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

A Final Evaluation of the Tampa Bay Region

November, 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

Emilie Ellenberg, MA, LMHC

Bonnie Brown, PhD

Melissa Carlson, BS

UNIVERSITY of SOUTH FLORIDA

College of Behavioral & Community Sciences

Tampa Bay THRIVES

A MENTAL WELLNESS COALITION

Contents

Executive Summary *December 2023*

Understanding Mental Health Perceptions and the Impact of Stigma on Accessing Behavioral Health Services: An Evaluation of Tampa Bay Region

SUBMITTED BY: Kathleen Moore, PhD; Emilie Ellenberg, MA, LMHC; Bonnie Brown, PhD; Melissa Carlson, BS; Carrie Zeisse, MBA; Daniel Mineo, BS

Evaluation Project Overview

In 2022, Tampa Bay Thrives (TBT) and the University of South Florida's (USF) Department of Mental Health Law and Policy (MHLP) embarked on an exploratory research evaluation project to gain insight into perceptions of mental health and behavioral health needs among community members within the Tampa Bay Region including Hillsborough, Pinellas, Pasco, and Polk Counties in Florida. Using qualitative methods, USF's research team conducted 13 focus groups (N=140) to obtain community perspectives on the following: (1) reasons for not seeking behavioral health services, (2) assess perspectives of mental health and stigma, (3) assess 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), (4) lived experiences with symptoms, diagnosis, and treatment, and (5) challenges and positive experiences related to accessing behavioral healthcare. This project consisted of two phases, which focused solely on the perspectives of Hillsborough County community members in Phase 1 (funded by the American Rescue Plan Act ARPA) and the perspectives of Pinellas, Pasco, and Polk Counties in Phase 2 (funded by TBT).

Key Takeaways

Stigma

- Stigma profoundly impacts community members and leads to a lack of help-seeking.
- Misinterpretations of mental illness and stigma are passed down generationally.
- Community members' experience of public stigma keeps them from engaging in services at all.

Mental Health

- While the view of mental health is changing, it is still seen as shameful.
- Community members want providers who understand their culture, gender, and religion.
- Focus should be placed on mental wellness rather than mental illness.

Barriers

- Long wait times, lack of transportation, and poor provider match affect individuals seeking care.
- Individuals learn barriers from peers and subsequently avoid services.
- Community members need off-hours service availability.

Service Accessibility

- Behavioral health services are not attainable for many community members due to a lack of insurance and the unaffordability of self-pay services.
- The opioid epidemic has had a significant impact on community providers and program availability.

Special Populations

- **LGBTQ+** community members often feel judged, misunderstood, and "worse when leaving a therapy appointment.
- **Veterans** desire providers who are part of or fully understand the Veteran community and military culture.
- **Older adults** believe that mental illness is 'taboo' and needs to be approached with different language (e.g., stress, sadness, etc.) and confide in older providers they can relate to.
- **Younger adults** want to focus on mental wellness and the prevention of mental distress.
- **Culturally diverse individuals** want providers who speak the same language, understand their religions, and look like them.
- **Community providers** are leaving the field due to burnout and poor pay.

UNIVERSITY of SOUTH FLORIDA

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

Overall Recommendations

Destigmatization

Information about available resources and services, coupled with destigmatizing content, should be integrated into anti-stigma initiatives. Targeted educational materials can enhance relatability, cultural inclusivity, and gender sensitivity to reduce stigma.

Marketing Strategies

Shift mental health marketing efforts towards normalizing and maintaining mental wellness rather than focusing solely on crisis intervention. Mental wellness should be emphasized as promoting healthy mental and physical well-being.

Education

Educating family and friends about behavioral healthcare and the importance of seeking treatment for mental health diagnoses is crucial for fostering understanding, empathy, and support. Normalizing the identification of signs and symptoms and empowering loved ones to recognize when someone may need help could bridge this gap.

Continuity of Care

Continuity of care in behavioral healthcare is crucial for patient well-being and the effectiveness of treatment programs. Allowing space for flexibility, stability, and minimizing challenges could assist longer engagements in services. Additionally, universally educating providers with specialized training materials, connecting them to resources, and fostering connections with peers could improve care and patient outcomes.

Behavioral Health System Navigation

Service navigation is crucial in the behavioral healthcare system to ensure individuals receive necessary support amid the complexities of mental health services. Integrating peer navigators or paraprofessionals with lived experience could provide unique perspectives and guidance, offering peer support, aiding in logistical processes, and assisting with resource identification.

Provider Training on Special Populations and Cultural Competence

Tailoring behavioral health training for providers to address special populations like the LGBTQ+ community, veterans, older adults, and males can significantly enhance the likelihood of these marginalized groups actively seeking and engaging in behavioral healthcare services.

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 multi-county Tampa Bay Region. Although recommendations are highlighted in the previous section, allowing key stakeholders the opportunity to discuss the identified recommendations and create implementation strategies can promote destigmatization and system navigation, increasing access to and awareness of available behavioral healthcare resources.

Understanding Mental Health Perceptions and the Impact of Stigma on Accessing Behavioral Health Services: An Evaluation of the Tampa Bay Region

Introduction

Background

In 2023, 19% (47.1 million) individuals in the United States are living with a mental health condition (Mental Health America, 2023). Concurrent with the escalation of behavioral health needs is the decreased incidence of service attainment (Coley & Baum, 2022). Understanding the dissonance between these phenomena is of utmost importance to allow the implementation of approaches that will increase service utilization and enhance behavioral health outcomes. There must be approaches in place to maximize positive behavioral health outcomes. To do so, we must first recognize behaviors and systems that both promote and discourage individuals from utilizing behavioral healthcare. Despite being studied widely (Pinedo & Villatoro, 2020; Scafe et al., 2021; Song et al., 2021; Stewart et al., 2018), understanding behaviors that lead to engagement or disengagement with behavioral health services is unclear. Additionally, studies have demonstrated that race/ethnicity (Garverich et al., 2021), health disparities (Pinedo & Villatoro, 2020), logistical barriers, transportation, insurance coverage or lack thereof (Scafe et al., 2021), and public as well as self-stigma (Garverich et al., 2021; Wijeratne et al., 2021), are key contributors to deterring service attainment. The public perception of the barriers and support in engaging with behavioral health services (Pinedo & Villatoro, 2020) and the understanding of stigma's impact (Garverich et al., 2021; Wijeratne et al., 2021) is of paramount importance in being able to reach these potential service recipients.

Research has shown that subgroups of the population who face more health disparities and increased impact of stigmatized views, both public and self-stigma (Moallef et al., 2022), include the LGBTQ+, veteran, older adult, and male populations. It is important to note that persons with mental health diagnoses face between 3 and 7 times more likelihood of being unemployed due to mental health stigma (Brouwers, 2020). Individuals within our identified subgroup populations with mental health diagnoses are at an even more exacerbated rate, impacting not only the individual but the community and society as a whole. The reasons for the increased difficulty in accessing services for these subpopulations are complex and varied. While it is well documented that many individuals within the LGBTQ+ community face behavioral health struggles (Goldbach et al., 2023), a recent study found that 27% of the study sample concealed their sexual orientation to secure mental health services (Moallef et al., 2022). The reasons for this are likely multifaceted but could be due to internalized and/or public stigma, as well as the lack of cultural competence in servicing the LGBTQ+ community.

Veterans have a significant history of feeling public and self-stigma due to mental health symptoms, significantly impacting their willingness and success with behavioral health services (Hansen et al., 2023; Shepherd-Banigan et al., 2023). Many veterans are limited to utilizing VA services with negative treatment experiences due to long wait times, inappropriate provider fit, or fear of being labeled (Shepherd-Banigan et al., 2023). One study (Shepherd-Banigan et al., 2023) utilized VA data and found that despite the efforts of the VA to increase mental health support to their veteran service recipients, rates of veterans with PTSD

utilizing services continue to be low. Additionally, veteran mental health difficulties have been exacerbated due to the COVID-19 pandemic, with specific spikes in PTSD, anxiety, and depression (Hansen et al., 2023), speaking to the importance of understanding how to make behavioral health services more accessible to this population.

Research suggests that older adults are up to 40% less likely to seek behavioral health services than their younger counterparts (Dow & Siniscarco, 2021). This is compounded by the risk of completed suicide, which is higher in older adults (Dow & Siniscarco, 2021), leaving this subpopulation at extreme risk of a mental health crisis. In phase one of this evaluation, younger participants routinely shared that their older relatives did not condone seeking behavioral health services or speaking about mental illness, often being prompted to keep these things within the family or to 'toughen up.' Older adults are a key demographic of focus for the current evaluation study to understand the cultural impact of living as an older adult in our community as it pertains to mental health.

Another highly stigmatized subgroup of focus with a significant risk of mental health crises and completed suicides is males. Males have a culturally defined masculinity to maintain, resulting in a lack of emotional disclosure and reduced help-seeking behaviors (Siegel & Sawyer, 2020). In the first phase of this study, all participants were predominantly female. Particularly poignant in the younger participants, a theme emerged that many of their male counterparts do not disclose their mental health struggles to professionals or their male peers, disclosing to a close female friend under the guise that it would not be disclosed further. This sentiment is echoed in the research (Robertson et al., 2018; Siegel & Sawyer, 2020) and begs for exploration to reduce these culturally sanctioned stigmas against male mental health.

Focus groups are a new aspect of behavioral health research that originated in business and marketing and has been altered to fit social science issues (Morgan, 1996). Although research is scarce regarding whether using 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 concepts, and productive disagreement (Kitzinger, 1995). This type of dialogue allows for 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; Toren et al., 2020). For example, Marcus Mol (2019) utilized focus groups to assess participants' perceptions of occupational health risk., leading to a call to action for reform of occupational health risk policy and intervention (Mol, et. al., 2019). 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 or substance use issue, and focus groups encourage individuals to realize they are not alone in what they are experiencing (Axelsson et al., 2020; Lester & England, 2006). Implementing focus groups can uncover the issues that must be addressed by listening to community members' 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 (TBT) 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 key 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 who 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 17 and older residents residing in Hillsborough, Pasco, Pinellas, and Polk Counties. Immediate care referrals are available in Hillsborough, Pinellas, and Polk Counties.

Current Project

In 2022, Tampa Bay Thrives (TBT) and the University of South Florida's (USF) Department of Mental Health Law and Policy (MHLP) embarked on an exploratory research evaluation project to gain insight into perceptions of mental health and behavioral health needs among community members within the Tampa Bay Region including Hillsborough, Pinellas, Pasco, and Polk Counties in Florida. Using qualitative methods, USF's research team conducted 13 focus groups (N=140) to obtain community perspectives on the following: (1) reasons for not seeking behavioral health services, (2) assessment of individual perspectives of mental health and stigma, (3) 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), (4) lived experiences with symptoms, diagnosis, and treatment, and (5) challenges and positive experiences related to accessing behavioral healthcare. Additionally, questions were asked to gain insight into the impact of COVID-19 on mental health symptomology and suggestions for destigmatization of mental health. Recruitment efforts were targeted to achieve a study sample consisting of individuals at least 18 years of age. This project consisted of two phases, which focused solely on the perspectives of Hillsborough County community members in Phase 1 and the perspectives of Pinellas, Pasco, and Polk Counties in Phase 2.

The funding for Phase 1 of 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. Phase 1 of this project focused on Hillsborough County residents, where six focus groups were conducted (N=63). Phase 2 was funded by Tampa Bay Thrives and focused on targeting the perspectives of more diverse subpopulations. Focus groups were conducted in surrounding counties, which included Pinellas, Pasco, and Polk Counties, where eight focus groups were conducted (N=77). Recruitment efforts for Phase 2 targeted subgroups who may face more health disparities and increased impact of stigmatized views, such as potential service recipients and providers, veterans, individuals identifying as LGBTQ+, and older adults (65+).

Methodology

Project Procedures

Phase 1

Six focus groups were conducted across Hillsborough County between September and November 2022. TBT and USF MHLP jointly recruited all focus group participants and communicated with willing hosting locations. Recruitment flyers were distributed to target special populations such as social service recipients, young adults, and working professionals. The duration of 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, and they were compensated with a $25 Walmart gift card for their participation, which was paid immediately upon completion of the focus group.

Phase 2

Eight focus groups were conducted across Pasco, Pinellas, and Polk Counties over the past five months between March and July 2023. TBT and USF MHLP jointly recruited all focus group participants and communicated with willing hosting locations. In addition, recruitment flyers were distributed to target special populations such as social service recipients, LGBTQ+, veterans, males, and older adults. Each focus group lasted between 60 and 90 minutes, and all eight focus groups were audio-recorded for accurate transcription. Focus group participants were allowed to take part 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 collected during both phases, which included age, zip code, gender, race/ethnicity, sexual orientation, level of education, and experience with seeking behavioral health services for self or others within the identified counties. *Demographic survey questions are provided in Appendix A.*

Focus Group Locations

Phase 1

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. Additionally, the 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 center for families in need, and (3) providing services and resources that assist children and strengthening families.

Phase 2

The eight focus groups were held at various locations throughout Pinellas, Pasco, and Polk Counties. 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. One focus group was held at a local library in Pinellas County. This

location was selected due to its ease of accessibility to many veteran programs in both Pinellas and Pasco Counties. An additional focus group was held at a senior services center in Pinellas County. This location was selected due to its ease of accessibility to the older adult population. This location additionally provides resources for participants, which include but are not limited to (1) peer support, (2) case management, (3) physical fitness resources, (4) professionally led support groups, and (5) community events.

One focus group was held at a community service organization in Pinellas County. This organization was selected due to its ease of access for members to attend and their commitment to servicing the local area. Among many other activities, his location provides (1) community service fundraisers, (2) international service, (3) youth service, and (4) provides gathering locations for support groups. Another focus group was held at a local non-profit, service, or resource-providing organization in Pinellas County. This organization was selected due to its programs of focus on the LGBTQ+ population, allowing an essential subgroup of focus to be easily accessed. This location additionally provides resources for participants, which include but are not limited to (1) counseling services, (2) peer support services, (3) HIV/AIDS resource linkage, and (4) resource referrals and connections for service recipients.

Three focus groups were held at non-profit, service, or resource-providing organizations in Polk County. These three 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, (3) providing services and resources that assist children and strengthening families and (4) various levels of clinical intervention and treatment.

The final focus group was held at a large non-profit, service, or resource-providing organization in Pasco County. This location was selected as the focus group followed a behavioral health community meeting, allowing for ease of participation by individuals already present for the prior meeting. This location allowed peer support specialists, providers of various types, and behavioral health advocates to participate. This location offers various services, which may include but are not limited to (1) comprehensive services for individuals with mental illness, (2) case management for families in need, (3) substance use disorder services, and (4) various levels of clinical intervention and treatment.

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 each group was led by a moderator, 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 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. *Focus group protocol questions are provided in Appendix B.*

Data Analyses

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 during study one 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

The following section reflects quantitative and qualitative cumulative results from Phase 1 and Phase 2 focus groups. Quantitative demographic information was combined to reflect the entire sample, and qualitative data was separated into respective themes. Findings and quotes are categorized by subthemes to provide a substantive perspective on lived experiences.

Participant Demographic Characteristics

Table 1 details the demographic characteristics of 140 participants. The mean age was about 39 years, with the majority between 25 to 34 years of age (ranging from 18 to 88). Most participants were female (72.3%), with a lower percentage of male participants (21.4%). The majority of participants were White Caucasian (64.3%), with 22.9% Black African American and 13.2% reporting Hispanic ethnicity. Most participants reported that they are straight/heterosexual (76.4%), with 13.6% reporting being gay/lesbian/homosexual. Almost all participants (92.8%) did graduate high school, with 28.6% completing some college, 28.6% reporting either an Associate's or a Bachelor's degree, and 17.1% reporting a Master's or Doctoral degree. About half of the participants reported that they did not seek behavioral health services (42.9%) or helped a friend seek out behavioral health services (42.1%). As presented in Table 2, participants lived in various zip codes, with Hillsborough County accounting for almost half of the focus group participants (45.7%).

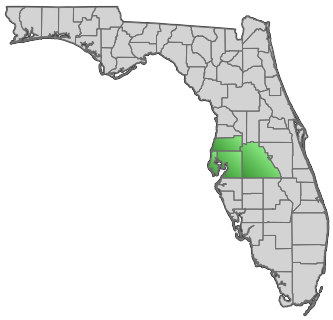
Table 1. Participant Demographic Characteristics (N=140)

Characteristic	N	% or Mean
Age (years)		**47.6**
24 or under	31	22.1%
25-34	32	22.9%
35-44	22	15.7%
45+	52	37.1%
Missing	5	3.6%
Gender		
Male	30	21.4%
Female	104	72.3%
Non-binary	2	1.4%
Missing	5	3.6%
Race		
White/Caucasian	90	64.3%
Black/African-American	32	22.9%
Asian	3	2.1%
Multi-racial	2	1.4%
Missing	8	5.7%
Ethnicity		
Hispanic/Latino	19	13.2%
Non-Hispanic	106	75.7%
Unknown	4	2.9%
Missing	11	7.9%

Characteristic	N	% or Mean
Sexual Orientation		
Straight/Heterosexual	107	76.4%
Lesbian/Gay/Homosexual	13	9.3%
Bisexual	6	4.3%
Pansexual	4	2.9%
Prefer not to answer	7	5.0%
Missing	3	2.1%
Level of Education		
Less than high school diploma	6	4.3%
High school diploma/GED	19	13.6%
Some college	39	27.9%
Technical degree	8	5.8%
AA/BA degree	40	28.6%
MA/PhD degree	24	17.1%
Missing	4	2.9%
Sought BH Services (Self)		
Yes	60	42.9%
No	72	51.4%
Prefer not to answer	3	2.1%
Missing	7	5.0%
Sought BH Services (Someone Else)		
Yes	59	42.1%
No	70	50.0%
Prefer not to answer	2	1.4%
Missing	9	6.4%

Table 2. Zip Codes by County (N=140)

Zip Code	County	N	% or Mean
33547 - 33713	Polk County	41	29.3%
33801 - 33898	Pinellas County	21	15.0%
33563 - 33584	Hillsborough County	64	45.7%
33638 - 33669	Pasco County	11	7.9%
No Response	N/A	3	2.1%



Focus Group Findings

The findings for this project were divided into themes based on participant responses to the focus group protocol questions. Once the data was coded, the results were filtered through the study's specific aims, and three primary themes emerged. These overarching themes are identified as (1) Mental Health, (2) Stigma, and (3) Help-Seeking Behaviors. The evaluation team examined and compiled similarities and differences in responses among the participants and within the subgroup populations of focus. These major themes are supported by sub-themes, and appropriate quotations were chosen to illustrate each theme. Finally, findings were analyzed and themed by special subgroup population and county. *A frequency table of salient codes with representative quotations is available in Appendix C.*

Mental Health

The primary theme expressed by participants regarding mental health centered around their perceptions of mental health or their understanding of what the term "mental health" meant to them or how they perceived the term was regarded by others. When participants were asked what the term *mental health* meant to them or how it made them feel, their responses were noted as being both positive and negative. Negative responses were over five times more prevalent than positive ones. Participants used words such as sad, depressed, anxiety, negative mindset, overwhelmed, and stressed to describe what thoughts came to mind when they heard the term *mental health.* Generational, cultural, and gender differences emerged with males being perceived as not able to express emotion and therefore not able to seek behavioral health services and several cultures (e.g., Asian, Latinx) not able to share their mental distress for fear of shame by their families. Additionally, they described negative actions taken towards those viewed as having "mental health concerns," such as: being undertreated, misunderstood, mistreated, underrecognized, forgotten, disabled, and denied. Some examples of direct quotes that represent the negative feelings associated with mental health include:

"I say all the time, I would rather be physically sick, than be mentally sick."

"Well, for myself, being from a Hispanic family, um if you talked about mental health issues or going to a psychiatrist or some kind of therapy, you were labeled as crazy, so you just didn't."

"So that was like my family's mantra, like, there's no crying in baseball because to shed tears or to show emotion, other than anger, um or like authority even it was, you weren't as respected."

"Well, me personally, I think they're kind of off the chain."

Stigma

Participants in each focus group were asked a series of questions that centered around stigma. Their responses shed light on their perception of what stigma meant to them and how they believe it impacts people. Most participants viewed the term stigma as synonymous with having negative or unkind thoughts about a person or group. When asked what came to mind when they heard the word stigma, some responses were: labeling, looking down upon, judgment, stereotyping, bias, and negative views. Several participants

explained that their stigma stemmed from beliefs they believed were true because of what they had been told or experienced. Many also expressed personal stigmas they carried towards others, were taught to them at a young age, and that their views or beliefs changed until they were grown and had specific life experiences.

> *"When somebody believes something about something, whatever that is, it does become their reality."*

One question asked what stigmas were associated with mental illness or seeking help for one's mental health. Participants overwhelmingly felt there was a negative or embarrassing social stigma placed on mental illness or seeking treatment. Those with lived experience seeking help or being diagnosed discussed the fear at the idea of others learning of their situation.

> *"I was terrified to go to therapy."*

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

> *"Part of the family members make fun of her because she's like, oh, she's just on her pills. Like that's, you know funny. And then also at work, they're like, so dismissive of her emotions."*

Help-Seeking Behaviors and Treatment

The common justifications for not choosing to seek treatment for all counties assessed stemmed from fear: fear of being judged, fear of having a bad experience, fear of telling their story and being vulnerable. Fear also arose from the idea of being placed on medication, or Baker Acted. Participants mentioned fear of not lawfully being able to purchase a firearm if they sought treatment for their mental illness. A common theme of all participants came out of concern that their mental health provider would be judgmental, not listen to or misdiagnose them. This concern was largely expressed because of previous experiences when seeking help.

> *"There is this fear or idea that if it gets out there that someone in our family is struggling, it might bring shame or embarrassment upon the family."*

> *"They [the providers] were terrible! That woman did not understand me at all. She wasn't listening to what I said, you know, especially, when I specifically said when I sat down no medication, no medication, I do not want medication! And halfway through the session, she's writing out a prescription for medication for me."*

Throughout all focus groups, logistical barriers they had experienced or believed they would encounter if they sought help for their mental health concerns proved to be an additional barrier to accessing care. These barriers included: long wait times, not having a provider near them, lack of insurance, feeling it was too expensive, taking time off work, lack of childcare, lack of transportation, service navigation difficulties, and language barriers. Often, these were expressed as reasons for not seeking care based on challenges others close to them had experienced rather than first-hand experience of their own. Still, many participants did have negative personal lived experiences with accessing or receiving services, and those experiences, they say, will prevent them from engaging again.

> *"I know for my sister, she has not gone … because of the price that it can be … and so she's kind of like, I don't even know if I wanna go down that road. It's gonna get expensive."*

> *"I mean unfortunately community behavioral health can be a rotating door for therapists. So sometimes they'll tell me in a year they'll go through two or three therapists."*

"It costs them $150 for 45 minutes. Yeah. And so I don't think some people get the mental health that they need or the care that they need because it costs so much money."

Subgroup Populations

When reviewing the data provided by specific subgroups (young adults, LGBTQ+, veterans, older adults, and providers), some common themes emerged among these groups, including the need to be understood by their providers, expenses of accessing care, and accessibility to services. Each subgroup, though, also had unique characteristics and needs.

Young Adults

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." Young adult participants shared how they are open with close friends and not afraid to share their mental health experiences (symptoms or treatment seeking) with their peers. However, this same sentiment did not transcend with their parents or within all cultures.

"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."

LGBTQ+

When it comes to logistical barriers to accessing care, the LGBTQ+ population expressed the most concerns, with over double the response frequency. Notably, members of the LGBTQ+ community shared experiences of finding it easier to access services when having an HIV-positive diagnosis, sharing they now have access to quality providers with limited fees. Several LGBTQ+ participants expressed that their peers, without an HIV diagnosis, are actively trying to contract the diagnosis to allow them access to quality mental health care demonstrating severe fault in our current behavioral health system of care.

"But in some ways, in some ways I'm glad that I'm HIV positive cause I have a range of services here that are not available to other people, and I don't know what I'd do if I didn't have it, there are bug chasers out there. Yeah. And that's terrible. I've run into a few of those."

"[Community Provider] is specifically for HIV people too. So, I don't know if I just had somebody who was just a regular person who was not HIV positive and didn't have any other physical health issues or something, but was and say was 30 years old, I don't know where I would send them… maybe to a doctor, just a regular physician."

"…you're offending me with how you're talking about me. Yeah. Too, like this is making me more upset than it's helping. Yeah. It's like I'm not here to educate you. I'm here to get the help and resources that I need."

Veterans

The veteran participants reported numerous logistical barriers within the VA, expressing difficulty with provider match, wait times, and service navigational barriers within the system. This is especially pertinent given that many active duty and veteran service members can only access affordable mental health care within the VA system of care.

"Try to get somebody to get an appointment with or get help with. I'm still waiting. I've been waiting six months for an appointment. Yeah. I, I'm not allowed to go on base or out of the VA, cause then I'll have to pay for it out of pocket."

"Getting an appointment. Mm-hmm. Getting somebody from the VA to call you back."

"I'm still waiting for some results from some tests that I did four months ago."

"If you try to talk to someone about veteran issues you may have experienced or being in the service with someone who has no experience with it or anything. It's hard to relate sometimes."

Older Adults

The older adult population had limited reports of experiencing stigma and logistic barriers but spiked in other reasons for not seeking services. Specifically, they expressed generational barriers to accessing care, noting that mental health was not an openly expressed topic growing up, resulting in difficulty expressing mental health concerns now. Several members of this subgroup population are reliant on self-help methods, both adaptive and maladaptive in nature.

"That's the hardest thing… reaching out and trust[ing] that the person can be there to help."

"Well, and growing up too, you know, if I go to my mother, even now to this day [if I] go to her for help or guidance. The comments that I get are get over it. You need to stop. Just force it."

Providers

Several focus groups included providers of behavioral health services. These providers were able to offer valuable insight into the difficulties of being both the facilitator of treatment services and in accessing services for themselves. Primarily, providers focused on the lack of consistency in the field, inequitable pay, and burn out rates. The providers expressed that therapists are not paid enough to stay within agencies, particularly once licensed. Additional concerns expressed were that of the inability to provide access to care for all callers based on their program specific admission criteria and the need for more opioid specific treatments.

"In a field that is supposed to be about stability, mental stability, there's a whole lot of instability."

"There's not a continuance of care."

"As somebody that employs counselors, I don't have enough money to keep people there."

Suicidality

Interestingly, suicide was mentioned among the subgroups more often than in any other participant group. This aligns with the research on the impact of stigma, veteran suicide rates, and the incidence of completed suicide being highest among older, white males. The veteran participants expressed more awareness of crisis intervention methods, with some sharing their experience of utilizing the crisis hotline, while both subgroup population participant members shared having lost individuals close to them due to completed suicide.

"Cause those individuals have kind of given up. Everyone has given up all … have given up most of what they've got."

"The suicides are in… the numbers are better but it's still too many."

"I went through probably six or seven years of being misdiagnosed and given medication, which was inappropriate…some of which made me suicidal, most of which made it way worse. Um, and I had to take some things into my own hands."

Findings by County

When reviewing the data provided by each specific county (Hillsborough, Polk, Pinellas, and Pasco Counties), many similarities emerged (e.g., difficulties with insurance coverage and long waiting times). There were also marked differences between them (see Figure 1: Findings by County Response Frequencies). Many of these differences can likely be attributed to the county's identification as urban or rural, with more urban counties typically having higher rates of behavioral healthcare access and less urban being less able to access behavioral health services (Gresenz, C. R., et. al., 2020). According to the United States 2020 Census, Polk and Pasco Counties are rural, while Pinellas and Hillsborough are urban (U.S. Census, 2023).

Hillsborough

With the largest sample (N=64) of the study, residents of Hillsborough County are the most widely represented. Participants expressed similar concerns about stigma, skewed perceptions of mental health, and reasons for not seeking care. However, this county expressed far more logistical barriers to seeking services. The most frequent logistic barriers expressed by Hillsborough County participants were long wait times, financial expense, inability to navigate the system of care, and inappropriate provider match.

"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."

"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."

Polk

This county was represented by three large focus groups consisting of behavioral health providers and service recipients. Polk County residents (N=41) comprised a large portion of the total sample. These participants expressed more lived experiences of stigma and significantly more reasons for not seeking care. This corroborates the literature on stigmatized views of mental illness being more prominent in rural than urban geographic locations, (Monteith, et al., 2020).

"If it gets out there that someone in our family is struggling, it might bring shame or embarrassment upon the family."

"…he told them about therapy and what he was learning from therapy. He had a couple of them get very upset with him and told him that they didn't want to talk to him anymore."

Pinellas

Having expressed proportionally more positive experiences of behavioral health services (when comparing sample size to response frequency), these participants are the most pleased with behavioral health care. Still, there were several logistic barriers and lived experiences of stigma.

"It's definitely good to talk cuz I don't like, I like an unbiased person or a n on-judgmental person."

"And once that's addressed, we can live so much fuller live [if] we seek out the appropriate care."

"Just trying to get an appointment somewhere? … everything that I hear, it's, it's almost, it's next to impossible."

Pasco

With three focus groups attempted and only one attended, Pasco County residents appear the most hesitant of the three counties to discuss mental health. Additionally, residents of Pasco County had the least to share regarding positive experiences with services (0 total responses) and more to report regarding logistic barriers to seeking care than both their Pinellas and Polk counterparts.

"There's resources out there, but [they're] not reachable."

"... you find out there's a six month wait and you're desperate and about to kill yourself. So you baker act yourself and then you're right back when you started."

"Transportation is a big problem in Pasco County. We have the bus route, and there are some free ways to get bus passes. But what if you don't know how to catch the bus route, and what about those areas that the bus don't go?

Figure 1. Findings by County Response Frequencies

Summary

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 multi-county Tampa Bay Region. This need is compounded by generational, cultural, and lifestyle differences requiring unique and individualized approaches. Community behavioral health leaders and key personnel must ensure that areas needing improvement are addressed, as both public perception and institutional practices that maintain disparities need to be rectified. Allowing key stakeholders the opportunity to discuss the identified recommendations and create implementation strategies can promote destigmatization and system navigation, increasing access to and awareness of available behavioral healthcare resources within the Tampa Bay Region.

Key Takeaways

Stigma	▶ Stigma deeply impacts community members and leads to lack of help-seeking. ▶ Misinterpretations of mental illness and stigma are passed down generationally. ▶ Community members experience of public stigma from providers keeps them from engaging services at all.
Mental Health	▶ While the view of mental health is changing, it is still seen as shameful. ▶ Community members want providers that understand their culturn, gender, and religion. ▶ Focus should be placed on mental wellness rather than mental illness.
Barriers	▶ Long wait times, lack of transportation, and poor provider match are credited as reasons for not seeking care. ▶ Individuals learn barriers from peers and subsequently avoid services. ▶ Community members need for off-hours service availability.
Service Accessibility	▶ Long wait times and staff turnover keep community members from seeking behavioral health services. ▶ Behavioral health services are not attainable for many community members due to lack of insurance and unaffordability of selfpay services. ▶ The opioid epidemic has had a significant impact on community providers and program availability.
Special Populations	**LGBTQ+:** Members of the LGBTQ+ community often feel judged, misunderstood, and "worse" when they leave a therapy appointment. **Veterans:** This community desires providers that are a part of, or fully understand the Veteran and military culture. **Older Adults:** Mental illness is 'taboo' and needs to be approached using different language (stress, sadness) and by older providers they can relate to. **Younger Adults:** This community wants to focus on mental wellness and prevention of mental distress. **Culturally Diverse:** Individuals want providers that speak the same language, understand their religion, and look like them. **Providers:** Community providers are leaving the field due to bum out and poor pay.

Recommendations and Actional Steps

Destigmatization

Despite the progression toward 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. A call for anti-stigma or destigmatization education and awareness is needed within the Tampa Bay Region to combat these stigmas.

Actionable Steps:

- Implementing anti-stigma programming across counties, using examples from different communities that have effectively brought awareness, understanding, and acceptance to mental illness and other human rights issues.
- Particular emphasis should be placed on promoting awareness of special populations and encouraging diverse groups to engage in mental health services.
- Information about available resources and mental health services for special populations, coupled with destigmatizing information, can be incorporated into anti-stigma programming or destigmatizing initiatives.
- Targeting educational material to specific populations can reduce stigma and make the material relatable, culturally inclusive, and gender-sensitive.

Marketing

It is recommended to 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. In addition, marketing strategies should target special populations such as individuals within the LGBQT+ community, veterans, older adults, and males. Those of non-white racial backgrounds and Hispanic individuals, as these sub-populations, are least likely to seek treatment and face many obstacles when attempting to access care.

Actionable Steps:

- Mental health marketing should be centered around the concept of 'mental wellness' rather than 'mental illness.'
- Promoting mental wellness to 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.
- Promoting inclusivity and diversity within marketing campaigns for mental health. Community members want to see others seeking care who look like them (e.g., age, sexual orientation, cultural background, racial/ethnic background, and field of employment).
- Campaigns should be relatable to the general public, and marketing materials should utilize analogies related to concepts already accepted and understood (e.g., the importance of self-care 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.

Education

Educating family and friends of individuals with mental health diagnoses about behavioral healthcare and the importance of seeking treatment is vital to fostering a culture of understanding, empathy, and support within a family dynamic and with loved ones. By openly discussing mental health challenges, we can break down the stigma surrounding these issues, creating a safe space for individuals to share their struggles.

Actionable Steps:

- Raising awareness about the signs and symptoms of various behavioral health conditions and co-morbidities can empower loved ones to recognize when someone might need help.
- Encouraging open dialogue about therapy, counseling, and other forms of treatment normalizes these interventions and emphasizes that seeking professional assistance is a sign of strength and self-care.
- Most focus group participants voiced a cultural and generational disconnect with family members when disclosing behavioral health issues. Engaging family and friends in a clinical setting, providing them with educational materials, and equipping those seeking treatment with strategies to have these difficult conversations can assist in bridging the gap of misunderstanding.

Continuity of Care

Continuity of care is paramount within behavioral healthcare, not only for the well-being of patients accessing care and providers engaging in the application of treatment methodologies but also for the effectiveness of treatment programs. From a provider's perspective, ensuring continuity of care involves addressing various key factors. Fair pay for healthcare professionals, especially within the field of behavioral health, is essential to retain skilled and compassionate staff who can form long-term therapeutic relationships with patients. This stability is pivotal in providing consistent support and guidance to assist patients in navigating the complexities of the behavioral healthcare system. Flexible program admission requirements can also help ensure that individuals accessing care receive timely and appropriate treatment, minimizing disruptions in their care journey. Many treatment programs have strict exclusion criteria for individuals seeking care with comorbidities, including a severe mental illness diagnosis or significant criminal record. Additionally, the opioid epidemic has further emphasized the need for increased program specificity on opioid addiction, providing tailored support to those affected. However, challenges such as burnout and high staff turnover have significantly hindered continuity of care. Addressing these issues is crucial to maintaining a consistent and reliable support system for providers and individuals accessing care, promoting recovery and overall well-being.

Actionable Steps:

- Universally educating providers with specialized training materials, connecting them to educational resources, and fostering connections with peers experienced in serving these special populations could play a pivotal role in cultivating an environment of understanding and rapport that could result in building stronger relationships with care providers.
- A program-specific level evaluation could improve overall continuity of care and reduce provider staff turnover. Staff burnout and turnover are often due to provider staff receiving sub-par compensation, training, and opportunities for growth within their role, resulting in lower job satisfaction, largely affecting patient outcomes.

System Navigation

Service navigation within the behavioral healthcare system is critical to ensuring that individuals receive the support they need while navigating the complexities of mental health services. The journey through any healthcare system can often be overwhelming, marked by potential barriers such as lack of information, stigma, and difficulty accessing appropriate care.

Actionable Steps:

- Integrating peer navigators or paraprofessionals to assist those seeking care can provide a smoother and quicker route to treatment. These individuals, often with lived experience, can offer a unique perspective and guidance that traditional professionals may be unable to provide.
- Peer navigators and paraprofessionals could assist in offering peer support, help in navigating logistical processes, and assist with resource identification. Their firsthand understanding of the struggles associated with behavioral health concerns allow them to empower those seeking help, and ultimately enhance the overall experience of accessing behavioral healthcare.
- Integrate a better system (e.g., technology matching system) to easily identify cultural, religious, and racial similarities when seeking a mental health provider (counselor, therapist, etc.).
- Examine issues around lengthy service wait times (4-6 months).
- Add additional bridge programs with system navigators for all types of treatment seekers (SUDs, MH, insured, uninsured, indigent, veteran, older adult, etc.)
- Integrate ACEs into baseline paperwork so providers have a better sense of trauma history and reduction of inappropriate fit.
- Integrate mental health check-ups into primary care and/or physical health visits.
- Implement universal services and resources across districts within the county (e.g, shared intake forms, universal HIPAA).

Provider Training on Special Populations and Cultural Competence

Tailoring behavioral health training information for providers to serve special populations such as members of the LGBTQ+ community, veterans, older adults, and/or males can significantly increase the likelihood of these marginalized groups actively seeking and engaging in behavioral healthcare services. Individuals who identified with a special population type expressed a hesitancy to pursue treatment, primarily driven by the perceived necessity to educate their providers about their unique backgrounds and identities before addressing their underlying concerns. This has led them to feel a lack of emotional vulnerability due to the fear of stigma, discrimination, and a sense of detachment from their providers. Specifically, participants identifying as part of the LGBTQ+ community felt reluctant to seek treatment, as they found themselves dedicating substantial time during appointments to explain their cultural nuances, preferred pronouns, and intricacies of their community dynamics.

Actionable Steps:

- Universally educating providers with specialized training materials, connecting them to educational resources, and fostering connections with peers experienced in serving these special populations could play a pivotal role in cultivating an environment of understanding and rapport that could build stronger relationships with care providers.
- Training specific for LGBTQ+, gender-specific, older adult population, veterans/military personnel, and young adults.

Additional and Alternative Supports

Providing alternatives for medication-assisted treatment and educational materials for self-care strategies outside of a treatment setting may be helpful for individuals seeking a holistic treatment style. Additionally, focus group participants spoke of a desire to expand the type of support services offered while seeking treatment.

Actionable Steps:

- Add local, free (or significantly reduced cost) stress management, grief, and other support groups.
- Provide parenting support within behavioral healthcare programs.
- Add childcare and care for aging parents. to allow all individuals to access care despite their care-taking responsibilities.
- Provide educational materials to adolescents regarding managing substance use (prevention).
- Increase access to care with additional offerings of telehealth services and off-hours schedules for providers.

Limitations

The validity of these findings relied on the participant's responses in each focus group. Also, the generalizability of the findings depended on our sample population's representativeness. Therefore, the first limitation and most impactful was the lack of racial and ethnic representativeness. The need for more diversity among participants was present, specifically in non-white racial backgrounds and the underrepresentation of Hispanic participation. In addition, despite phase two of the evaluation study capturing more of the male voice than phase one, gaining a larger male perspective on these topics would be beneficial to balance findings.

The evaluation team sought out specific recruitment strategies to gain the participation and perspective of older adults (65+) and Pasco County residents but were met with low to no attendance. Mental health stigma remains a significant barrier to seeking help and support among older adults, often preventing them from accessing the vital resources they need for their well-being. The lack of representation within Pasco County speaks to the stigma that remains in this area regarding discussion of mental health. Three focus groups were attempted, but only one was attended. To combat these recruitment difficulties, it may be helpful to reword recruitment materials and outreach efforts to destigmatize mental health discussions and promote a more inclusive, age-friendly approach.

An additional limitation lies in potential data skewness. Given that phase exclusively represented Hillsborough County community members, this county's representativeness far outweighs the other three counties. Therefore, comparisons cannot be taken at face value (e.g., the frequency table). Understanding the comparisons requires data immersion to determine each county's actual needs, status, and perceptions. Another potential area of skewed perception could lie in the representativeness of providers within the study's sample. Providers were not a directly targeted subgroup population, but they attended several focus group meetings. The evaluation team agrees that the providers' perspective adds strength and depth to the data received in this evaluation. Providers can demonstrate what's happening at the front line of behavioral health services, a perspective that service recipients cannot provide. Additionally, provider participants also discussed their experiences as service recipients, aligning with the study's aims.

The following limitation lies in the need for expansion of the demographic survey. Although the survey captures important, de-identified information, it would be helpful to capture more information related to employment, mental health history, and service experience. Focus group participants often mentioned their reluctance to be emotionally vulnerable due to their field of work (e.g., law enforcement, military, etc.). The

demographic survey did not include questions related to employment or area of work, which could have identified additional special population sub-groups such as first responders. In addition, a large majority of participants were quoted as having "lived experience," by expanding the demographic survey to include questions related to lived experience, mental health diagnoses, and service experience, the evaluation team could have provided additional quantitative findings.

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, who are unwilling to speak openly about mental health. The evaluation team also encountered difficulties navigating recruitment, as commonly used recruitment and advertisement strategies sometimes failed to produce an adequate number of focus group participants.

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 multi-county Tampa Bay Region. This need is compounded by generational, cultural, and lifestyle 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 and system navigation, increasing access to and awareness of available behavioral healthcare resources within the Tampa Bay Region.

Appendix A – Demographic Survey Questions

Age: _____ **Current Zip code:**_____

(Please check your response)

What county do you currently live in?

- ☐ a. Pinellas
- ☐ b. Pasco
- ☐ c. Polk

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 answer
- ☐ 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

Have you utilized the "Let's Talk Tampa Bay Hotline" for behavioral health resources with Tampa Bay Thrives?

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

Do you feel that the COVID-19 pandemic affected your mental well-being?

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

Do you feel the COVID-19 pandemic affected your experience accessing behavioral health care services? (if yes, please explain)

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

Appendix B – 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 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).	N = 193	*"I found it a lot easier to seek mental health care in California than here. Why is that? Because there was a lot of low cost, free cost availability there"* *"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"*
Reasons for Not Seeking Help	Named reasons or examples of why participants negated seeking assistance with their mental health.	N = 256	*"a lot of people don't want to share or disclose because they're afraid of fallback or what someone will think of them. And I think that's a big barrier to them getting, you know, services because they're scared of what people think"* *"One bad experience is enough, especially the severity of the bad. Right. If it's bad because we didn't fit, that's one thing. If it's bad because we left feeling judged and worse than how we came, Speaker 5: I didn't wanna go back"*
Examples of Lived Experience (Positive Results to Services)	These are examples of participants' positive lived experiences associated with seeking treatment or accessing services.	N = 107	*"I called the crisis line once… actually, I called the crisis line twice, uh, it was like a Saturday or Sunday. It was, you know, years ago, uh, when I was feeling guilty and, and was dealing with some stuff and they helped me."* *"It was like so many of us having the same issues and it just made me feel like so safe and so comfortable and like I'm just like so glad that I did that because I almost didn't and it was like probably the best thing for me."*
Examples of Lived Experience (Public Stigma)	Personal or witnessed experiences of being judged, labeled, or avoided due to mental health.	N = 154	*"… they went to court behind my back, and they terminated my rights, and they played the crazy card. And I've been, I've been judged, and I've been not treated right at all by my family."* *"Yeah, definitely shunned. Looked down upon. "Something is wrong with me," you know what I'm saying? They'll look down upon like, "Why can't you get it together? Other people are functioning and doing what needs to be done, so why can't you do it? What's wrong with you?"*

Code	Definition	N	Salient Quote
Cultural Differences Related to Mental Health	Personal or witnessed experiences of having one's culture (e.g., geographic region, subgroup population)	N = 222	*LGBTQ+* *"Like Psychology Today and all these different websites where you can filter and everyone says they're LGBTQ competent and specifically as a trans person, I've had like maybe three sessions with multiple people and just had to break it off and be like, you don't understand."*
			Veteran *"I can remember one time when I came back from Vietnam, I could tell that I was different. … So I go and talk to the First Sergeant and I tell him how I was thinking and everything. You know what he told me? He said, that's the way the Marine Code wants you to think."*
			Older Adult *"the baby boomers didn't perceive it, I don't believe… that was taboo. You don't talk about that. You don't share, you don't do that kind of stuff. And I think going down the generations, I think that the younger generations are much more in tune with it,"*

References

Axelsson, M., Schonning, V., Bockting, C., Buysse, A., Desmet, M., Dewaele, A., Giovazolias, T., Hannon, D., Kafetsios, K., Meganck, R., Ntani, S., Rutten, K., Triliva, S., van Beveren, L., Vandamme, J., Overland, S., & Hensing, G. (2020). Lived experiences: A focus group pilot study within the MentALLY project of mental healthcare among European users. *BMC Health Services Research, 20*(1), 605–605. https://doi.org/10.1186/s12913-020-05454-5.

Brouwers, E. P. M. (2020). Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: Position paper and future directions. *BMC Psychology, 8.* https://doi.org/10.1186/s40359-020-00399-0

Coley, R.L., & Baum, C.F. (2022). Trends in mental health symptoms, service use, and unmet need for services among US adults through the first 8 months of the COVID-19 pandemic. *Translational Behavioral Medicine, 12*(2), 273-283. https://doi.org/10.1093/tbm/ibab133.

Dow, C., & Siniscarco, M. (2021). Culture, mental health, and stigma. *Journal of Psychosocial Nursing and Mental Health Services, 59*(2). 5. https://doi.org/10.3928/02793695-202010114 -02.

Ewart, S. B., Bocking, J., Happell, B., Platania-Phung, C., & Stanton, R. (2016). Mental Health Consumer Experiences and Strategies When Seeking Physical Health Care: A Focus Group Study. *Global Qualitative Nursing Research, 3,* 2333393616631679–2333393616631679. https://doi.org/10.1177/2333393616631679.

Garverich, S., Prener, C.G., Guyer, M.E., & Lincoln, A.K. (2021). What matters most: Factors impacting the recovery process among outpatient mental health service users. *Psychiatric Rehabilitation Journal, 44*(1), 77-86. https://doi.org/10.1037/prj0000407.

Goldbach, J.T., Rhoades, H., Rusow, J., & Karys, P. (2023). The development of proud & empowered: An intervention promoting LGBTQ adolescent mental health. *Child Psychiatry and Human Development, 54*(2), 481-492. https://doi.org/10.1007/s10578-021-01250-2.

Gresenz, C. R., Stockdale, S. E., & Wells, K. B. (2000). Community effects on access to behavioral health care. *Health Services Research, 35*(1 Pt 2), 293.

Hansen, K.T., Plouffe, R.A., Walker, D.L., Wanklyn, S.G., Lamrock, L., Maher, P., Nazarov, A., & Richardson, J.D. (2023). Impact of COVID-19 pandemic on the mental health and well-being of veteran's spouses: A cross sectional analysis. *BMC Psychiatry, 23*(1). https://doi.org /10.1186/s12888-023-04687-y.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. British Medical Journal, 311, 299. https://doi. Org/10.1136/bmj.311.7000.29. Moallef, S., Salway, T., Phanuphak, N., Kivioja, K., Pongruengphant, S., & Hayashi, K. (2022). The relationship between sexual and gender stigma and difficulty accessing primary and mental health services among LGBTQI+ populations in Thailand: Findings from a national survey. *International Journal of Mental Health and Addiction, 20*(6), 3244-3261. https://doi.org/10.1017/s11469-021-00740-7.

Lester, H., Tait, L., England, E., & Tritter, J. (2006). Patient involvement in primary care mental health: a focus group study. *British Journal of General Practice, 56*(527), 415–422.

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.

Mental Health America. (2023). State of Mental Health in America Report. *Mental Health America - Printed Reports*. Retrevied from https://mhanational.org/issues/mental-health-america-printed-reports.

Moallef, S., Salway, T., Phanuphak, N., Kivioja, K., Pongruengphant, S., & Hayashi, K. (2022). The relationship between sexual and gender stigma and suicide attempt and ideation among LGBTQI+ populations in Thailand: findings from a national survey. *Social psychiatry and psychiatric epidemiology, 57*(10), 1987-1997.

Mol, M.P.G., Cairncross, S., Greco, D.B., & Heller, L. (2019). Urban waste collectors in Belo Horizonte, Brazil: Their perceptions of occupational health risk. *Qualitative Health Research, 29*(3), 371-381. https://doi.org/10.1177/1049732318797934

Monteith, L.L., Smith, N.B., Holiday, R., Holliman, B.A.D., LoFaro, C.T., & Mohatt, N.V. (2020). "We're afraid to say suicide": Stigma as a barrier to implementing a community-based suicide prevention program for rural veterans. *Journal of Nervous and Mental Disease, 208*(5), 371-376. https://doi.org/10.1097/NMD.0000000000001139.

Moore, Kathy, Brown, Bonnie, Ellenberg, Emilie, Carlson, Melissa, & Morehead, Amy (2023), Understanding mental health perceptions and the impact of stigma on accessing behavioral health services: An evaluation with Hillsborough County.

Morgan, D. L. (1996). Focus Groups. *Annual Review of Sociology, 22*(1), 129–152. https://doi.org/10.1146/annurev.soc.22.1.129.

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.

Robertson, S., Gough, B., Hanna, E., Raine, G., Robinson, M., Seims, A., & White, A. (2018). Successful mental health promotion with men: The evidence from 'tacti knowledge.' *Health Promotion International, 33* (2), 334-344.

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.

Siegel, J.A., & Sawyer, K.B. (2020). "We don't talk about feelings or struggles like that": White men's experiences of eating disorders in the workplace. *Psychology of Men & Masculinities, 21* (4), 533-544. https://doi.org/10.1037/men0000253.

Shepherd-Banigan, M., Shapiro, A., Stechuchak, K.M., Sheahan, K.L., Ackland, P.E., Smith, V.A., Bokhour, B.G., Glynn, S.M., Calhoun, P.S., Edelman, D., Weidenbacher, H.J., Eldridge, M.R., & Houtven, C.H. (2023). Exploring the importance of predisposing, enabling, and need factors for promoting Veteran engagement in mental health therapy for post-traumatic stress: A multiple methods study. *BMC Psychiatry, 23*(1). https://doi.org/10. 1186/s12888-023-04840-7.

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.

Toren, S., van Grieken, A., Lugtenberg, M., Boelens, M., & Raat, H. (2019). Adolescents' Views on Seeking Help for Emotional and Behavioral Problems: A Focus Group Study. *International Journal of Environmental Research and Public Health, 17*(1), 191–. https://doi.org/10.3390/ijerph17010191.

U.S. Census (2023, September). *Urban and Rural.* Census.Gov. Retrieved November 8, 2023, from https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html

Notes

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