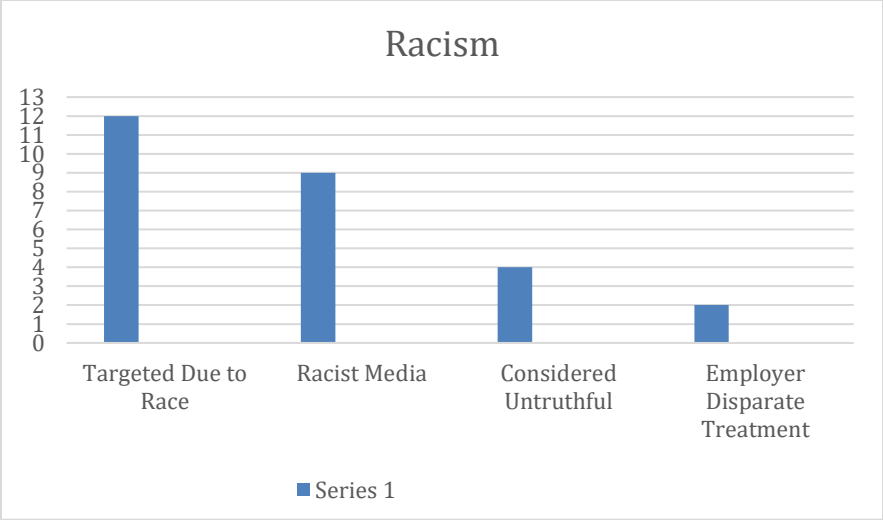
When asked to describe any barriers they encountered to accessing mental health services participants provided the following direct quote responses. The list of quotes is not exhaustive, but it is comprehensive and offers support of the identified barrier.

Theme 1: Racism

The participants understood racism in the context of this study to include the belief that police targeted them because of their race, the media helped spread the myth that most Black men are criminals, the medical community does not believe that blacks can be victims and that Black employees are not treated the same or given the same access to mental health benefits as whites. The aggregate of participant responses that were grouped into these four categories are pictured in Figure 3.

Figure 3

Participant Defined Barrier Theme #1 - Racism



Participants supplied responses to the interview questions that lead to the emergence of racism as a barrier to accessing or attempting to access mental health care services after their encounters. Some of the direct quotes related to their understanding of racism as a barrier are included below.

Participant 1 stated, “Medical treatment culture is the same as police culture. They take care of their own while everybody else suffers.” Participant 2 noted,

> In my case I kinda fell into something and the police treated me like I was a wanted drug kingpin. After my incident, which was pushed out to the general public on a constant basis for weeks, I was treated like a hardened criminal. People at my job, in my neighborhood, at my church gossiped about me and made me feel like I was a horrible person. How was this fair? The white guy who was in the same situation as me didn’t seem to suffer the character assault that I was going through. Black people always get treated differently. I did try to get some

> assistance through my job from the EAP program but I could never find the right person. How is a young, white, female going to be able to empathize with me?

Participant 3 shared some of the same sentiments as Participant 1:

> The media does not help us at all. They always portray us as drug dealers. When the police put that target on our backs the media helps them tell the world we are criminals. No matter where you go, we are the bad guys. I was involved in a car accident and had cuts on my face, arms, legs everywhere. The people in the emergency room made me wait while they took care of white people who weren't even hurt. This happens to us everywhere. Why try to get help only to be treated like that? Just because I'm Black don't mean I'm a bad person.

Participant 4 stated,

> We always fit the description of the perpetrator. No matter what, you fit the description and no matter what happens you are guilty because the police say you are. Once they say you're a criminal that's it, everybody believes you are a criminal. They believe that you lie about everything and you're always running game. Why seek help when the person you talk to doesn't believe you? It wasn't worth the headache.

Participant 8 replied,

> Nobody believes that Black people can be victims. Not the police, not the lawyers or the judges. Not the preachers or the doctors. When I did speak to someone about what happened to me she accused me of making more out of my situation than it was. She basically said "Now (name deleted) sounds to me like you're just

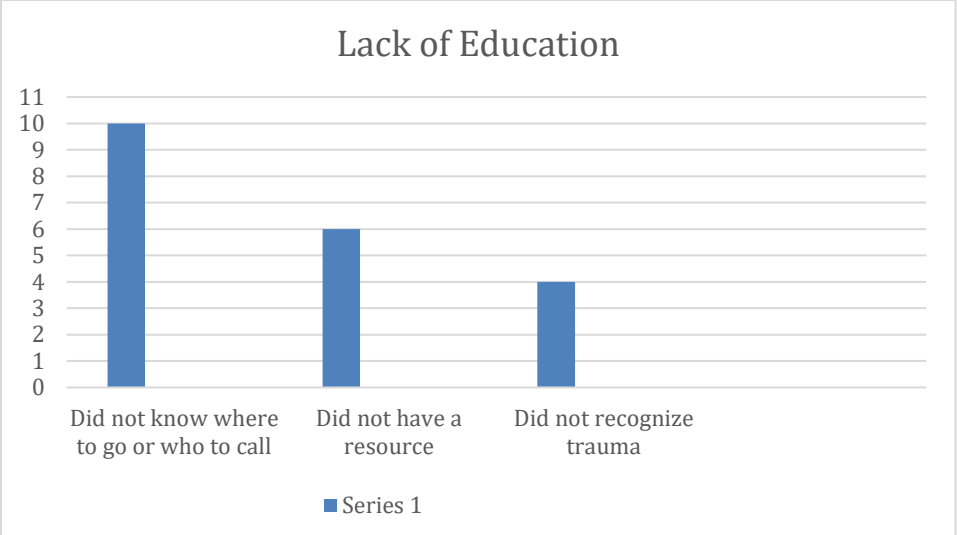
trying to get more time off work. I find it hard to believe that after all this time you're still not ready to go back. You can't still be feeling scared and anxious." I work with people who have seen this same therapist and she writes them notes to stay home for months at a time because they have panic attacks. But for me, she accuses me of lying about still feeling bad. Keep in mind those other people are white.

Theme 2: Lack of Education

The lack of education the participants expressed was not limited to not knowing who to call for help or where to go for mental help. They were not able to grasp the concept that being physically assaulted, even if there are no visible injuries could leave them mentally impaired. Several of the participants noted, if you get sick or are involved in an accident you go to the hospital or the clinic. But none of them seemed to have any knowledge of how to source mental health practitioners or facilities. Figure 4 is a representation of participant responses denoting lack of education as a barrier to mental health care access.

Figure 4

Participant Defined Barrier Theme #2 – Lack of Education



Participant 3 responded,

> There's a lot of African American men walking around who have been assaulted. Who have been harmed are suffering mentally and don't know where to go. Everybody heard about what happened to me when I got assaulted but who was there to help me? How was I going to get help?

Participant 4 noted, "I did not realize at the time what I was doing was trauma-bonding with friends. I did not know what was going on with me or how to fix it. None of us did."

Participant 5 stated,

> I did not know that I could get help for something like that. I did not know who to call or where to go. Besides, what was talking about it going to do? It wasn't going to change anything. I chose to focus on my outlet which was roller skating. That's how I dealt with it. I didn't even know for sure what was wrong with me. I

> know now that I was traumatized at the time but I didn't know it at the time. I didn't realize that it was trauma I was experiencing.

Participant 6 replied,

> I don't even know where to begin to get help for dealing with that. I just really don't know. I don't know where you go to get help when you have had such an experience. I can't turn on the tv and there's "Hey if you have been assaulted or beat up by the police for no apparent reason call this number…1-800-I got your back. There's a lot of people out here that have had this experience and there needs to be a resource that they can go to get help in these particular situations."

Participant 7 responded,

> I didn't understand until much later that everything I was going through tied back to the thing with the police. I was not able to see that the way I was acting up was because I had been mentally traumatized. I just did not see it at the time. I wish I had.

Participant 8 noted,

> I knew I wasn't just going to be able to forget and move on. I mean I was handcuffed and thrown in the back of a police car and my kids were there. They were screaming and crying. They were scared and there was nothing I could do for them. I mean, what was I supposed to do? I keep replaying the scene in my head like a dream. I knew it was going to haunt me but I didn't know what to do. Who was I supposed to call? Eventually I contacted an attorney and that helped

some but I still have flashbacks. I wish I had someone to help me then, but I didn't know who to call.

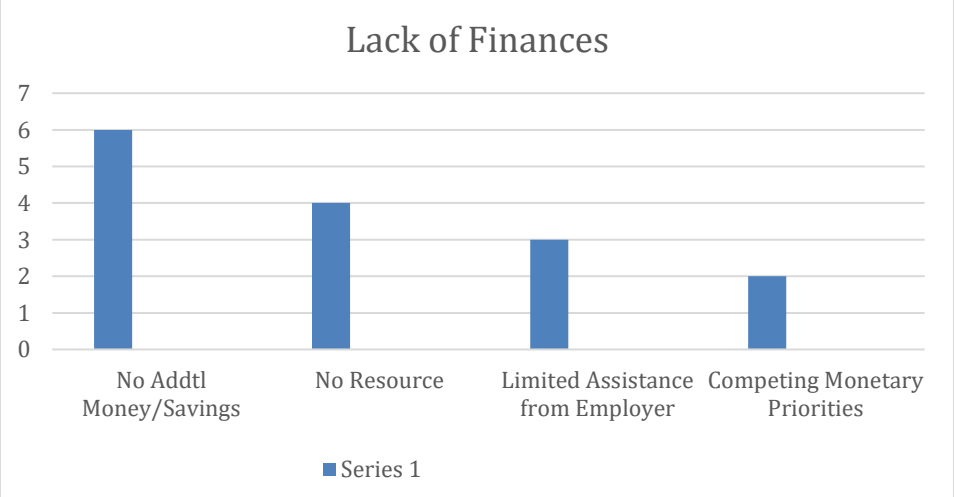
Theme 3: Lack of Finances

Lack of financial standing/ability to pay for services presented a serious barrier to the participants who wanted to or attempted to access professional mental health services. Without someone offering to pay for them or their employer, if they were employed, increasing the number of company paid visits, obtaining professional help seemed completely out of reach.

Figure 5 represents the number of participants who identified lack of finances as a barrier to accessing mental health care services. They understood lack of finances to include, no savings, no additional money in the budget, no resources to borrow money from, limited help offered by employers and/or competing priorities.

Figure 5

Participant Defined Barrier Theme #3 – Lack of Finances



Participant 1 noted,

> I would have to go about this in a different way. I would have to call around to see if I could borrow the money because I certainly don't have it. Mental health counselors charge quite a bit of money. Talking to a psychiatrist or a psychologist for an hour or two could cost me as much as a pair of Jordans or a nice steak dinner. I mean…I just don't have that kind of money sitting around.

Participant 2 stated,

> Part of what needs to change is that I need to become more financially independent, and in an expeditious manner so I would not have to work at all. My employer offers some assistance through EAP, but it is not enough.

Participant 4 stated,

> I am not 100% sure that I could personally cover it. I've never had to seek help before for something like this. But I could check to see how much it would cost to get this kind of help. My job does offer some type of assistance but like I said, I've never had to use it.

Participant 7 said the following,

> Who is going to pay for me to go to a counselor, a complete stranger, to cry about what happened to me? Where is this money going to come from? I have to eat and I have to put gas in my car. Nothing in life is free, especially stuff like this. If I had the money then maybe yes, maybe I would have found a therapist but the fact is I don't have the money. I don't have anybody I can borrow the money from so that's that.

Lastly, Participant 8 responded,

> I am a father of four children. I make a decent enough living but I do not make enough to take $150 to $200 out of my household budget to pay some counselor to listen to me talk about what happened. I have a mortgage, a car note, groceries to buy and the list goes on and on. Nobody is going to provide services for free, so what do I do? My job has an employee assistance program I think, but it only covers 2 or 3 visits. How would I pay for it after that?

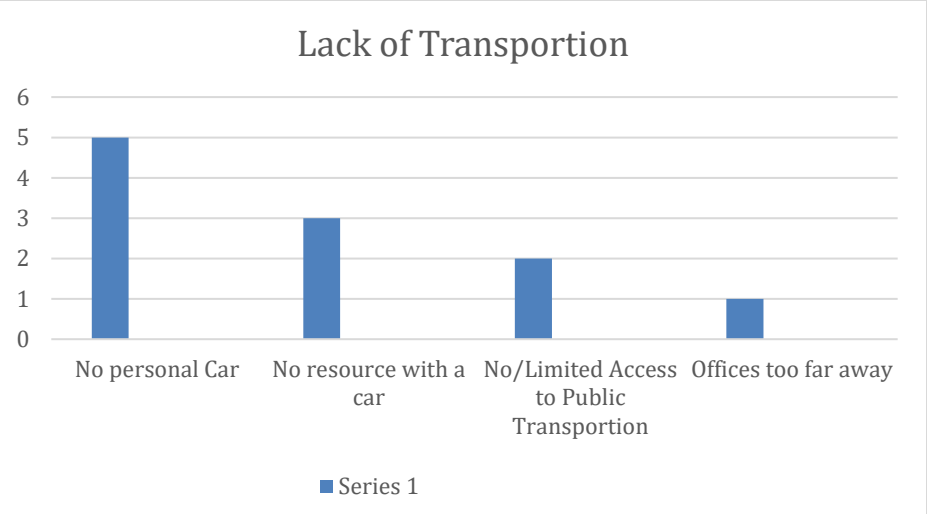
Theme 4: Lack of Transportation

The lack of reliable transportation, just as with the lack of finances, presented an almost insurmountable barrier to accessing mental health care services for these participants. They had no way of getting to work, school, or other important places if family and friends did not help out. Several participants mentioned public transportation was their only option for mobility and even then the bus did not always go where they needed it. Without reliable transportation or access to someone with reliable transportation getting to an appointment was not achievable.

Figure 6 represents the number of participant responses that identified lack of transportation as a barrier to accessing mental health services. Lack of transportation included no personal car, no/limited access to someone with a car, limited access to public transportation and final destination being too far to ask for a ride or to catch the bus.

Figure 6

Participant Defined Barrier Theme #4 – Lack of Transportation



Participant 3 stated,

> I don't have a car right now. I had one a long time ago but lost it when I lost my job. I have to take the bus everywhere I go, including to work. A lot of times the bus doesn't go where I need to go so I can't go to certain places. I can't go a lot of places even when the bus goes there because I don't have bus fare.

Participant 5 responded,

> I had a car at the time but it was parked in my mom's driveway. My transmission went out and I couldn't get it fixed. I couldn't come up with the money and my mom had the car towed away. It would have been hard for me to get to a doctor back then without a car or someone willing to drive me. And even if I could have found a doctor, most of these places, these fancy medical offices, are way out there in places like Creve Coeur and Chesterfield. There is no way I could have gotten all the way out there.

Participant 7 replied,

> I wish I did have a car back then but I had to take the bus everywhere, even to work. Man…no one would give me a ride. They would say they were coming and then call me at the last minute saying something came up. That's how I lost my job. It's hard, you know, it's real hard to keep a job when you can't get there. How could I go see a therapist when I couldn't even get to work?

Participant 9 stated,

> I had a car but it was always breaking down. One week it would be fine then the next week the water pump would go out or the brakes, or battery would die out. After a while I just junked the car, it was too expensive to keep fixing it.

Participant 11 noted,

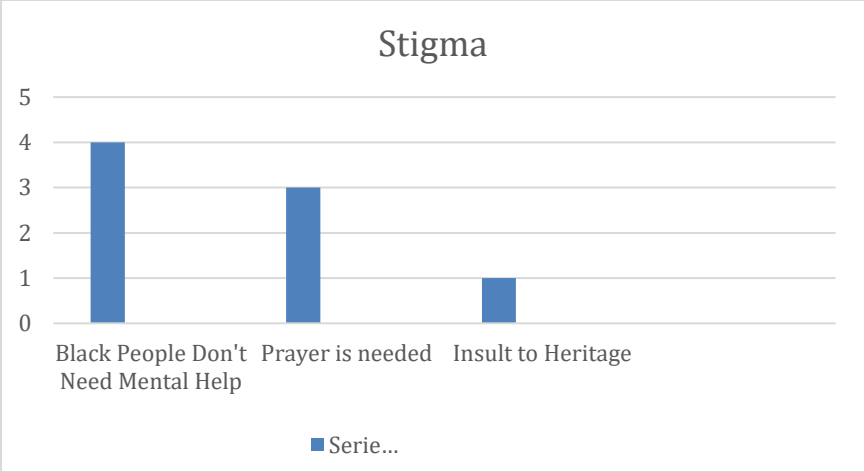
> I didn't have a car then, and I still don't have one. I didn't have rich parents who gave me a car like some folks I know. I get around the best way I can. Sometimes my girl will give me a ride or sometimes a partner of mine but most times I stay home.

Theme 5: Stigma

The cultural stigma these participants experienced was still palpable decades later. Family members and friends embarrassed them and made light of their mental ailments. A majority of the participants voiced concern regarding the lack of support when it came to them wanting to seek mental health assistance after his encounter. Figure 7 shows the aggregate responses of participants who identified cultural or familial stigma as a barrier to access.

Figure 7

Participant Defined Barrier Theme #5 – Stigma



Participant 1 stated,

> African American individuals think that we don't need mental help they think you can just pray everything away like they would try to talk you out of going to see a psychiatrist or a psychologist because that's not culturally who we are.

Participant 2 replied,

> Whether at home or at school or at work, Black people, especially Black men are expected to be okay with whatever happens to us. We are never supposed to cry, we are not supposed to hurt. We are supposed to smile and get over it. It we show weakness we are ridiculed for being weak.

Participant 3 noted, “Sometimes I am not able to manage my emotions on my own, but who do I go to? No one will understand what I am feeling. They just say man-up, be strong.”

Participant 4 responded,

> We grew up with this idea that Black people don't seek mental health assistance. We have been taught to just go on about your day, just man-up. You don't always feel like you should or that you need to seek further help. You just go about your day the best way you can.

Participant 5 stated,

> Nobody in my family that I know of went to a psychiatrist. It just wasn't done. There's this stigma in our community, in the Black community, about getting mental health assistance. We don't believe in it and if someone asks about it they are made fun of and embarrassed.

Participant 7 noted,

> If you say that you need to see a doctor everybody assumes that you are sick in your body and that is okay, its acceptable. But if you say no, I need to see a doctor because I don't feel right in my head, in my thoughts, that's not okay. They look at you like you're crazy. They say all kinds of stuff to you that makes you feel worse than you do. I mean even your family says things that hurt you even more. It could be your own mama who says, boy ain't nothing wrong with you, you just need to pray. If I had told anybody that I was feeling like I was sick in the head they would have kicked me out of the family. So, I kept everything to myself. I still keep everything to myself.

Participant 10 offered the following:

> My family believes prayer can solve anything. Prayer can heal everything that is wrong with the body and with the mind. I tried going to my Mom and talking to her about what happened to me and she told me that I was stronger than any demon trying to attack me. I wasn't stronger and it was not a demon. I needed help and no one would help me. No one would even let me talk about what happened to me. I just gave up.

Facilitators of Access

Analyzing the interview responses and reporting on the participant's perceptions regarding barriers to mental health access was only one part of study results. The second part involved analyzing those same responses and reporting on their perceptions regarding the concepts they viewed as facilitators to access. Three overall themes emerged from the data analysis portion. Those themes were, having a good support system, having sufficient finances or access to a resource with available finances, and having sufficient education or access to a resource that had the information.

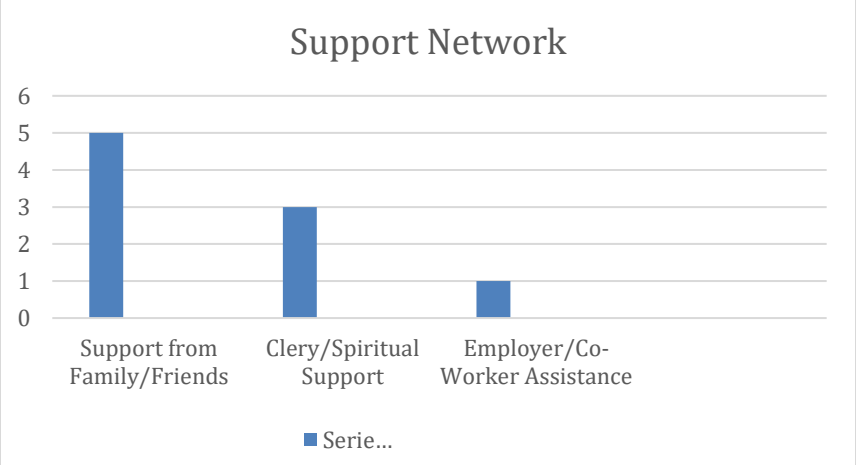
Theme 1: Support Network

When the participants were asked to describe anything or person, they felt helped them when attempting to access mental health services they offered the following direct quote responses. As with the list of quotes related to identified barriers, the list of quotes is not exhaustive, but rather represents a comprehensive examination of the participants' experience of the facilitators they encountered.

Having a strong support network may not have assisted all of the participants with gaining access to professional mental health services but it did help them navigate their lives following the police encounter. In at least two cases members of the support network encouraged the participant to seek help despite the cultural stigma he was going to experience. In another instance the contact information one participant received from his close friend was the catalyst to him searching for a doctor on his own. Having a strong support network facilitated the healing process for these participants. Figure 8 shows the breakdown of all responses correlated to Facilitator Theme 1, support network.

Figure 8

Participant Defined Facilitator Theme #1 – Support Network



> Participant 1 stated, “My grandmother really helped me out a lot during that time. She is always there to help me. She listened to me and really helped talk me through some bad stuff back then.”

Participant 2 noted,

> After everything happened some extended family members fell away. They stopped talking to me, stopped coming around. But my parents and my siblings, they were there for me. If it had not been for them supporting me and encouraging me to get help I would have ended my own life. That's no exaggeration. They helped me during the worst time of my life. Without them, without me having a spiritual connection, I would not have made it.

Participant 3 responded,

> There are some people in this world who don't have any type of support network at all. They are easily targeted because people know that there's going to be no one to come and defend them. But I had my grandmother. She was in a nursing home, but she was still there for me, I wasn't alone and that helped me.

Participant 4 noted,

> There has been so much trauma that has affected Black folks for the past 10, 20 years it seems like it's almost never going to end. I started to get really depressed about what happened but I had folks around me to pull me through. I have a really good support network. I had people around that I could count on.

Participant 6 responded,

> Well, I think that family, you know, they don't know exactly how to help you. I mean they're not professionals, they don't know exactly how to help you. But they try to give you encouragement and love and advice and all those things are

> great. It still may not be all that is needed to deal with the lasting impact of such an incident but it does provide comfort.

Participant 10's reply was similar to Participant 6:

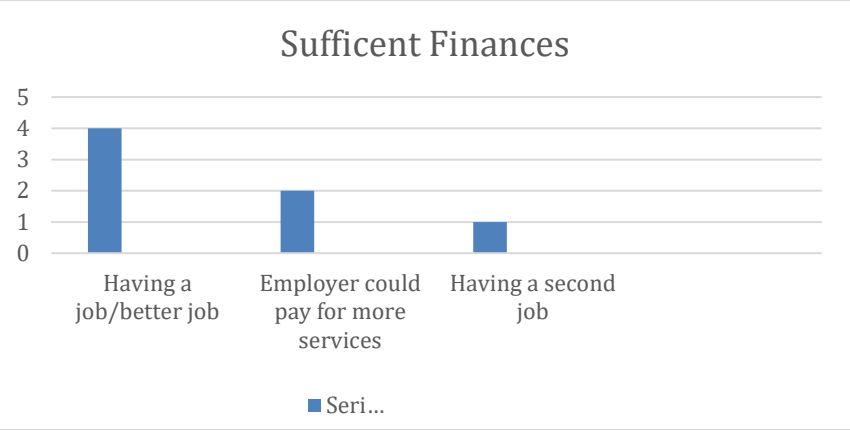
> My mom tried her best to help. I mean, she prayed for me and with me when things got really bad. I don't think the prayer really helped but at least she was there. She had some people from the church praying too. They would call to check on me and sometimes they would stop by the house. It felt good, you know, it was nice to have people think good about you. Everybody else was being mean and talking about me behind my back but some people were nice. Some people tried to help.

Theme 2: Sufficient Finances

Finances was listed as both a barrier to and a facilitator of gaining access to mental health care services. The same was true of education. The reason for this is because the lack of finances limited access for the participants while having sufficient finances would have made accessing health care easier. Whether the participant had enough money of his own or had someone in his network who had money he understood that having money would open doors for him to get the treatment he needed if he wanted to pursue it. Figure 9 captures the number of participant responses that identified sufficient financial standing as a facilitator.

Figure 9

Participant Defined Facilitator Theme #2 – Sufficient Finances



Participant 2 stated,

> Having money, having more than enough money gives you options. If I had more discretionary money at the time I would have sought treatment more diligently. Instead, I had to rely on what my employer was able to provide me with. Some people say more money means more problems. I say more money opens more doors and alleviates problems.

Participant 4 replied,

> My job offered assistance but it wasn't enough. I don't think I would have been able to cover the costs 100% out of pocket. However, if I had a better job where I made more money or had access to more money, getting treatment would have been a lot easier. Money is important no matter the situation. A lot of people have found themselves in financial trouble after a hospital stay for an accident or illness. But if they had more money they could just pay the bill and get on with life. If I had more money then I could have paid for the help I needed.

Participant 7 stated,

> You can't do anything without money. You can't buy food, you can't' get to work, you can't rent an apartment, you can't do anything. If I am sick I have to go to the free clinic so that I don't get a bill. I can't afford to get sick. If I had more money it would make my whole life easier. I could buy food, I could get a car, I could go to the doctor. Having money makes everything better.

Participant 8 noted,

> I always need money. I have a wife and four kids. I have a house note and a car note. I always need money. If I had more money back then maybe I would have found my own doctor instead of going to the company doctor but I couldn't afford it then. I could not take off more time from work either. But maybe I could have found a way to cover the bills if I had another job or something.

Participant 11 shared some of the same thoughts as Participant 8:

> Everybody seems to have money but me. Or they have people around them willing to pay for everything. I have never had enough money for anything. When the police beat me up I couldn't even go to the hospital because I didn't have any insurance or any money. The people who have money get everything. Poor people like me get nothing. Maybe if I had some money, I could have found someone to help me out.

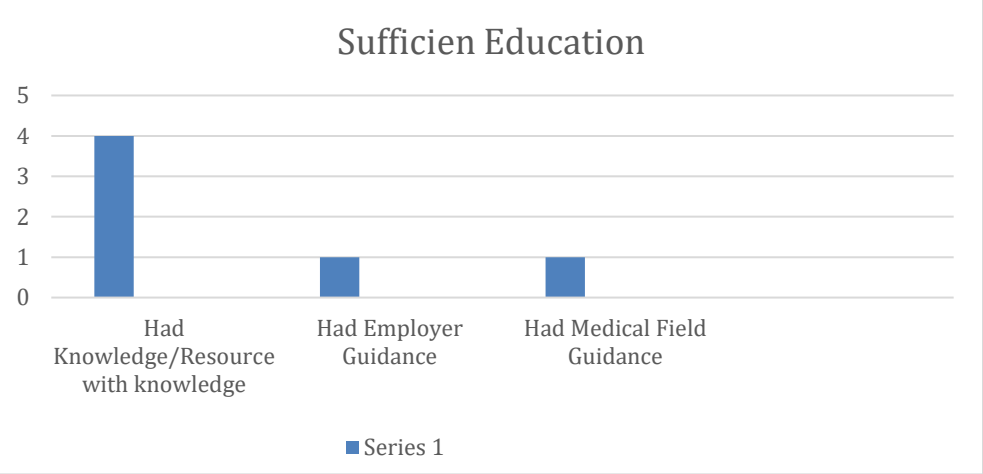
Theme 3: Sufficient Education

It is difficult to gain access to services of any kind when you have no personal knowledge and no one around you who is informed. The participants who responded that

being educated about available mental health resources or at least having someone in your network who was educated would make the process of getting help easier. Figure 10 represents the total number of participant responses indicating being educated acts as a facilitator to getting access to professional mental health services.

Figure 10

Participant Defined Facilitator Theme #3 – Sufficient Education



Participant 1 noted,

> Yes, I know where to go if I need help. I see the posters and things at the clinic when I take my grandmother to her appointments. They tell you who to call if you are feeling depressed or you feel like you might kill yourself. I never felt like I was suicidal. It's like you get mad and you have to go somewhere and calm down but I'm not going to hurt myself.

Participant 2 stated,

> I knew my job had an EAP benefit. They gave us a book during orientation that had doctor's names and contact information in it. I did reach out to set up a few appointments but it never worked out. But, to answer the question, yes, I knew where to go to get the mental help I needed.

Participant 5 replied, "My wife's been a counselor. She told me who I should call. I didn't call right away because I didn't think I needed to. But after a few weeks I did reach out."

Participant 8 stated,

> Like I said earlier, my job has an employee assistance program. They told us about it when we first got there. I knew they offered this kind of help if anybody needed it but it was only for like 3 visits. I didn't think it was enough, but at least it was something. I had somebody I could call who could try to help me. I went for 1 visit to meet the doctor and talk a little about what happened. But when I went back again she acted like she didn't believe what I was saying so I didn't go back.

Participant 10 replied,

> Most of the people around me just told me to keep praying. But there was this one lady from the church who told me that she could put me in touch with someone if I wanted to talk about what happened. I didn't get the name or number of the lady she was talking about.

Summary

In this chapter, I discussed how this general qualitative study proceeded through the steps of participant identification and selection, interviewing, coding and thematic development and the presentation of results. I correlated interview responses with the categories and themes that emerged from the data analysis phase using both a manual coding and software coding approach.

The research question I addressed was the perceptions of African American males in north Saint Louis County, Missouri, and the facilitators of and/or barriers to accessing mental health care services after experiencing a use-of-force encounter with police. The direct quotes and interpretive responses provided the data needed to answer this question. Participants shared their personal experiences with attempting to gain access to professional mental health services following the encounter. They depicted the barriers and facilitators they encountered that formed their perceptions about the process using the rich, thick, descriptive language written about by Ravitch and Carl (2016)

In Chapter 5, my interpretation of the study findings are presented. I also discuss the limitations of the study, the conclusions I drew from the results, and make recommendations for future research on this topic.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative research study was to examine the perceptions African American males in north Saint Louis County, Missouri, have regarding the facilitators of and/or barriers to accessing mental health care following a use-of-force encounter with police. Their perceptions were explored through their lived experiences related to mental health care access following a use-of-force encounter with law enforcement. The participants ranged in age from 19 to 45 years and were selected using Patton's (2015) purposeful, snowballing sampling technique. The goal of the study was to gather data sufficient to answer the central research question: What are the perceptions of Africa American males in north Saint Louis County, Missouri, about the facilitators of and/or barriers to accessing mental health care services after experiencing a use-of-force encounter with police? This research question was answered by analyzing the participant's responses to the interview questions listed in Appendix B. The interviews were conducted via phone and in person between October 5th, 2023, and December 16th, 2023. All interview sessions were audio recorded, averaging approximately 34 minutes in length.

In this chapter, I discuss my interpretation of the data that resulted from the interview session as well as the limitations of the study. Recommendations are made for possible future studies, and in the implications section, suggestions are made for local and state level government officials in north Saint Louis County, Missouri, to implement new/revised policies. These suggestions to changes in policy could improve public

mental health programs for underserved communities for African American males. The new/revised policies could work to ameliorate the oppressive issues the participants spoke about and possibly change the perceptions they have about access to professional mental health services in north Saint Louis County, Missouri.

Interpretation of the Findings

In Chapter 2, I conducted an extensive literature review of existing studies that discussed some of the facilitators of and barriers to access to mental health care for varied populations including African American men. For this study, I sought to obtain data sufficient to address the research question: What are the perceptions of Africa American males in north Saint Louis County, Missouri, about the facilitators of and/or barriers to accessing mental health care services after experiencing a use-of-force encounter with police? The data analysis conducted in Chapter 4 resulted in the emergence of five barriers to access themes and three facilitators of access themes that addressed the research question and began to fill the gap in the existing literature. In the following sections, I interpret the findings through the lens of the literature review and through the lens of the theoretical framework.

Interpretation Through the Literature Review

Barrier Theme 1: Racism

The first barrier theme discussed in the literature review was racism. Racism acted as a barrier to both mental and physical health care access with regards to racist medical policies, racism in the media, and historical racist treatment at the hands of police officers. Because racism is something that appears to be woven into the very fabric

of the United States (Combs, 2018; Hannah-Jones, et al., 2021), it was not surprising that it emerged as a barrier to access theme in this study. Participants spoke about being treated as less than human if/when they did seek treatment, and they talked extensively about being portrayed as criminals when they were victims. They viewed this disparate treatment as an outcome of racist ideologies because they were being adjudged guilty based on the color of their skin. Cooper Owens and Fett (2019), DeVylder et al. (2020), and Dukes and Gathier (2017) all conducted studies that listed racism as a barrier to health care access. In DeVylder et al.'s study, the authors wrote that racist policing underscores a personal feeling of reduced intrinsic value in minority individuals. In other words, due to a legacy of racism, it has become acceptable for police officers to treat Black people as less than human because in the eyes of society they are less than. Cooper Owens and Fett tied this discriminatory ideology to the disparate treatment of African Americans in the medical community to the time of slavery. Compared to the results of this study, it appears not much has changed since then.

Racism is more than an ideology; it is a systemic pattern of practice that seeks to subjugate African Americans to second class status. The participants in this study expressed despair and seemed to believe they would never be treated with a sense of fairness or equality in the medical field, in the media, or during interactions with police officers. They lived in a constant state of terror and felt as though being born Black was a curse. Gilmore (2020) and Smith Lee and Robinson (2019) discussed this state of constant fear in their studies, acknowledging the acceptability of a class system. The participants of this study seem to be resigned to the belief that their humanity would

never be acknowledged and that they would never rise to the status of equal with non-Black citizens.

Barrier Theme 2: Lack of Education

The second theme that emerged during the data analysis phase was lack of education. The participants seemed to be confused about where to go, who to talk to, and who to call following the use-of-force event. Nearly 50% of them did not understand that the emotions they were feeling were related to the use-of-force event. It is also possible that these participants lacked the requisite knowledge to get help because that information is sometimes withheld by mental health providers who do not seek to treat marginalized people, as McCandless and Blessett (2022) wrote in their study. Knowledge is power, and without it, these participants were not able to gain access to the mental health services they needed.

Lindsey et al. (2010) also discussed lack of education as a barrier to health care access. They wrote that having institution-based mental health programs that share information about mental illness and mental well-being are very effective in increasing treatment gains and helping families. If more information were made readily available to the participants of this study, perhaps they would have had sought the care needed early on rather than hope the situation would correct itself.

Over time, supplanting social/cultural mores with objective, data driven information about the causes of and available treatments for mental impairments could help abate the lack of education barrier. However, until the time that the gatekeeping of the required knowledge ends, lack of education about options and treatments will

continue to impede the desired access. McCandless and Blessett (2022) wrote about public administration being a field where fair and just policies should be the foundation on which a governing structure is built. The authors went on to say that in reality, due to supremacist ideologies, White people keep all the power, privilege, resources, and knowledge to themselves.

Policy makers, health care professionals, police officers, and court systems do everything within their power to withhold resources, impede access, and limit available health information. McCandless and Blesset's (2022) finding were consistent with the results of this study. Information about where to go and/or who to call when someone has experienced a traumatic event was not readily accessible for the participants in this study. Lack of access to this educational information presented as a serious barrier to accessing professional mental health services.

Barrier Theme 3: Lack of Finances

The data that resulted from the participants' responses regarding their perception of the financial limitations they experienced when they attempted to access mental health services were as homogenous as expected in comparison with the literature review in Chapter 2. Several of the participants noted the lack of finances or financial resources among the primary reasons why they did not seek care or could not maintain care of they did seek it. Lichtenstein and Weber (2016) and Planey et al. (2019) wrote about the lack of financial resources as being a serious barrier to marginalized populations receiving care for mental infirmities in their studies. When families have to make the choice between paying rent, buying groceries, and seeking mental health care treatment, they

will forgo the latter most every time. The participants in this study faced this same decision-making dilemma. More times than not, they chose to go to work rather than take time off to seek treatment because they had to make money.

Lack of available money was not the only financial barrier the participants spoke about. Sometimes it was a matter of not being able to miss time at work for therapist appointments. Participants expressed concern about working for employers that did not offer paid time off and/or would not allow them to make up time for hours missed. They were already not making enough money, so there was no way they could miss hours at work to go to an appointment. Gaskin et al. (2007) discussed the lack of employer financial support as a barrier also. These authors added the concern of not having enough money to pay for childcare as an additional financial hurdle. In situations where the employer did allow the time off, if the employee had small children and could not pay for childcare, often they could not make the appointment anyway.

Several of the participants expressed that the costs of seeing a therapist were prohibitive. In the best-case scenario, the employer allowed them to take the time off, with pay, to see a mental health professional, and they could use the company's EAP benefit so there would be no impact to their immediate financial situation. However, even then it would be a challenge because they would only be able to see the therapist for the allowable three visits and then they would be expected to pay out of pocket. Lack of financial resources including personal money and/or family members or friends to borrow from was an almost insurmountable barrier. The lack of sufficient finances and/or

finance options emerged as a serious barrier to care in this study just as it did in studies completed by Alang et al. (2017), Huber et al. (2019), and Morrison (2020).

Barrier Theme 4: Lack of Transportation

This barrier theme emerged quickly during the data analysis phase. Those participants who sought treatment as well as those who did not expressed a concern about not having reliable means of mobility. Several participants did not have a car or had a car that was in disrepair. Other participants stated their only form of mobility was public transportation and often it would not take them to their final destination. Huber et al. (2019), listed a lack of reliable transportation as a barrier to accessing health care in his study. The participants in this study could barely get to the grocery store or to work, so they did not have the capacity to try to find a ride to a mental health appointment on top of their other transportation issues.

Even if they had a car, getting to the doctor's office was a challenge due to distance. The majority of therapist offices that service this area are primarily located near regional hospitals and/or in more economically stable neighborhoods. This could be more than 10 to 20 miles for this marginalized population. Sometimes the vehicle was unreliable, and other times safety was a concern. Whatever the issue with the car may have been, the participants felt it was not worth the trouble to travel long distances to seek care for a mental issue.

Without a vehicle or access to a resource with a vehicle, many of the participants could not make it to work, to the grocery store, to church or any number of other desired locations. Trying to find a ride to a therapist office was a very low priority. Bejleri et al.

(2017) mentioned that trying to find a ride to a doctor's appointment never made the list of things to be worried about on a day-to-day basis. The same outlook held true in this study. Participants had other, more pressing things to worry about than finding transport to a mental health care appointment. What did make the list was how family and community members would stigmatize the participants for seeking mental health care in the first place.

Barrier Theme 5: Stigma

The participants voiced a fear of being labeled weak or crazy by their family members if they expressed feeling unsafe, unsure, or insecure after the police encounter. Of the 11 participants interviewed for this study, six of them talked about the fear of being thrown out of the family for being sick in the head. African Americans are taught to believe that the best way to deal with mental illness is to keep it a secret (DeVylder et al., 2020). This is also what most of the participants said they felt they had to do. Talking about feelings, trying to get help with one's mental state is frowned upon and will expose the person to ridicule not just among family members but among community members as well. The participants decided to keep quiet about their problems because the risks of admitting to a mental infirmity were too great. The fear of losing family connections overrode the need/desire to seek professional mental help.

African American males are already viewed as inherently dangerous by external social groups, police departments, and news media. The stigma associated with having a mental infirmity is not limited to being ostracized by family or friends. There are those in the church who view mental illness as a punishment from God. The belief that prayer can

heal you from all infirmities prevails in the African American community over much of the evidence that may be contrary (Lindsey et al., 2013).

Even if the participant was able to overcome the personal stigma of family, friends, and church members, he still had to be willing to face the threat of being labeled crazy and dangerous by those outside of his network, including police officers and those in the medical community, as mentioned by Fripp and Carlson (2017). Overcoming the fear of being stigmatized was not something the participants were able to do. They stayed locked in cycle of needing help but not seeking it because they feared getting professional help would make their daily lives worse.

The barrier themes presented above aligned with many of the barriers that were discussed during the literature review. Historical racism and racism in the media and the medical community as well as within police departments were listed as barriers to mental health care access by Combs (2018), Cooper Owens and Fett (2019), Planey (2019), and Menifield et al., (2018), just to name an additional few. Lack of education, lack of finances, and lack of transportation were listed as barriers in studies completed by Alang et al. (2017) and Gaskin et al. (2007). Stigma was listed as a barrier in several studies, including those by DeVylder et al. (2020) and Fripp and Carlson (2017). Barriers to mental health care access emerged quickly and frequently while facilitators of access were slower to emerge. The themes that emerged as facilitators of access to mental health care services are discussed in the next section.

Facilitator Theme 1: Support Network

The existence of a reliable support network was the first facilitator to emerge during the data analysis process. Members of the support network identified by the participants included spouses, children, siblings, grandparents, church members, friends, and sometimes coworkers. These network members played integral parts in helping the participants cope with what happened to them as well as providing guidance regarding seeking access to care. In some cases, close members of the support network, for example, spouses/significant others and parents, were the determining factors in the participant choosing to get professional mental assistance.

Participants relied on family and friends to help them navigate their new realities. They spoke about friends giving them a safe place to discuss the event as well as developing stronger relationships with those friends who shared a similar experience. While the individuals were not mental health professionals, they did play a very important role in helping the participants manage their emotions and feelings. Not only did they provide emotional support, but they helped them to face the stigma associated with getting mental health care that was prevalent in their communities. These findings were very similar to those found in studies conducted by Bauer et al. (2020), Bryant-Davis et al. (2017), and Taylor and Kuo (2019). In each of these inquiries, the authors listed having a strong support network as being one of the most impactful determinants in study participants choosing to seek professional care. In Bryant-Davis et al.'s inquiry, the authors mentioned the use of Emotional Emancipation Circles as a way to help African Americans cope with police brutality. These groups were formed for the specific purpose

of offering those who have experienced a use-of-force encounter at the hands of police a safe place to meet and talk about their experience. This is the kind of support participants of this study spoke about needing to help them move past their trauma. They needed people in their corner, giving power to their voices, and credibility to their trauma. If they had this kind of supportive network, it empowered them to seek the help they needed.

African Americans, especially African American men face a number of challenges from their own community members when it comes to seeking health care for a mental infirmity. They are told they are weak, not spiritual enough, and are an embarrassment to their elders who suffered a lot more than they did. The participants who sought professional health care talked about their spirituality providing guidance for them even when support members did not. Avent Harris et al. (2019) and Eproson (2021) conducted studies that highlighted the importance of participants being spiritually connected as a foundation of decision making. Without a support network and being spiritually connected to a higher power, it is unlikely that the participants who sought professional help would have done so. They would have opted to just press through and learn to cope with the trauma through repression and/or trauma bonding as posited by Avent Harris and Wong (2018).

Facilitator Theme 2: Sufficient Finances

Financial standing emerged as both a barrier and a facilitator to gaining access to the mental health care system based upon the participant's perceptions. Just as not having enough money proved to be an almost insurmountable obstacle to receiving professional services having sufficient enough money provided options that were previously

unavailable. Having enough money to take care of wants and needs facilitated the participant's efforts to accessing mental health care services. Studies completed by Borba, 2011; Bryant-Davis et al., 2017; Planey et al., 2019 listed being financially stable as a determinant for pursuing mental health assistance as well. The participants who had jobs that paid them enough, offered assistance, or would allow paid time off considered those benefits complimentary to seeking the care they needed when they needed it.

Having more money than what was needed made things easier. If the participants had sufficient personal finances or access to financial resources they would have been able to get the help they wanted and needed. According to Bohannon (2017) the U.S. Department of Health and Human Services (DHHS) stated the psychological distress African Americans suffer from is correlated with their income level. This finding correlated with the results of this study. Having enough money or at the very least having a resource that could help out when needed was a precursor to the participants even considering seeking professional mental health services.

Facilitator Theme 3: Sufficient Education

Education also emerged as both a barrier to and a facilitator of access to mental health care. Lack of education was an obstacle because the participants did not know where to go or who to call to get assistance. When the participants had this knowledge or had access to someone who did, education operated as a facilitator. It was easier for them to navigate the mental health care maze if they had prior knowledge of where mental health professionals were located and what services they offered. This is consistent with Weible and Sabatier (2018) who found that being connected to a person who was willing

to share health care information with those who needed it, operated as a facilitator to obtaining professional health care services. For the participants whose jobs offered EAP options, they were given this information during the orientation period. Because they knew this service was available to them and they had the contact information for mental health counselors and therapists, being educated assisted them when it came time to actually seek the help needed.

For the participants who were not employed or whose jobs did not offer EAP services and who spoke of education as a facilitator, they had other avenues to gain access to this information. Sometimes it was a family member, a neighbor, or a church member who was able to give them the information they needed. In other cases, it was a medical professional i.e., a nurse practitioner or family physician who provided access to health care information. These individuals proved to be valuable educational conduits, helping the participants sort out what information was relevant and person centered as found by Unger, Morales, De Paepe and Roland (2020). The fact that this kind of information is not readily available for anyone who might need it speaks to the unintended consequences of organizational polices at best and continued subjugation at worst. Gate-keeping this kind of knowledge creates social inequities and prevents marginalized communities from obtaining equal access to public services (McCandless & Blessett, 2022).

One of the most alarming concerns that emerged during the data analysis phase but not listed as a barrier to access, was the overwhelming sense of fear the participants felt when they encountered police. They felt any kind of interaction with police would

lead to force being used. A simple traffic stop, a noise complaint, a loitering accusation, looking suspicious, a "you fit the description" interaction could lead to a loss of life or great bodily injury.

Smith Lee and Robinson (2019) wrote that the participants in their study had this same sense of dread often stating that a run in with the police was the number one fear in their lives. This fear arose from the belief that African American lives were not worth as much as their non-Black counterparts. Participants in this study repeatedly expressed that their civil rights were regularly violated by police and there was no accountability or punishment for their actions. The daily oppression they felt was real and it kept them in a perpetual, emotionally heightened state. Being in this state could lead to significant negative, mental healthcare outcomes such as depression, anxiety, hypertension, and feelings of hopelessness and despair (McCluney, Bryant, King, & Ali, 2017; Staggers-Hakim et al., 2016). Depression, feelings of inadequacy, anger, and failure were just a few of the emotions my study participants expressed experiencing nearly every day of their lives.

Interpretation of Theoretical Alignment

The data gathered from the participant interviews when viewed through the lens of Benet's (2006, 2013) polarities of democracy theory provide support for the theory. The perceptions of the participants informs their reality. If they feel they are being treated unfairly, denied access to health care, misrepresented in the media, and stigmatized by their own communities for needing mental health care regardless of the actual matter, those beliefs are true to them. Working to overcome the oppression African American

males in north Saint Louis County, Missouri are exposed to on a daily basis could lead to the development of healthy, sustainable communities for all, which is the goal of polarities of democracy theory (Benet, 2006, 2013).

The polarity pairs that form the foundation of Benet's (2006, 2013) polarities of democracy theory, while not mentioned specifically during the interviews, did emerge through interpretation of the responses. For example, the Freedom and Authority polarity was observed during data analysis as the participants discussed feeling distressed about having their personal freedoms disregarded by those in positions of authority. They spoke about being made to feel that their words and rights did not matter because those in charge said so. Participants feel like the police are not there to protect them but rather to target them through oppressive actions that are supported by public policy. This sentiment highlights how the personal freedoms the participants believe they should enjoy are regularly denied by those in positions of authority with no recourse.

Evidence of the diversity and equality pair also emerged during the data analysis phase. For some of the same and/or closely related reasons noted under the freedom and authority pair, the participants felt the health care community disregarded their concerns due to their ethnicity and race. Their complaints about feeling depressed, overly anxious, or even suicidal landed on deaf ears because medical professionals believed they were exaggerating. One participant noted that his therapist told him that she felt he was "perhaps making things appear worse than they were to get out of work." He stated that if he had been white or maybe female his concerns would have been taken more seriously.

Participants talked about their rights being violated by the police, but they did not speak directly about access to health care being a human right. Additionally, they did not state directly that the government having an obligation to provide them with care. Nonetheless, support for the need to manage the tension between Human Rights and Communal Obligations was found through data interpretation. Citizens have rights, among them is a right to health care as argued by the UN Universal Declaration of Human Rights (1948). They give up some of the personal responsibility for protecting and preserving those rights when they agree to be governed. It stands to reason that they would then expect the governing structure to provide those rights for and to them (McCandless & Blessett, 2022).

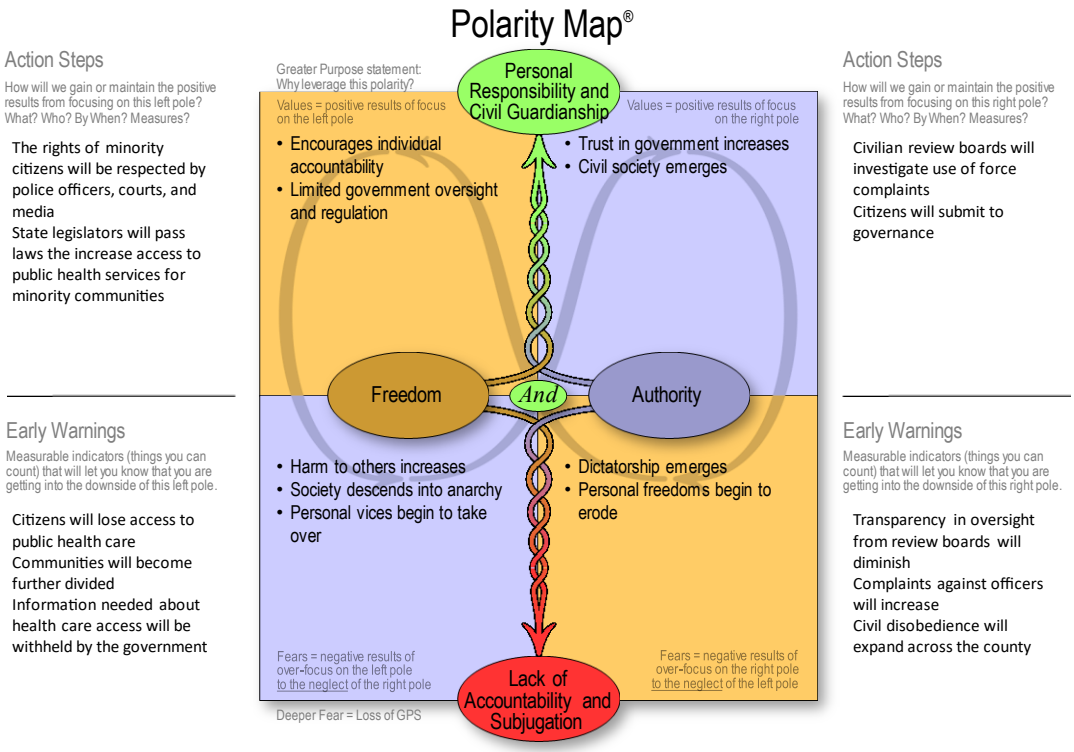
The goal of polarity management is to keep the infinity loop in the upper quadrants of the map as much as possible (Johnson, 1992). The goal of polarities of democracy, creating healthy, sustainable communities for all, is realized when the ten values identified by Benet (2006, 2013) are effectively leveraged, increasing the positive outcomes of the polarities while simultaneously minimizing the negative outcomes. For this study, participants spoke about their rights being violated. They made reference to the people in power disregarding their humanity because of the positions they held and the support those individuals received from the courts and media.

Proper management of the tension of the freedom and authority polarity could lead to individuals feeling empowered to govern their own behavior without fear of reprisal or punishment and to the preservation of a civilized communal environment as positive outcomes. Effective management could also lead to a decrease in negative

outcomes like causing others to be harmed and fostering dictatorships. Figure 11 represents this one possible set of outcomes that could be realized through effective management of the freedom and authority polarity.

Figure 11

Study Findings Presented as a Polarity Map for Freedom and Authority



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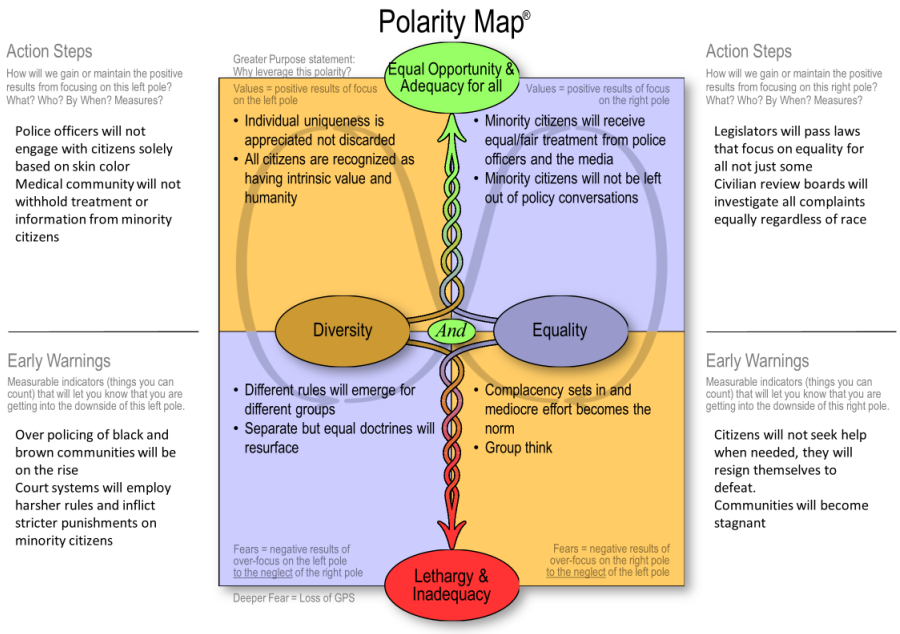
The pairs are interdependent and because of this interdependence when the tension between one pair is not being effectively managed it will negatively impact the

other pairs. The participants of this study spoke of being subjected to disparate treatment at the hands of police, in the medical community, and in the media. Their responses were interpreted to mean that the tension between the diversity and equality pair is not being properly leveraged. Proper management of the tension of that polarity could lead to an increase in positive outcomes like honoring differences and respecting individual humanity while at the same time causing a decrease in negative outcomes i.e., creating a caste system and encouraging apathy in the community. Figure 12 represents one set of possible outcomes effective management of the diversity and equality pair could look like in the future.

Figure 12

Study Findings Presented as a Polarity Map for Diversity and Equality



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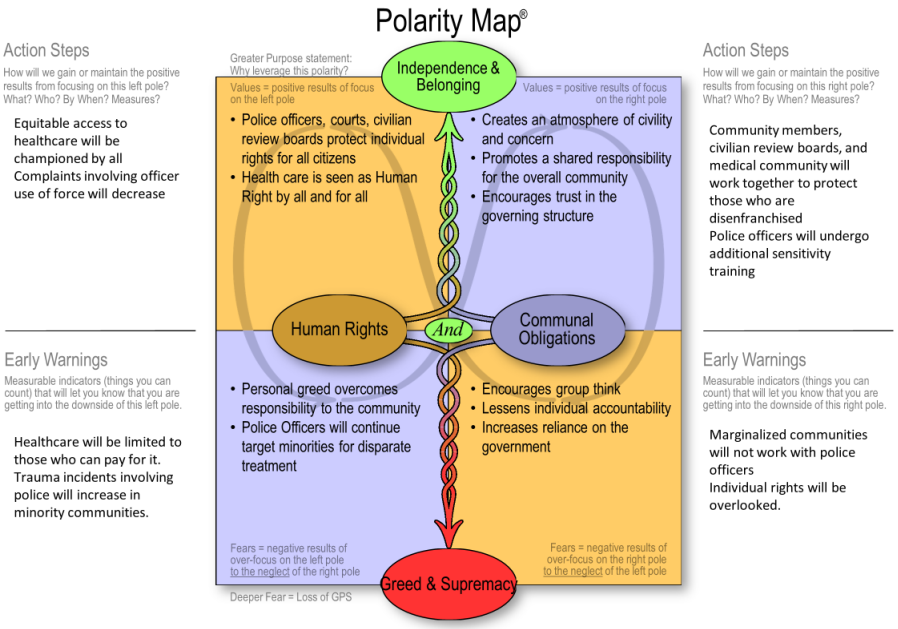
Support of a third polarity, human rights and communal obligations emerged during the data analysis. As stated earlier, Alang et al.,2017; Ford, 2020, believe that healthcare is a human right. And others i.e., Kagan, 2018; McCandless & Blessett, 2022, argue that the government has an obligation to provide rights to/for its citizens. If those two things are true then the participants of this study have a right to receive mental health care services and the governing structure in Missouri has an obligation to provide access to that care. As with the other polarities identified by Benet (2006, 2013), effective management of the polarities is not a zero-sum game. While there are no winners or losers, gains and losses will be experienced on both ends of the pole. Effective management of this polarity could lead to positive outcomes like government protecting the rights of all citizens and increased trust in the government structure in the upper quadrants and a decrease in the negative outcomes like rights being violated and unchecked government power in the lower quadrants. Figure 13 represents one possible set of outcomes that could be realized through appropriate leveraging of the human rights and communal obligations polarity.

Figure 13

Study Findings Presented as a Polarity Map for Human Rights and Communal Obligations



Note. Image reproduced with permission of Polarity Partnerships LLC and the Polarities of Democracy Institute.

Limitations

One of the possible limitations of this study first noted in chapter one was realized as probable now that the study has concluded. The data analysis is representative of a very small segment of the target population. Although the possible participant pool included African American males who resided in any of the 80 plus municipalities in north Saint Louis County, Missouri, ages 18 to 45, only 11 participants were selected to participate. Interpretation of the data was limited to the responses those 11 individuals

provided to the questions listed with the interview opening statement (Appendix B). Due to the limited number of participants in the study the results, as expected, are not generalizable to other geographical populations, other ethnicities, other ages, or other genders. However, as stated in chapter four, saturation, as defined by Guest and Bunch (2006) was achieved after seven interviews were completed. Four additional interviews were conducted after this point. In line with guidance provided by Shufutinsky (2020), the data gathered from these additional interviews bolstered the trustworthiness of the study.

The second possible limitation stated in chapter one was researcher bias. Bias was controlled using reflexive journaling as well as dialogic engagement as suggested by Ravitch and Carl (2016). Bias was also controlled in real time by repeating questions or asking for clarification during the interview process. Applying this member check method helped control bias and it helped improve the accuracy of the coding process as mentioned by Birt et al. (2016). Additionally, after the interviews were transcribed participants that requested it were provided with a copy of their interview responses and there were no questions or concerns raised about how their responses were interpreted. Bias was controlled but bias remains a study limitation for any qualitative undertaking.

The purpose of this study was to examine the perceptions of African American males, ages 18 to 45, had about the facilitators of and/or barriers to professional mental health care access following a use-of-force encounter with police. There are other inquiries along this same vein that could be undertaken for future research endeavors. Recommendations for future research studies are discussed next.

Recommendations

Eleven men were selected to take part in this study. They were selected using Patton's (2015) purposeful snowball sampling technique. The participants were asked about their personal experiences when attempting to access mental health care services following a use-of-force encounter with police. During the interview process each of the 11 participants talked about being afraid of the police. Each of them recounted being in fear for their lives both during and after the encounter. Some of their responses were outside the scope of this inquiry but are ripe for future research. Gilmore (2020) spoke about this fear and wrote that the beatings African Americans get from police officers leaves them traumatized and in fear for their very lives from that day forward. The assaults on African American males are not increasing, as some would believe, they are simply getting broadcast on a regular basis. Exploring the origin of this fear in a future study may lead to information that could increase police officer awareness/sensitivity when policing communities of color.

Another possible future research avenue would be to conduct a qualitative inquiry with African American women who are part of the familial, community, and social networks of the participants in this study. Having a good support network functioned as a facilitator for the participants when they attempted to access the mental health care system. A study that sought to examine the role African American women play in reinforcing or challenging cultural beliefs could address another gap in the literature, overcoming the stigma associated with seeking mental health care in the African American community.

A study could also be undertaken to examine the perceptions African American females have about accessing mental health care following their own use-of-force events with police officers. Menifield et al., (2018) report the cumulative impact of certain police polices in Ferguson, Missouri led to the over policing of this and other minority communities. It would stand to reason that African American females living in this geographical area would be subject to the same kind of use-of-force events as African American males. A study that sought to examine their perceptions could prove to be a worthwhile undertaking. Either of these future studies has the potential to impact the lives of African Americans in a positive and meaningful way.

Implications

Making suggestions that could affect positive social change in the lives of the targeted population was one of the desired outcomes for this study. More specifically, and in line with Benet's (2006) theory, helping African American men in north Saint Louis County, Missouri, overcome the oppression they are under could have a transformative effect on their mental well-being. Individuals that are mentally healthy show up in society able and prepared to do their part to contribute to the success of their community (Shafritz, Ott, & Yang, 2016). Sharing the study results with local and state legislators in Missouri could help them make more informed decisions that lead to the desired results of policies instead of more unintended consequences.

For example, Missourians voted to expand Medicaid coverage for some 250 thousand plus citizens in 2020. The expansion was achieved in spite of Missouri legislators fighting against the initiative. Voters gathered signatures, lobbied their

representatives, and showed up at the state capital to argue their case. These actions showed Missouri legislators that voters will not stand for their voices being ignored. Now that the politicians are more attuned to what their citizens actually want, these study results can be used to inform them about the perceptions African Americans males in north Saint Louis County have about their ability to access mental health services in the area.

The participants expressed great concern about not having sufficient finances to receive the mental healthcare they needed. Legislators have a prime opportunity to address this issue by expanding Medicaid coverage once again. With the most recent expansion Medicaid now covers individuals making less than $18,000 per year, families of four making less than $37,000 a year but still does not offer any kind of mental health treatment (Centers for Medicare & Medicaid Services, 2021). Expanding the Medicaid program again to include mental health care coverage addresses the lack of sufficient finances barrier and it effectively leverages the Human Rights and Communal Obligations polarity (Benet, 2006, 2013). Each Missouri citizen who qualifies, would be afforded equal access to professional mental health care services regardless of his/her ability to pay.

The study data also strongly suggests that Missouri legislators need to address the lack of mental health care locations and provider options. A majority of the medical offices that offer mental health care services are located in neighborhoods that are too far away for participants to travel to. Even in cases where they knew they needed help and had finances to pay for treatment, the offices offering treatment were twenty to thirty

miles away. To help abate this problem state legislators could lobby federal officials to approve and then expand upon *H.Res.639*.

This resolution was introduced in the House of Representatives on August 1, 2023. It calls for an increased awareness of the mental health crises that exist in minority communities. The resolution speaks to lack of education, insufficient local provider locations, and stigma among the primary reasons as to why minority populations are not seeking the mental care services they need. The resolution calls for the federal government to increase access to mental health care by allocating federal resources and increasing state funding.

State legislators that represent the 1st, 2nd, 73rd and 74th districts in Missouri could make it a priority to contact the federal representatives for the state and voice their support for this resolution. They could lobby the federally elected senators to approve the resolution and to appropriate as much funding as possible to establish local mental health programs and build mental health facilities within their districts. Increasing mental health awareness is important but it only goes so far. Monies must be made available to mental health facilities within the communities that need the services the most.

Constructing new clinics may not be feasible due to costs and time constraints but in the alternative state legislators could allocate money from the resolution to offer mental health services within local police departments. More than 70 of the 80 sovereign communities in north Saint Louis County have their own police departments. Funds from the resolution could be earmarked for the sole purpose of hiring mental health therapists and/or counselors to run the new departments. The close proximity of these professionals

would help overcome the barrier of mental health assistance being out of reach for those who need it.

The participants in this study spoke frequently about their civil rights being violated by police officers who seemed to operate with impunity. One way to combat this kind of unwarranted behavior would be to create civilian oversight boards that had the power to discipline or at least recommend discipline of an officer's license for repeated violations. Civilian review boards have been established in Saint Louis city but have been met with opposition in Saint Louis County.

After the death of Michael Brown in Ferguson, Missouri, the Department of Justice conducted an audit of the police department and the local municipal court. The results were alarming and called for immediate changes to policy and ongoing monitoring of the entire department. Legislators in Missouri could use the information that came out of that report to garner support for the establishment of civilian review boards in Saint Louis County. State officials could also use the results of a study completed by McMillan et al. (2023) to bolster the argument for the need to establish civilian review boards. These authors undertook an inquiry that examined one of the six pillars necessary for effective community policing as identified in the *21st Century Policing Report* from 2015. That pillar is Policy and Oversight.

In the study conducted by McMillan et al. (2023) the authors worked with the Polarities of Democracy Institute and the National Organization for Black Law Enforcement Executives (NOBLE) to examine the strategies recommended in the report through the lens of the polarities of democracy theory. The analysis found the strategies

were aligned with the values identified in the theory. Further, authors McMillan et al. (2023) identified specific strategies geared towards the particular polarities connected to law enforcement and civilian oversight. This study offers objective data secured from surveys completed by law enforcement officials indicating the need for and support of civilian oversight and review boards.

The data from this study and the analysis conducted by McMillan et al. (2023) firmly suggests that police officers need more training, oversight, and accountability. Establishing community review boards in north Saint Louis County directly addresses the concern of consistent civil rights violations mentioned by the participants in this inquiry. Police departments that come under the watchful eye of public oversight boards may be less inclined to turn a blind eye to officers who target citizens for disparate or abusive treatment.

The public transport system in this area, known as Metro, does offer bus service, private pick up, and light rail options but if you can't get to the pickup spots or don't have the money to pay for transport, none of these options are viable. During the last 15 years, Metro removed several bus stop locations in north Saint Louis County due to residential decline and decreased demand. As a result of the eliminated bus routes, the residents of these communities sometimes have to walk up to a half mile to catch a bus.

To alleviate the lack of transportation barrier, Missouri legislators could incentivize the Metro transit system to offer free or reduced transportation for community members residing in the most impoverished parts of north Saint Louis County. This could be done by offering the transit system tax abatements or by giving the entity tax credits.

If Metro is allowed to allay its tax obligations to the state for 10 or more years it could use that money to purchase more vans, buses, and bus passes. When Metro discontinued bus service for a large portion of Saint Louis County residents it seriously limited the mobility options of neighborhoods that had already been disenfranchised. Increasing bus service and providing free bus passes to those in need could help individuals who need mental health services make it to those appointments.

The lack of publicly available information related to mental health care services is something that could be relatively easy for policymakers to address. Legislators have line items within their budget denoted as unallocated funds. They could use this money to build a marketing team that would develop and distribute information about mental health care services to communities in their districts. The campaign could include information about providers including where they are located, treatment options offered, and contact information. It would not take much to have flyers and posters printed with this same information and to have those materials conspicuously posted in local health clinics, dentist offices, and even local churches. State officials could also work with social workers assigned to the local Family Support Offices, to get this information into the hands of their clients who they know need this kind of professional, mental health services.

If state legislators do not want to use unallocated funds for this purpose, they also have the option of introducing new legislation that addresses the lack of publicly available information much like S.2423. This bill was introduced by the Senate in July 2023. It calls for the creation of a digital advertising platform that specifically focuses on

mental and behavioral health resources. We live in the age of technology where most of what we consume comes to us through the internet. Missouri legislators could implement policies that disseminate mental health resource information like they disseminate election related material.

These recommendations do not guarantee the perceptions of African American males who have experienced a use-of-force event with police will change but they at least provide a starting point for worthwhile debate. Citizens in Missouri are mentally suffering, and they are not getting the professional mental health services they need. They have agreed to be governed as part of a civilized community, but their government is failing to take care of their needs and protect their rights. Missouri legislators at both the local and state level have an opportunity to help their citizens overcome the oppression they are under by implementing the recommendations listed above. Implementing these suggestions could be the first step in establishing a healthy, sustainable north county community.

Conclusions

This study represents an extension of the current body of research on the topic of facilitators of and barriers to mental health care access for African Americans; and it provides an increased understanding of the perceptions they have about health care access in the state of Missouri. Addressing the barriers that emerged as themes in this study may help not only African Americans but may also have a positive impact on the larger audience. Healthy, happy individuals tend to show up as their authentic selves ready, willing, and able to contribute to the overall success of their families, churches, and

communities. When the system works as it should everyone benefits from its overall production.

Positive social change can be achieved not only for the participant population identified in this study but for Missouri citizens at large. Equity is not a zero-sum concept, there is enough for all Missouri citizens to have sufficiency of rights, including health care. A win-win scenario can be realized if all parties work together to shift from either/or thinking to both/and thinking. Advancement for some does not mean that others will be set back.

Missouri legislators could improve their current law-making process by utilizing Benet's (2006, 2013, 2022) polarities of democracy theory. If the goal of government is to preserve and protect the rights of the governed, as McCandless and Blessett (2022) posit, using the theory as a guidepost could help governing bodies identify and work to alleviate oppressive policies. Creating sustainable, healthy communities can be achieved when oppression is eliminated.

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Appendix A: Interview Protocol

Once the interview has been scheduled I will find an interview location suitable for my purposes. The location will be private/semi-private, free from distraction, safe, easy to find and access, and will have the necessary technology required.

I will notify the participant where the interview is to take place.

Before his arrival I will (following a written script and using Patton's (2015) guide;

Create a safe, private space

Greet the participant respectfully

Go over any housekeeping items

Explain, again the purpose of the interview

Verify informed consent was returned to me via email.

Ask for permission to audio/video record the session

I intend to conduct these interviews in person whenever possible. I am choosing this approach because in person interviews allow for synchronous questions and responses (Opdenakker, 2006). In person interviews will allow for me to pick up on non-verbal cues that could indicate the participant is under stress or perhaps not being truthful (Novick, 2008). In person interviews also allow for rapport to be established, lessens the chance for data loss or disruption, and maintains contextual data related to environment and physical features (Novick, 2008). Face to face interviews do not have the disadvantage of requiring multiple contacts thereby decreasing the time commitment on the part of the interviewer and the participant (Meho, 2006).

Appendix B: Opening Interview Statement and Interview Questions

Thank you for agreeing to be interviewed. I appreciate your time and look forward to hearing your story. Again, this interview is being conducted as part of the program requirements in my pursuit of a PhD at Walden University. I have about twelve questions to ask you, centered around your experience with law enforcement and their use of force and your subsequent efforts, if any, to seek mental health treatment. Out of respect for your time I am going to be using an interview guide to pace the interview so that time and effort are not wasted. Please know that you may take as much time as you need to answer questions and that you are free to circle back to questions or even skip questions if you desire. You may take breaks if you need to and please be mindful that this interview is completely voluntary. You are free to stop the interview and leave at any time. I would like to ask your permission to record this session. Do you have any questions before we begin? Let us begin.

- Conduct the interview, using the follow questions from the interview guide
    - Tell me a little about your background.
    - Paint the picture for me, of the events that led up to your encounter with the police.
    - Share with me, as much as you feel comfortable, what was going through your mind when you realized the encounter was escalating?
    - How did the encounter come to an end?
    - How did you feel immediately after the encounter ended?
    - What feelings have you had about the experience in the past few months?

- Tell me about an average day in your life prior to the encounter.
- Tell me about an average day in your life since the encounter.
- Comparing and contrasting the two days, share with me the similarities and differences between the two.
- How has your health…mental, physical, or emotional been affected by the encounter?
- Describe, in your own words, what you think mental trauma looks like.
- Looking back on the experience and thinking about your mental health today, do you believe you were traumatized?
- Did you seek mental health treatment after the counter?
    - Why or why not?
- If you did seek mental health treatment describe for me the barriers you encountered as well as anything you experienced that helped you get access to the services needed.
- Tell me about the role, if any, your family played in helping you cope with the aftermath of the encounter.
- Is there anything else you want to share with me?

Concluding/Closing statement

I would like to thank you again for your time. I sincerely appreciate you sharing your experience with me. I will take all steps necessary to keep your information confidential and to keep your identity concealed. I will store the audio, video, my notes, and any other correspondence that could lead to your identity in a secure, locked location.

When I finish my report any data that could lead to you being identified will be deleted from all reports and shared documents. No one, including faculty and staff at Walden University will know who you are. I will share the sections of my analysis that reflect your story with you, to make certain that what I have written is accurate. If you find something is not accurate, I will correct it. Again, thank you for your time. It is my sincere hope that by sharing your story with policy makers and administrators' changes can be made to our health care system that would make it easier for minority members of our society to gain access. Here is my contact information if you need to reach me before the analysis is complete.