Understanding Mental Health Perceptions and the Impact of Stigma on Accessing Behavioral Health Services:

An Evaluation with Hillsborough County

January, 2023

AUTHORS

Tampa Bay Thrives

Carrie Zeisse, MBA, President & CEO
Daniel Mineo, BS, Program Director

USF Mental Health Law & Policy Evaluation Team

Kathleen Moore, PhD
Bonnie Brown, PhD
Emilie Ellenberg, MA, LMHC
Melissa Carlson, BS
Amy Morehead

UNIVERSITY of SOUTH FLORIDA
College of Behavioral & Community Sciences

Tampa Bay THRIVES
A MENTAL WELLNESS COALITION

Hillsborough County
BOCC APPROVED
Funded by the American Rescue Plan

Contents

Appendix

Hillsborough County
BOCC APPROVED
Funded by the American Rescue Plan

UNIVERSITY of SOUTH FLORIDA
College of Behavioral & Community Sciences
Department of Mental Health Law & Policy

Tampa Bay THRIVES
A MENTAL WELLNESS COALITION

Understanding Mental Health Perceptions and the Impact of Stigma on Accessing Behavioral Health Services:
An Evaluation with Hillsborough County

Introduction

Background

In a time when behavioral health issues are reaching an all-time high, it is critical that there are approaches in place to maximize positive behavioral health outcomes. To do so, we must first recognize behaviors and systems that promote and discourage individuals from utilizing behavioral healthcare. Behaviors that promote and deter individuals from accessing behavioral health services have been widely studied (Pinedo & Villatoro, 2020; Scafe et al., 2021; Song et al., 2021; Stewart et al., 2018) with mixed results. Routinely, though, findings suggest that race/ethnicity (Garverich et al., 2021; Pinedo & Villatoro, 2020) and logistical barriers are paramount in deterring individuals from seeking services. In addition, Hispanic and Black community members are less likely to utilize behavioral health services (Garverich et al., 2021). They are more prone to health disparities resulting in logistic barriers such as insurance coverage or lack thereof (Scafe et al., 2021), transportation (Stewart et al., 2018), and financial hardship (Song et al., 2021).

Of equal importance are potential service recipients' perceptions of mental health, the perceived need for treatment (Pinedo & Villatoro, 2020), and the impact of stigma (Garverich et al., 2021; Wijeratne et al., 2021). Defined as internalized belief systems that result in judgment, discrimination, and discouragement of treatment-seeking behaviors, mental health stigma operates throughout society and can be transferred by health professionals, media, and can be passed down through family systems (Ahmedani, 2011). Schnyder and colleagues (2017) completed a meta-analysis of the impact of stigma on help-seeking behaviors. They demonstrated that self- and public stigma have routinely been found to deter an individual from accessing services. It has even been found that public stigma, which is considered the stigmatized perception that society may make of one seeking services for their mental health, can influence and lead to the development of self-stigma, defined as internalizing or self-labeling for seeking mental health services (Vogel et al., 2013). This finding speaks to the consistency in the literature on the need to destigmatize mental health as a primary goal for improving behavioral health outcomes and service utilization. To destigmatize successfully, we must understand the community's perspective of potential service recipients.

Focus groups are a new aspect of treatment research utilized in behavioral health situations relative to existing forms of treatment and therapy. Originating for business and marketing strategies, the idea of focus groups was altered to fit social science issues (Morgan, 1996). Although there is not much research regarding whether the use of focus groups leads to positive change in behavioral health outcomes, the existing literature is promising, particularly on counseling and psychotherapy implementation research (Luke & Goodrich, 2019). A strength of focus group data collection is the nature of how the data is gathered. Rather than a researcher prompting questions to an individual participant, focus groups promote communication among participants, which allows and encourages the exchange of ideas, question asking, reinforcement of ideas, and productive disagreement (Kitzinger, 1995). This type of dialogue allows a breadth of understanding that is rich and more closely aligned with the community perspective.

Conducting focus groups assists behavioral healthcare providers in understanding the positives and negatives associated with behavioral health treatment (Lester & England, 2006; van den Toren et al., 2020). Bronwyn and colleagues (2019) discuss how clients receiving substance use treatment perceive outcomes related to their treatment experiences. Treatment components essential to clients' perceptions of positive outcomes could be adapted into treatment if not already present. Barriers regarding access to care and satisfaction levels of services for clients can also be addressed with focus groups (Ewart et al., 2016). Some individuals do not know where to start when seeking assistance for a mental health issue or substance use disorder, and focus groups encourage them to realize that they are not alone in what they are experiencing (Axelsson et al., 2020; Lester & England, 2006). Implementing focus groups can uncover the issues that need to be addressed by hearing the community's experiences. Doing so will also contribute to gaps within the literature and assess how focus groups lead to changes in behavioral health outcomes.

Tampa Bay Thrives

Tampa Bay Thrives is a diverse cross-sector coalition led by a board of community members from the public and private sectors to improve mental health in the Tampa Bay area. The organization was founded in 2019 by leaders who sought an innovative approach to improving mental health in our community. The organization receives ongoing support and commitment from local organizations and community leaders. The mission of Tampa Bay Thrives is to *"mobilize the community to strengthen behavioral health outcomes for depression, anxiety, and substance use disorder, focusing on improving early intervention, access, and awareness."* The mission helps drive their three primary areas of focus: (1) improve navigation of available resources, (2) increase access to behavioral health short-term counseling, and (3) decrease stigma through public awareness.

Tampa Bay Thrives is working to improve the navigation of available resources by enabling community members to seek services and resources to support them, with the assistance of the organization's online program titled *"Let's Talk,"* first launched as a pilot program in Hillsborough County during the summer of 2021. The program aims to help community members navigate the complex system of support while offering a free, confidential, 24/7 behavioral health support call center. The *Let's Talk* lines connect callers with trained counselors that provide emotional support, information, and referrals. These referrals are to service agencies with licensed clinicians who can help people begin their journey to better mental health and overall emotional wellness. While this program began in Hillsborough County, it is now available for all residents, ages 17 and older, that reside in both Hillsborough and Pasco Counties.

In 2022, Hillsborough County committed to prioritizing the mental well-being of its citizens by allocating financial resources to meet the community's needs. The County earmarked nearly 2 million dollars over two years to support efforts to improve mental and behavioral health access and resources. Tampa Bay Thrives was a recipient of this financial support and plans to utilize it for its *Let's Talk* program support line, which includes marketing, advertising, research, and program evaluation. Lastly, funding will be used to offer short-term bridge counseling sessions as part of the increased access program, announced in May 2022.

Current Project

As part of Tampa Bay Thrives' commitment to accommodating community needs, it embarked on an exploratory research evaluation to gain insight into the perceptions of mental health and behavioral health needs among its community members. The organization partnered with the University of South Florida's (USF) College of Behavioral and Community Sciences (CBCS) Department of Mental Health Law & Policy (MHLP). Tampa Bay Thrives and the USF evaluation team collected qualitative data by conducting six focus groups with a cross-sector of Hillsborough County residents. The funding for this project was provided by the Hillsborough County Government as part of their allocation of funding from the American Rescue Plan Act (ARPA). The primary goal of the ARPA support is to provide multi-purpose strategies for Hillsborough County residents impacted by COVID-19 and to strengthen behavioral health outcomes for depression, anxiety, and substance use disorder, focusing on improving early intervention, access, and awareness. In addition, the following objectives were addressed during the focus groups: (1) assessment of individual perspectives of mental health and stigma, (2) assessment of how stigma may or may not be a barrier to accessing local resources and services for a behavioral health diagnosis (e.g., depression, anxiety, and substance use disorders), (3) how to destigmatize mental illness, and (4) challenges and positive experiences related to accessing behavioral healthcare within the Hillsborough County community. *Focus group protocol questions are provided in Appendix A.*

Methodology

Project Procedures

Six focus groups were conducted across Hillsborough County between September and November 2022. Tampa Bay Thrives was responsible for recruiting all focus group participants and communicating with willing hosting locations. In addition, recruitment flyers were distributed to target special populations such as social service recipients, young adults, and working professionals. Each focus group lasted between 60 and 90 minutes, and all six focus groups were audio recorded for accurate transcription. Focus group participants were allowed to participate in one focus group. They were compensated with a $25.00 Walmart gift card for their participation, which was paid immediately upon completion of the focus group.

Non-identifiable demographic information was also collected, such as age, zip code, gender, race/ethnicity, sexual orientation, level of education, and experience with seeking behavioral health services for self or others within Hillsborough County. *Demographic survey questions are provided in Appendix B.*

Focus Group Locations

The six focus groups were held at various locations throughout Hillsborough County. These sites were selected because of their ability and willingness to accommodate and host a focus group. In addition, locations were chosen for convenient access to participants, minimizing logistical barriers for participants and increasing attendance.

Two of the focus groups were held on higher education campuses. One of which is home to a large, public research university that is a member of the State of Florida University System. That focus group was comprised of undergraduate students. The other higher education campus is a private four-year and considered medium-sized university, with all focus group participants identifying as undergraduate college athletes.

The remaining four focus groups were held at non-profit, service, or resource-providing organizations throughout Hillsborough. These four community-based focus groups were purposely held at these locations due to accessibility and the diverse demographic of possible participants. These locations also allowed recipients of services and resources to participate alongside service providers. These locations offer various services, which may include but are not limited to: (1) comprehensive services for at-risk and homeless families in underserved and impoverished neighborhoods, (2) resource referral and connections centers for families in need, and (3) providing services and resources that assist children and strengthening families.

Qualitative Data Methodology

Each focus group discussion was led by a skilled moderator and was held in a positive atmosphere that allowed for anonymity and minimal distractions. Although a moderator led each group, all focus groups were accompanied by trained qualitative researchers, who documented field notes and collected demographic information. The focus group protocol questions were relayed in an open-ended format to encourage the participants to freely share their beliefs, attitudes, and experiences. All present researchers were active in the discussions but remained cautious not to steer the conversation or offer personal input.

The research team relied on an inductive approach to conduct data analysis. This method was chosen because it highlights similarities and differences in people's thoughts, feelings, and lived experiences. Each focus group was audio recorded, and the recordings were transcribed using a transcription service and uploaded for coding. Coding was conducted using ATLAS ti 9th edition, a web-based qualitative data analysis software. Each focus group transcription was coded separately. Codes were initially created around the central aims of the project and then refined to best suit the data as it organically unfolded. The codes were written and defined in agreement by two trained qualitative researchers, and the first transcription was coded in tandem and compared to ensure inter-rater reliability.

Findings

Participant Demographic Characteristics

Table 1 details the demographic characteristics of 63 participants. The mean age was 30.4 years, with the majority between 18 to 24 years of age (ranging from 18 to 60). Most participants were female (92%), with a lower percentage of male participants (6%). Most participants were White Caucasian (65%), with 25% Black African-American and almost a third (18%) reporting Hispanic ethnicity. Most participants reported that they are straight/heterosexual (86%), with 5% reporting being gay/lesbian/homosexual. Almost all participants (98%) did graduate high school, with 40% completing some college, 29% reporting either an Associate's or a Bachelor's degree, and 16% reporting a Master's degree. Most participants reported that they did not seek behavioral health services (59%) or helped a friend seek out behavioral health services (56%). As presented in the map of Hillsborough County, participants lived in various zip codes, with the top five including 33606 (29%), 33610 (4%), 33613 (4%), 33614 (4%), and 33637 (4%).

Table 1. Participant Demographic Characteristics (N=63)

Characteristic	N	% or Mean
Age (years)		**30.4**
18-24	28	41%
25-34	15	24%
35-44	8	13%
45+	12	19%
Gender		
Male	4	6%
Female	59	92%
Non-binary	1	2%
Race		
White/Caucasian	41	65%
Black/African-American	16	25%
Multi-racial	1	2%
Other	5	8%
Ethnicity		
Hispanic/Latino	11	18%
Non-Hispanic	47	75%
Missing	5	8%
Sexual Orientation		
Straight/Heterosexual	54	86%
Lesbian/Gay/Homosexual	3	5%
Bisexual	2	3%
Pansexual	1	2%
Prefer not to answer	3	5%
Level of Education		
Less than high school diploma	1	2%
High school diploma/GED	8	13%
Some college	25	40%
Technical degree	1	2%
AA/BA degree	18	29%
MA/PhD degree	10	16%
Sought BH Services (Self)		
Yes	24	38%
No	37	59%
Missing	2	3%
Sought BH Services (Someone Else)		
Yes	24	38%
No	35	56%
Missing	4	6%
Zip Code		
Hillsborough County	60	95%
Out of Hillsborough County	2	3%
Missing	1	1%

Figure 1. Hillsborough County Zip Codes

Focus Group Findings

The findings for this project were divided into two sectors based on participant demographics. The first sector comprises college students, comprising two focus groups at local universities. The second sector contained working adults, comprised of four focus groups within the Hillsborough County community. Both sectors had a similar number of participants (N=30 and N=33, respectively), and the division of the two sectors allowed the evaluation team to examine similarities and differences. Once the data was coded, the results were filtered through the study's specific aims, and three primary themes emerged. The major themes are supported by sub-themes, and appropriate quotes were chosen to illustrate each sub-theme.

Adult Community Members

Perceptions of Mental Health. This theme consisted of what participants believed to be the definition of mental health, examples of specific diagnoses, and adjectives they associate with the words "mental health." Examples of this included:

> *"anxiety, depression, crazy, trauma, crisis, homelessness and suicide"*

Participants' perceptions also included feelings they associated with their understanding of mental health, in both a positive and negative light, such as

> *"sad, hopeless, overwhelming, a battle, blame, broken."*

While others used words like:

> *"personal well-being, overcoming something, empowerment, and compassion."*

Overall, there were more than twice as many negative words associated with mental health than positive ones. Reinforced by fellow members of the group, one participant shared that while we do speak more about mental health as a community, we're not capturing the entirety of the concept:

> *"And yes, we talk about mental health, but we wanna compartmentalize it. We wanna keep it in a bottle, we wanna put it on a shelf and we wanna find a solution for it. Counseling medication, great. That's not what we're talking about. Mental health is so much more..."*

Echoed by many participants was the understanding that an individual's definition, views, and associated words with mental health would vary depending on one's background, culture, age, and experiences. A perception shared by many participants was the idea that under the umbrella of mental health lay varying levels of severity based on a person's symptoms or diagnosis. There was a collective perception that some diagnoses or symptoms were considered more intense and warranted different responses and considerations. In contrast, others were little more than one's feelings or a temporary state of being. A quote that illuminated this from a participant was:

> *"I suppose it depends on the condition, I feel like we characterize people who are depressed, as lazy, unhygienic, don't really care about things, but you might perceive somebody who has schizophrenia as scary or dangerous, so make judgments based off of the diagnosis maybe."*

Perceptions of Stigma. This theme revolved around labeling and classifying an individual based on symptoms or diagnosis. Participants note that diagnoses related to anxiety are more accepted, and less judged, while depression is often associated with being *"lazy"* and schizophrenia is associated with being *"crazy," "scary,"* and much more likely to be considered dangerous. The general feelings associated with stigma were negative and centered around false information or stereotypes. Responsibility of the person was mentioned by participants in an indirect fashion, noting that individuals with mental illness are found *"blaming it on other things"* and needing *"to stay on the right track."* Many participants repeated that they perceived stigma as a judgment or fear of a person based on their specific symptoms or given diagnosis. For instance, the perception that individuals with specific mental health diagnoses are "dangerous" or "unstable." A quote from a participant that articulates this sentiment is:

> *"I mean, I think stigma is associated with labels. It can also be associated with fear. It prevents people from maybe speaking out or talk or moving forward or admitting to something."*

Access to Care. There was a clear delineation among working adults between their reasons for not seeking treatment and the logistical barriers that prevented them from seeking treatment. Their reasons for not seeking treatment involved personal feelings, such as needing to be *"vulnerable,"* attitudes, beliefs, or the repercussions they feared might occur due to their seeking treatment. Lastly, their previous lived experiences or cultural and generational influences played into their reasons for seeking or not seeking treatment. An example of a lived experience that ultimately became a fear in seeking treatment was shared when a participant explained that *"every time I say I'm struggling I get Baker Acted."* She explained how this response conditioned her to fear disclosure, so she went years without seeking treatment. Another shared example was when a participant expressed that she feared disclosing her symptoms of depression for fear that her children might be removed from her care.

In addition to the concern of physical repercussions or restrictions that might follow disclosing personal symptoms or a desire to seek help, participants worried about the public and institutional stigma, particularly the shame or embarrassment accompanying seeking treatment or services. A quote shared by a participant that explained she was a single mom and worried about how her family and friends might perceive her if she sought services for her symptoms said:

> *"Because what are they gonna look at me like I can't raise my child. You know? I, I was even in fear of like my child being taken from me by emitting that I am suffering mentally again. There's that fear. That's what I was gonna say of the system taking my children because I'm emitting that I am mentally just suffering."*

Besides the participants' shared lived experiences, cultural and generational differences also influenced their treatment-seeking attitudes and behaviors:

> *"And a lot of the time, with me, I had this stigma when I was growing up, and background, culture, I wasn't really around to kind of express to others how I was feeling when I was going through something or whatever the case may be, and so I would just kind of hold that in. When I grew older, to a certain point in age, I used to think, "What's the point of talking to a counselor? What do I need them for?" I would just assume from that stigma from what I was being told, that, "Oh, they just want in your business. They just want to know," and it's like would you receive help, would you receive the advocacy that you're looking for if you express how you're feeling?"*

Another example, one participant shared that when she talked to her family about her emotional struggles and the stress after having two children within two years, her mother and aunts expressed to her that the women for generations before her had learned to cope and that she needed to do the same. They dismissed her pleases for help and instead made her feel weak or inadequate for not being *"as strong as they were."* Another example shared was:

> *"I also think that it's also a culture thing as well that, like the young lady was saying, you know, men are taught to be macho, not emotional. Where we as women, we're seen as the*

> *emotional ones. You know, the ones that we can open up a little men. And I also think that because men are taught that showing emotion is weak, don't be vulnerable. That they suffer just as much as we do. But I feel like we're more open to opening up about it versus them."*

Participants expressed there was a difference between *"their reasons and their barriers,"* the reasons denoted a level of choice or personal decision-making, while barriers were imposed upon them and created by people as hurdles that were outside of their control. When describing their barriers, they provided specific examples that stood in their way when seeking treatment or receiving the services they desired. Examples ranged from insurance coverage issues to time, transportation, and feasibility. One participant stated:

> *"So time is another big problem. Uh, a lot of doctors or you know, therapists or people you can see for behavioral health are open when you're working and that makes it difficult."* Another participant said, *"finding a provider that speaks Spanish has been a big challenge."*

The logistical barriers shared by participants were stated with a sentiment of frustration or confusion. Many seemed to be less sharing their experiences and more venting about the never-ending obstacles they have faced while trying to access treatment or acquire services for a loved one. Some participants discussed how they had found workarounds for "the system," while others shared people, online outlets, or agencies that assisted them. Several participants expressed that the barriers proved too overwhelming or impossible to remedy and abandoned their search for treatment altogether. A few quotes that speak to this are:

> *"Cause I went through my, my insurance company so I'm sure it's different, for like whatever website you're on. But like I just found it extremely overwhelming. Like trying to narrow it down to what I feel like I would match well with,"* or

> *"Everything I pay is out of network and I get my, you know, $2,000 back a year, you know, out of countless thousands that, you know, I throw at it. It's just painful,"* and

> *"Yeah, they're, I mean, finances can be huge barrier. A huge barrier."*

Young Adults / Students

Perceptions of Mental Health. These participants' perceptions of mental health and stigma are markedly less negative. Participants overwhelmingly shared their perception that the stigma around mental health is improving and had open-minded views of mental health, often seeing it as something that all people have. When asked to define mental health, many participants shared diagnoses such as *"anxiety"* or *"depression."* Additionally, they shared the propensity for *"student-athletes"* to struggle with mental health symptoms due to the pressures they're often under and expect to be physically and mentally strong. Notably, student perceptions of mental health included mental well-being significantly more than their adult participant counterparts referring to *"mental hygiene"* that *"needs upkeep."*

Often participants shared how they openly converse amongst themselves and their trusted peers about their mental well-being – both for mental health upkeep and maintenance as well as for mental health difficulties. For example, one participant shared her view on a friend openly utilizing social media to express her journey with depression symptomology and treatment:

> *"She's very open about it and she always has been since I've known her and took like she was always telling people I don't care of me, I take medication… to make sure that people knew somebody was doing it and that I saw her doing that and I didn't think of her [any] less, I actually felt more of her opening up about it and so that made me want say it cause I'm like you never know who needs to hear that so that's awesome."*

Perceptions of Stigma. Throughout the student participant focus groups, the sentiment was routinely shared that it is safe to share their mental health struggles with friends and peers, noting empathy toward those who struggle with their mental health, stating:

> *"It's like you like don't understand like the whole of situation."*

Additionally, participants noted the frequency that they are *"shocked"* when they learn of someone struggling with their mental health. In juxtaposition of this, the routinely shared perception of the student participants that mental health is not something to be judged by and something that needs attention and focuses on being maintained, referring to the positive mental health and well-being of a person being equally salient and applicable as the distress that is often associated with mental health. However, the sentiment of the student participants does still reflect that differences in diagnosis determine the perception of the community, with anxiety being a more well-accepted ailment, depression as being perceived as *"lazy"* or *"unhygienic"* and schizophrenia as *"crazy,"* and *"dangerous"* which speaks to the stigma that permeates through the community even in populations which are generally more open and accepting of mental illness. In providing personal definitions of stigma, student participants were primarily pragmatic in their responses, sharing that it is *"public perception," "generalization,"* or *"negative connotation."*

Often, when discussing stigma around mental health, the student participants referenced their upbringing and parent(s) views on mental health as the *"conditioning"* of their initial understanding, explaining that they now view mental health from a different, less stigmatized lens as they've become more autonomous. Further, they have noticed a difference in the stigma that exists among themselves (all female) and their female peers as opposed to their male friends, noting that for men, the stigma continues to exist that mental health struggles are a sign of *"weakness."* If a male peer confides in them, they're promised not to divulge the information to anyone else for fear of judgment:

> *"I think it's very gender-based personally. Like I've had many male [friends] through my life come and tell me they're depressed, whatever. They have some sort of mental health issue but they're like, you cannot tell."*

> *"I know like a friend and their whole like situation with mental health and like not getting any help is cause it's a male and like, especially as a male reaching out and you need help and being labeled as like, oh like you, like you can't like handle your own emotions. Like that was a big factor in why that person like reached out to like close friend, but it's not gonna go and actually see someone."*

Access to Care. The influences of student participants' attitudes, beliefs, and behaviors about mental health and treatment are vast. Factors mentioned by the students contributing to not accessing care were logistic and related to stigma (fear of judgment, not wanting to be labeled). Logistic barriers included prioritizing the time to attend services, the financial burden of services, and navigation of how to access services.
One student shared:

> *"Cause I went through my insurance company, so I'm sure it's different for like whatever website you're on. But like I just found it extremely overwhelming. Like trying to narrow it down to what I feel like I would match well with."*

Many of the students are not independently financially stable and expressed that despite having counseling center availability on campus, the sessions are limited, the waiting times are long, and the ability to choose a therapist of best fit is limited. In addition, when attempting to go off campus for services, they report having to rely on their parents to pay or rely on insurance coverage, which is challenging: Label avoidance and the influence of public stigma was also prominent in the student participants, sharing:

> *"Mostly for me I think it's the questions because they're gonna be like, like what's wrong with you? Why are you in therapy? Like, you don't need to be there. Like, you're fine."*

Additionally, it is essential to note where students are going for informal and de facto mental health support. Often students utilize social media as opposed to formalized treatment due to its accessibility, anonymity, and the ability to fully express oneself without worrying about others' feelings, thoughts, or judgments. For example, student participants shared that it:

> *"takes the emotions out," and "on social media … you can [be] like very detailed and specify your feeling."*

This sentiment was echoed throughout the student participants that social media is more accepting and safer for expressing mental health hardships. This trend is documented in the research as many individuals seek self-help through TikTok, podcasts, and other social media platforms (Kucuk & Ozdil, 2022). The outcomes of self-help through social media seeking behavior is multifold with a general decrease in stigma, but a lowered perceived need for formal support through behavioral health care services (Kucuk & Ozdil, 2022).

Another significant influence on students' behaviors related to accessing care is culture and generational patterns within their families. Students routinely shared that how their parents and families handled their own mental health, did or did not access care, and responded to them when they needed support is prominent in their own help-seeking behavior. Often expressed was a desire not to notify parents that they were seeking therapeutic services for fear of being discounted or questioned, *"what's wrong with you?,"* or *"why are you in therapy?"* One participant shared her experience in speaking with her grandfather about mental health:

> *"Every time like he hears about like someone having anxiety about something or like someone being depressed about something. Like he and like people his age are just like, well when I was a kid, like I was fighting in a war. Like just, I think like just the experience that older people have had compared to the experience that we have is just so different that like personally I just have no idea how to like contact that generation and like get them to understand."*

When addressing cultural influences that may impact both the ability to seek services and informal support, students routinely expressed their desire to have a professional with cultural competence as well as the impact of their culture on their help-seeking behaviors. One student expressed her parents' inability to understand mental health as a basic need:

> *"I think personally because my parents are immigrants, so when they were struggling, at their time in need, it had to do with their basic needs, housing, income, those like basic necessities. So now, now that we have different experiences, they try to comprehend and try to understand what we're going through, but I feel it's a bit more difficult for them to understand because those basic needs are being [met] for us. Like, we have food, we have shelter, we have, good health, so what more do we need? So I think that's difficult for them to understand."*

This type of response for the student participants leads to reduce the propensity to seek both formal and informal support of services as they feel invalidated and believe sentiments such as:

> *"I think like okay, yes I'm struggling but my struggle is not as bad as this person's [or] that person. So I try to convince myself that this isn't a real problem."*

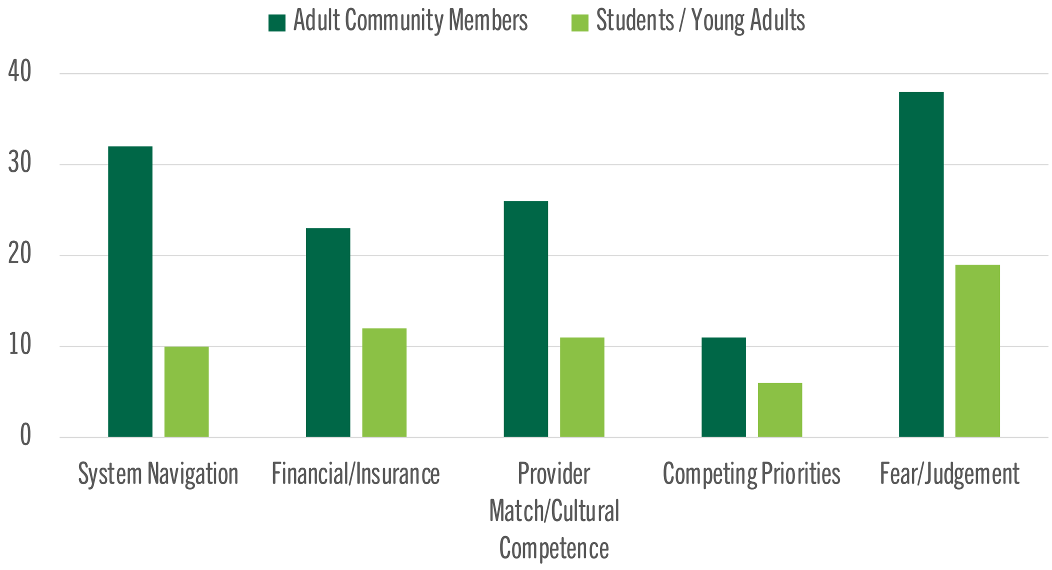
A final example of parental influence on help-seeking behaviors for our student participant group is related to religion:

> *"From my father's side of the family, religion is a huge part of their culture. A lot of responses I would get from them. When I bring up my mental health issues it's, you know, you don't need therapy [you need] to talk to God. So I think it's definitely a cultural thing for sure."*

In this example, we can see the apparent influence of the parents on discouraging help-seeking through formal behavioral health support. In addition, these experiences often result in self-stigma, leaving the individual to wonder why they cannot figure things out for themselves.

Accessing Care: Comparison of Groups. There are clear similarities and marked differences when comparing the perceived and logistical barriers to accessing care. While the top five barriers are the same for each group of participants (system navigation, financial/insurance, provider match/cultural competence, competing priorities, and fear/judgment), the emphasis of those barriers varies greatly (See Figure 2). For example, while fear and judgment were the most significant barriers for both groups in accessing care (N=38, N=19), system navigation is a close second barrier for adult community members (N=32). For the student/young adult community members, finances were the second closest barrier to accessing care. Additionally, the adult community members reported these top five barriers to accessing care in greater frequency (N=110) than the student participants (N=58). A frequency distribution table describing the utilized codes, their definitions, and the total frequency of occurrence in the entire sample related to accessing care is available in Appendix C.

Figure 2. Barriers to Accessing Care – Between Group Comparison



Summary

The data collected in this study reflect the pervasive nature of stigma and its impacts on the behavioral health care system. Within the sample, generational and cultural influence guided their perceptions of mental health and their behaviors related to accessing care. Seeking support from family members who are discouraged or coming up against a system that is difficult to navigate or failed them in the past adds to their belief systems. Further, significant logistic barriers make accessing care difficult, even for those seeking treatment. Insurance coverage, out-of-pocket fees, scheduling, provider matching, and a general lack of awareness of available services and how to find them stop individuals from accessing the care they want and need. Additional contributing factors related to accessing care in Hillsborough County are gender and social media. Notable in our sample demographics and participant report, men are more unwilling to speak about mental health or seek services. In addition, social media appears to be acting as a de facto mental health system of care for younger adults who cannot seek services for themselves, regardless of the reason.

Recommendations

Destigmatization

Promote destigmatization of mental illness and seeking treatment for mental health issues:

Despite the progression towards societal acceptance and recognition of the toll and burdens associated with mental illness and an increase in effective and more accessible treatment options, a sizable amount of stigma still exists surrounding the topic of mental illness and against those seeking treatment. The concepts of shame, embarrassment, or fear of repercussions were sentiments echoed by many participants and are still being expressed widely within the community. To combat these stigmas, a call for anti-stigma or destigmatization education and awareness is needed within the community. To address this concern, the following are recommended:

- Implementing anti-stigma programming, using examples from different communities that have done so effectively to bring awareness, understanding, and acceptance to mental illness and other human rights issues. The literature demonstrates that to effectively infuse anti-stigma programming into a community, a partnership between community-based advocacy or prevention organizations, evidence-based researchers, and policymakers is the first step.
- Particular emphasis be placed on promoting awareness of men's mental health and encouraging men to engage in mental health services.
- Information about available resources and mental health services for men, coupled with destigmatizing information, be incorporated into anti-stigma programming or destigmatizing initiatives.

Marketing

Steer future marketing efforts to focus mental health advertisements toward 'normalizing' and 'maintaining' mental health rather than identifying it as a tool only needed when in crisis. This includes the following:

- Aim of mental health marketing be centered around the concept of 'mental wellness' rather than 'mental illness.'
- Promotion of mental wellness be seen as working in unison with physical wellness and the importance of caring for the whole body, not merely waiting until we need emergent or immediate aid when in crisis.
- Campaigns be relatable to the general public in which marketing materials should utilize analogies related to concepts already accepted and understood (e.g., importance of caring for ourselves through exercise and a healthy diet, practicing self-care, setting emotional boundaries, or engaging in stress relief). Additionally, infusing the idea that asking for help when needed is healthy and not a sign of weakness.

Comprehensive Integrated Mental Health Care

Traditional standard of practice for a referral from health care practitioners to behavioral health clinicians is typically referred to as a 'warm handoff'. In a program that operates as an integrated behavioral health service system, a primary care or emergency room physician will directly introduce a patient to a behavioral health clinician. However, this standard of practice has been reduced to usually a primary care office or physician, providing a patient with a list of community-based agencies within their geographic area. Traditional warm handoffs have benefits for patients, including building trust in behavioral health clinicians, stigma reduction, and increasing attendance in subsequent behavioral health appointments. However, when there is a breakdown in this process, patient care is negatively impacted and findings revealed an effective 'warm handoff' was not being implemented with fidelity. It is recommended:

- Gaps between primary and emergency care integration and behavioral health care should be explored more closely.
- The 'warm handoff' process should be replaced with a more comprehensive bridge program to improve system navigation and connect patients more effectively to the required resources and services.
- Mandatory implementation of a mental health evaluation component in a patient's routine physical or emergency room visit. For patients presenting with concerns to a physician, a referral to a bridge liaison would be the health care provider's responsibility. This would ultimately ensure that a comprehensive health evaluation was completed and a connection to behavioral health was made if warranted.
- Recognizing patient-driven decision-making as a critical component of an effective system. This begins by understanding differences in cultures, religions, race, and gender and accepting the differences has a range of implications for behavioral health practices ranging from an individual's view on mental health illness and treatment-seeking behaviors, and even the nature of a therapeutic relationship and trust.
- Identifying qualities and characteristics of a mental health provider that align with those being sought by a patient. A technology matching system is recommended to allow those seeking services access to provider qualities and characteristics to assist people in making an informed decision when choosing a mental health care provider.
- Information regarding a patient's financial responsibility for services, accepted insurance practices and policies, and other offerings such as extended hours, transportation, and bi-lingual services would help make choices that best suit needs and increase likelihood of following through with appointments and decrease attrition rates.
- Need for behavioral health clinicians to integrate a screener for adverse childhood experiences (ACEs) into their initial or baseline paperwork. This baseline assessment would allow clinician to gain more insight into a patient's previous interactions with trauma and allow for a more trauma-responsive approach to services. Ultimately, gaining more perspective and increasing provider's holistic understanding of a patient's needs, increases the likelihood of desired outcomes of treatment and allows for the most appropriate form of treatment to be applied.

Services and Resources

Implementing universal services and resources across districts within the county would dramatically reduce the burden on community members seeking services. An example of this need from the community's perception comes with having an appropriate provider match as a necessity. When individuals do not find a good match with their first attempted provider, they are reluctant to "start over" with a new provider or organization. A universal release form allowing the free-flowing sharing of information between providers would alleviate this and provide more seamless care. Universally shared resources and information would additionally help ease the provider's burden, assisting with burnout by providing critical background information and the ability to apply interventions and treatments more readily.

Treatment Wait Times

Further study should review reasons behind lengthy wait times for specific services. Such services include seeing a mental health provider, psychiatry appointments, psychological testing, and family counseling. A common belief among participants of this study was that the amount of time between scheduling and receiving services was between four to six months. It is recommended that:

- Information be corroborated and, if accurate, examine issues that are imposing such lengthy wait times for services, such as the maxed capacity of treatment programs and a deficit of service providers and agency staff.
- Once accurate wait time information is available, that information should be passed throughout the community to correct any misconceptions hindering individuals from seeking services.

Specific Populations

Individualizing mental health information specific to people's needs or self-identifiers helps people feel understood and more connected to the resources, therefore:

- Providing information that speaks to specific populations.
- Targeting educational material to specific populations can reduce stigma and make the material relatable, culturally inclusive, and gender-sensitive.

Limitations

The validity of this study's findings relied on the participant's responses in each focus group. Also, the generalizability of the findings was dependent on the representativeness of our sample population. Therefore, the first limitation and most impactful was the need for more diversity among participants, specifically in special populations (e.g., veterans, LBGTQ+, seniors, etc.) and the underrepresentation of male participation. Future focus groups will expand to those populations not otherwise covered in this study.

The next limitation lies in the varying levels of education and intellectual abilities of the sample population. This variation among participants led to their inability to accurately articulate their perception and experiences with behavioral health services due to their lack of familiarity with specific vocabulary and poor understanding of behavioral health practices. This limitation could have impacted the accuracy of some quotations during coding. To remediate this limitation, the context of some quotes was examined to help determine the participant's intended responses.

Lastly, our sample population included community volunteers. These participant volunteers donated their time to the organizations that hosted the focus groups, and therefore their views on stigmatization may not have been equivalent to that of a participant from the general public, especially demographics with more stigmatized views, which are not willing to speak openly about mental health. Our team also realized that the effects of COVID-19 were not addressed in any focus group protocol questions. Some focus group participants spoke in-depth about how the COVID-19 pandemic affected not only their and others' mental health but significant barriers to accessing care, even though we did not directly ask questions related to the COVID-19 pandemic.

Conclusion

The findings of this evaluation emphasize the importance of addressing perceptions of mental health and stigma and how it affects access to behavioral healthcare within the Hillsborough County community. This need is compounded by generational, cultural, and gender differences requiring unique and individualized approaches. Although recommendations are highlighted in the previous section, community behavioral health leaders and key personnel must be identified to ensure that areas needing improvement are addressed as both public perception and institutional practices that maintain disparities need to be addressed. Allowing key stakeholders the opportunity to discuss the identified recommendations and create implementation strategies can promote destigmatization, increasing access to and awareness of available behavioral healthcare resources within Hillsborough County.

Appendix A – Focus Group Protocol Questions

1. **What comes to mind when you hear ‘mental health’?**
    a. Tell us how you view mental health
    b. How do you feel when you hear someone that struggles with their mental health?

2. **If you or a someone close to you have experienced mental health symptoms, did you (or them) avoid getting help in fear of being labeled or stereotyped?**

3. **Do you know what stigma is?**
    a. How would you define stigma?
    b. How does stigma make you feel/what do you think about stigma?

4. **Tell us about a time where you or someone close to you was judged or treated differently because of their symptoms related to mental health.**

5. **How do you think people who struggle with their mental health are treated differently than those who do not?**

6. **Can you think of a time where you or someone close to you was lost out on an opportunity (e.g., employment, new relationships, etc.) due to a mental illness or experiencing symptoms related to mental health.**

7. **What do you think could be done to destigmatize mental illness?**
    a. What can be done at the individual level?
    b. What could be done at the societal level?

8. **What challenges have you faced while seeking access to behavioral health services in your area?**
    a. Do you have any positive experiences to share related to accessing care?

Appendix B – Demographic Survey Questions

Age: ______________________ **Current Zip code:**___________________

(Please check your response)

Gender:

☐ 1. Male
☐ 2. Female
☐ 3. Non-binary
☐ 4. Not listed
☐ 5. Prefer not to answer

Ethnicity:

☐ 1. Hispanic
☐ 2. Non-Hispanic
☐ 3. Unknown

Race:

☐ 1. American Indian, Native American, or Alaskan Native
☐ 2. East Asian, South Asian, Southeast Asian, or Asian American
☐ 3. Black, Haitian, or African American
☐ 4. Native Hawaiian or Pacific Islander
☐ 5. White
☐ 6. Prefer not to say
☐ 7. Not listed

Sexual Orientation:

☐ 1. Lesbian, gay, or homosexual
☐ 2. Straight or heterosexual
☐ 3. Bisexual
☐ 4. Pansexual
☐ 5. Not listed
☐ 6. Prefer not to answer

Highest Level of Education:

☐ 1. Grade school (k-8 grade)
☐ 2. High school graduate or GED
☐ 3. Some college
☐ 4. Trade/technical/vocational training
☐ 5. Associate's degree
☐ 6. Bachelor's degree
☐ 7. Master's degree
☐ 8. PhD/MD/JD

Have you ever sought out behavioral health services in Hillsborough County?

☐ 1. Yes
☐ 2. No
☐ 3. Prefer not to answer

Have you ever helped a close friend or family member seek behavioral health services in Hillsborough County?

☐ 1. Yes
☐ 2. No
☐ 3. Prefer not to answer

Appendix C – Frequency Distribution of Codes

Code	Definition	N	Salient Quote
Logistical Barriers or Challenges to Treatment	The logistical hurdles to treatment or services for participants to access (e.g. time, finances, insurance).	88	*"Also a lot of places are like nine to five. Everybody has a job. You can't just like, I have to go to like every week I have to leave and go not do my work. Like not everybody is gonna be in a workplace can do that."*
Reasons for Not Seeking Help	Named reasons or examples of why participants negated seeking assistance with their mental health.	113	*"If it was a bad experience, why would you do that again? I already feel like crap."*
Examples of Lived Experience (Positive Results to Services)	These are examples of participants' positive lived experiences associated with seeking treatment or accessing services.	48	*"I think emitting that and breaking those barriers is what opened my life and my possibilities because I was sitting there for years thinking that I would never have kids and being told that too."*
Examples of Lived Experience (Public Stigma)	Personal or witnessed experiences of being judged, labeled, or avoided due to mental health.	82	*"I was avoided because my little brother was targeted by teachers growing up because of his diagnoses and he was viewed as the problem child. He always was hovered over like a hawk by um, teachers and like the resource officers alike and cause of that it increased his anxiety about the whole situation."*

References

Ahmedani, B.K. (2011). Mental health stigma: Society, individuals, and the profession. *Journal of Social Work Values Ethics, 8*(2). 411-416.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal, 311,* 299. https://doi. Org/10.1136/bmj.311.7000.29.

Kucuk Ozturk, G., & Ozdil, K. (2022). The window to the world for individuals with mental disorders: A qualitative study about social media. *Archives of Psychiatric Nursing, 39,* 20-27. https://doi.org/10.1016/j.apnu.2022.03.001.

Luke, M. & Goodrich, K.M. (2019). Focus group research: An intentional strategy for applied group research? *The Journal for Specialists in Group Work, 44*(2), 77-81. https://doi.org/1080/01933922.2019.1603741.

Pinedo, M., & Villatoro, A.P. (2020). The role of perceived treatment need in explaining racial/ethnic disparities in the use of substance abuse treatment services. *Journal of Substance Abuse Treatment,* 118. https://doi.org/10.1016/jsat.2020.108105.

Scafe, M.J., Mapes, A.R., Guzman, L.E., & Bridges, A.J. (2021). Rural verses urban primary care patients' behavioral health needs and service utilization. *Journal of Rural Mental Health, 45*(4), 268-280. https://doi.org/10.1037/rnh0000178.

Schnyder, N., Panczak, R., Groth, N., & Schultz-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: Systemic review and meta-analysis. *The British Journal of Psychiatry, 210*(4), 261-268. https://doi.org/10.1192/bjp.116.189464.

Song, A.A., Oslin, D.W., & Wolk, C.B. (2021). Characteristics of patients who attended behavioral health services after primary care referral management support. *Psychiatric Services, 72*(12), 1455-1459.

Stewart, M.T., Horgan, C.M., Hodgkin, D., Creedon, T.B., Quinn, A., Garito, L., Reif, S., & Garnick, D.W. (2018). Behavioral health coverage under the affordable care act: What we can learn from marketplace products? *Psychiatric Services, 69*(3), 315-321. https://doi.org/10.1176/appi.ps.201700098.

Vogel, Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is Stigma Internalized? The Longitudinal Impact of Public Stigma on Self-Stigma. *Journal of Counseling Psychology, 60*(2), 311–316. https://doi.org/10.1037/a0031889.

Wijerante, C., Johnco, C., Draper, B., & Earl, J. (2021). Doctor's reporting of mental health stigma and barriers to help-seeking. *Occupational Medicine, 71*(8), 366-374. https://doi.org/10.1093/occmed/kqab119.

Hillsborough County
BOCC APPROVED
Funded by the American Rescue Plan

Tampa Bay THRIVES
A MENTAL WELLNESS COALITION

UNIVERSITY of SOUTH FLORIDA

College of Behavioral & Community Sciences
Department of Mental Health Law & Policy