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

# An Evaluation of the Tampa Bay Region

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A MENTAL WELLNESS COALITION

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## Introduction

### Background

Individuals who experience behavioral health issues have reached an all-time high as rates have significantly increased over the past few years. 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. 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. Often, 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.

Focus groups are a new aspect of treatment 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, 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, Bronwyn and colleagues (2019) explored 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 listening to the 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.

In 2022, Tampa Bay Thrives (TBT) and the University of South Florida's (USF) Mental Health Law and Policy (LHLP) Department embarked on an exploratory research evaluation project to gain insight into perceptions of mental health and behavioral health needs among its community members within Hillsborough County, Florida. Using qualitative methods, USF's research team conducted six focus groups (N=63) to obtain community perspectives on the following: (1) reasons for not seeking behavioral health services, (2) views on mental health, (3) perspectives on stigma, (4) lived experiences with symptoms, diagnosis, and treatment, and (5) positive experiences with behavioral health services. The study sample consisted of men and women at least 18 years of age and included potential service recipients, college students, and working professionals, including those in the behavioral health field. The sample consisted primarily of heterosexual, white, female participants who had not sought behavioral health services for themselves or others. Results showed that the primary reasons for not seeking behavioral health services were difficulties with system navigation, financial barriers/insurance or lack thereof, difficulty with finding an appropriate provider that matched the participant's needs and cultural background, not prioritizing behavioral health services, and fear of being judged or labeled. These results speak to the need for systems of care to prioritize mental health destigmatization, reduce unnecessary system navigation barriers, and improve provider cultural competence training.

## 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 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, Pasco, Pinellas and Polk Counties. Immediate care referrals are available in Hillsborough and Polk Counties with an upcoming launch of immediate care resources referrals in Pinellas County.

## Current Project

As part of Tampa Bay Thrives' commitment to understanding community needs regionally outside of Hillsborough County, it embarked on a second evaluation study partnering 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 focus groups with a cross-sector of Polk, Pinellas, and Pasco County residents as well as a more diverse subpopulation. 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 to be 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 in an effort 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 supports to their veteran service recipients, rates of veterans with PTSD utilizing services continues 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 being higher in older adults (Dow & Siniscarco, 2021), leaving this subpopulation at extreme risk of a mental health crisis. In our prior evaluation study (Moore et al., 2023), 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 are 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 our first 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.

Therefore, the primary goal of the current study is to gain a better understanding of behaviors that aid and hinder behavioral health service provision within a larger geographic region outside of Hillsborough County and more diverse subpopulations. 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, (4) challenges and positive experiences related to accessing behavioral healthcare within Polk, Pinellas, and Pasco Counties, (5) impact of COVID-19 on participant's mental health symptomology, and (6) the co-occurrence of chronic health conditions.

# Methodology

## Project Procedures

Seven 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 seven 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 also collected, including 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

The seven 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 as well as to their commitment to servicing the local area. Among many other activities, his location provides (1) community service fundraisers, (2) international service, (3) youth service, (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.

The three remaining 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.

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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.

## Qualitative Data Methodology

Each focus group discussion was led by a skilled moderator and was held in an 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 participants to share their beliefs, attitudes, and experiences freely. 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

## Participant Demographic Characteristics

Table 1 details the demographic characteristics of 65 participants. The mean age was about 47 years, with the majority between 25 to 34 years of age (ranging from 23 to 88). Most participants were female (51.5%), with a lower percentage of male participants (37.9%). The majority of participants were White Caucasian (60%), with 21.5% Black African American and 10% reporting Hispanic ethnicity. Most participants reported that they are straight/heterosexual (65.2%), with 15.2% reporting being gay/lesbian/homosexual. Almost all participants (84.4%) did graduate high school, with 19.7% completing some college, 22.7% reporting either an Associate's or a Bachelor's degree, and 15.1% reporting a Master's degree. Almost half of the participants reported that they did not seek behavioral health services (48.5%) or helped a friend seek out behavioral health services (53%). As presented in Table 2, participants lived in various zip codes, with Pinellas and Polk Counties occupying most of the focus group participants.

**Table 1. Participant Demographic Characteristics (N=63)**

| Characteristic | N | % or Mean |
|---|---|---|
| **Age (years)** | | |
| 24 or under | 3 | 4.6% |
| 25-34 | 16 | 24.6% |
| 35-44 | 11 | 16.9% |
| 45-54 | 15 | 23.0% |
| 55-64 | 9 | 13.8% |
| 65+ | 8 | 12.3% |
| Missing | 5 | 7.6% |

| Characteristic | N | % or Mean |
|---|---|---|
| Gender | | |
| **Male** | **25** | **37.9%** |
| Female | 34 | 51.5% |
| Non-binary | 1 | 1.5% |
| Missing | 5 | 7.6% |

| Characteristic | N | % or Mean |
|---|---|---|
| **Race** | | |
| White/Caucasian | 39 | 60.0% |
| Black/African-American | 14 | 21.5% |
| Asian | 3 | 4.6% |
| Multi-racial | 1 | 1.5% |
| Missing | 8 | 12.2% |
| **Ethnicity** | | |
| Hispanic/Latino | 7 | 10.6% |
| Non-Hispanic | 49 | 75.3% |
| Unknown | 3 | 4.6% |
| Missing | 6 | 9.2% |
| **Sexual Orientation** | | |
| Straight/Heterosexual | 43 | 65.2% |
| Lesbian/Gay/Homosexual | 10 | 15.2% |
| Bisexual | 2 | 3.0% |
| Pansexual | 3 | 4.5% |
| Prefer not to answer | 4 | 6.1% |
| Missing | **3** | **4.5%** |

| Characteristic | N | % or Mean |
|---|---|---|
| **Level of Education** | | |
| Less than high school diploma | 5 | 7.6% |
| High school diploma/GED | 11 | 16.7% |
| Some college | 13 | 19.7% |
| Technical degree | 7 | 10.6% |
| AA/BA degree | 15 | 22.7% |
| MA/PhD degree | 10 | 15.1% |
| Missing | 4 | 6.1% |
| **Sought BH Services (Self)** | | |
| Yes | 25 | 37.9% |
| No | 32 | 48.5% |
| Prefer not to answer | 3 | 4.5% |
| Missing | 5 | 7.6% |
| **Sought BH Services (Someone Else)** | | |
| Yes | 24 | 36.4% |
| No | 35 | 53.0% |
| Prefer not to answer | 1 | 1.5% |
| Missing | 5 | 7.6% |

Table 2. Zip Codes by County (N=65)

| Zip Code | County | N | % or Mean |
|---|---|---|---|
| 33547 - 33713 | Polk County | 41 | 63.0% |
| 33801 - 33898 | Pinellas County | 19 | 29.2% |
| 33563 - 33584 | Hillsborough County | 2 | 3.0% |
| 33655 | Pasco County | 1 | 1.5% |
| No Response | N/A | 2 | 3.0% |

## 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 four primary themes emerged. These overarching themes are identified as (1) Mental Health, (2) Stigma, (3) Help-Seeking Behaviors, and (4) Recommendations for System Improvement. 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. *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*. 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:

> *"When I think about mental health, I think about a chemical imbalance cause people with mental health got a chemical imbalance."*
>
> *"Well, me personally, I think they're kind of off the chain."*
>
> *"I say all the time, I would rather be physically sick, than be mentally sick."*

The participants also expressed words that demonstrated compassion for those who were struggling with mental health issues. One positive perception expressed was that having mental health concerns, a diagnosis, or engagement in treatment, has become more accepted, thus making more resources available and more people willing to get help.

> *"But nowadays, it is more known that like you don't need to be put on medication… there is also therapy, you can just talk and then you feel a lot better."*

An additional positive perspective some participants shared, particularly female participants, is that having a mental health diagnosis result in them being deeper thinkers, more able to connect to others, and comradery. One participant even coined it as a 'superpower'.

> *"… it's a superpower at the same time because I see the world differently."*
>
> *"We're all here trying to help each other get better."*

However, some generational and cultural differences were expressed regarding participants' perceptions of mental health in general. Some of the different cultural groups included nationality, gender, race, ethnicity, sexual orientation, and military presence. Some collective perceptions among these groups, such as some Hispanic and African American groups, voiced that discussing mental health concerns were viewed as a weakness or shameful to discuss openly amongst their family or community members.

> *"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."*

In several focus groups, it was mentioned that being emotionally vulnerable or discussing one's emotions or feelings was not as acceptable for males as it is for females. This comment was mostly expressed by males. When talking about their childhood, they remember being told to "toughen up" or being too embarrassed to cry. Several males also stated that they wouldn't feel comfortable discussing their mental health or feelings with another male due to the importance of masculinity in society and the 'weakness' that having mental health symptoms projects. Specifically, veterans and law enforcement members expressed trepidation about discussing their mental state or concerns with someone else. Some veterans stated they would seek treatment now, given that they have been out of the military for quite some time, but were confident they would not have sought treatment if they were still on active duty.

> *"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."*

> *"I think there's … a couple layers with men and veterans. Those are two areas that I think add an extra layer that makes it harder to open up and discuss something like mental health."*

> *"I have buddies that are in law enforcement, and there's this stigma against law enforcement officers, that have um, you know, mental disabilities."*

There were also generational differences among the participants' views on mental health. Comments mostly centered around the idea that discussing mental health or one's feelings in past generations was frowned upon or viewed as negative. In comparison, it was perceived that today's youth or young adults feel a sense of confidence in expressing themselves, including their mental health.

> *"I think the younger generations are just much more in tune with it."*

> *"The baby boomers did perceive it, they just thought it was taboo, you didn't talk about that."*

> *"Bipolar… we just didn't have that stuff when I was growing up."*

**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.

> *"It was not until I left home at 20 years old to go to college, for the first time, that my whole world and life view changed."*

> *"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 hide so much that it doesn't bother me, I have isolated myself from the whole world, because of my fears."*

> *"I had a client who told me that when he told his family he was at a family dinner with aunts, uncles, cousins, that kind of thing, and 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."*

Some participants shared examples of lived experiences where they had been mistreated due to public stigma after sharing about their mental illness. Some examples of these include:

> *"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."*

> *"We have a friend of ours in this group and, and we know when he's up and we know when he's down. Like, we're aware of this, of who he is, and I'm, and I'm sure this has affected him professionally in terms of his business in he should be at a certain level of his profession, but he's not there because of that."*

> *"Especially within the LGBTQ community, it's like we've all kind of experienced [stigma] in some shape form. Right?*

**Help-Seeking Behaviors and Treatment.** Several questions were asked to evaluate participants' views and experiences with seeking help for mental health conditions or symptoms for themselves or others. Their responses were divided into three sections: reasons for not seeking help (which included logistical barriers and challenges), self-help behaviors, and positive experiences from seeking help.

After coding each of the transcripts, participants spoke of reasons for not seeking treatment more than any other category. Some echoed similar motives for not wanting to seek help for themselves or what they believed were explanations, and some gave unique and personal details as to why they chose not to or would not again. A few of the more common justifications for not choosing to seek treatment stemmed from fear. Participants expressed concerns over not fully understanding what treatment meant; others feared the repercussions from family, their employers, friends, church members, fellow military, or law enforcement. 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. Additionally, participants expressed apprehension about seeking treatment 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.

> *"Oftentimes people don't reach out for help because of their current employment status. Like the military or those going into law enforcement roles, so on and so forth. So, if you raise your hand and say, I'm struggling, then the fear is that there's gonna be a repercussion."*

> *"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"*

> *"So, I know with mental health, I believe you won't be able to keep a gun license. I'm just not gonna pursue my mental health, I'm just gonna leave it just to be able to keep a license."*

> *"My husband, I think he's actually diagnosed with depression, but whenever it comes up, a lot of people just lie because we do have a right to bear arms in this country and you know, my husband's a veteran for instance, so he's gonna have his guns."*

> *"They 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."*

Of note, is the participants' feelings of providers lacking cultural competence despite their help-seeking behaviors and service provision efforts. Many participants expressed difficulty finding a provider whom they believed could truly understand and help them. This is especially poignant within the subgroup populations of focus. Veteran participants felt that it was too difficult to meet with civilian providers due to their unique service experiences, particularly when having combat-related mental health symptoms. For LGBTQ+ participants, the difficulty of feeling 'worse' after meeting with a provider was often expressed, sharing the sentiment that when seeking help, they do not want to be inadvertently offended by their provider not being LGBTQ+ competent. Older adult participants felt providers were too young to be relatable.

> *"How are you going to adequately diagnose a mental health condition from me if you're not really listening to me?"*

> *"No one was LGBTQ friendly."*

> *"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."*

While each of these explanations was mentioned numerous times at various focus groups, the overwhelming sentiment amongst participants was the logistical barriers they had experienced or believed they would encounter if they sought help for their mental health concerns. Participants voiced facing barriers to seeking help for mental illness, such as long wait times to see a provider, not having a provider near them, lack of insurance, feeling it was too expensive, could not get the time off work, lack of childcare, lack of transportation, service navigation difficulties, and language barriers. It should be noted that frequently participants stated these as a concern or explanation for not seeking help but didn't have first-hand experience with these barriers, but rather inferred these would be possible challenges due to others' experiences. While others 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."*

> *"I know some good therapists around. There's a therapist here in town whose kind of become the Quaker therapist. There's a lot of people in my congregation who go to see him, but he's expensive and I don't have that kind of money."*

At the conclusion of the discussion about logistical barriers and after hearing all the reasons why participants were hesitant to seek treatment or what they thought was preventing them or others from getting help, the moderator would ask if anyone could share a positive result or experience with getting assistance for, their mental health. The responses to this question were usually short, but also reaffirming. Participants mentioned positives such as: getting sober, learning to live again, living life to the fullest, finally making friends, becoming physically stronger, keeping their kids out of jail, giving them their family back, bringing them closer to a loved one, and helped them heal after a deployment.

> *"I wake up sober every morning."*

> *"I have regained a relationship with both of my younger children. My husband and I are finally on the same page."*

> *"Like it's been a complete 180 from where I was when I started to where I am now. I can't describe it enough how being with the therapist that I'm with and being in the group that I'm with, oh how you develop a friendship, a circle."*

> *"Like my dad just recently passed and I was able to pick up a phone and call somebody to talk me through that."*

> *"I went from the bottom, no car, no home, nothing, to being an assistant manager! Like I said, I just got a new job, I got a new car, like I'm on my way to the top like, you know, the life, and friends."*

> *"Girlfriends and friends that's something I never had before, and friends that, you know, that will last a lifetime."*

A couple of the focus groups had participants who were licensed mental health providers. They shared how the positive moments with clients and success stories over the years are what continue to motivate them. Several providers spoke of the powerful feeling that they felt when one of their clients began advocating for themselves. Another spoke of the pride she felt when she witnessed what she described as a cycle of dysfunction, finally being changed. A few of the provider participants mentioned that some clients not only were able to achieve long-term recovery but also went on to become peer mentors.

> *"For them to see that someone's standing up for them."*

> *"Especially if it's for addiction, typically everybody else has kind of written them off. So, to work with a client and see them start to get hope again or to work with a client and see them start to change their family culture and get their kids going in a different direction. Not let themselves be abused anymore. I mean that, that's an amazing thing to see."*

> *"Sometimes you witness like a cycle of this being broken."*

## Recommendation for System Improvement

Each focus group ended with asking participants what recommendations they had or what they wished would happen for system improvement. The most frequent response was more education and awareness in the community about mental health. Specifically, more education about what services and resources are available. Participants would like to see treatment providers advertise alternatives to medication and speak about more ways for clients to help themselves outside of therapy. There was a desire for more community education on self-help methods for more minor mental health concerns or parenting support. Overwhelmingly, participants recommended an expansion of the type of services offered. Examples of such requests were: stress management groups, parenting support, managing substance use, teen, and adolescent support, caring for aging parents, medication management, more telehealth options, and off-hours or flexible schedules for providers.

Veterans and those with ties to the military requested more information be provided about the services offered not only through the military but through the community as well. They hoped that accessing treatment for themselves or for their loved ones would be more openly discussed, to help reduce stigma. Despite research supporting an expansion of mental health services within the VA (Shepherd-Banigan et al., 2023), veteran participants also expressed a desire for the VA to expand mental health services, noting very long wait times and limited choice in assigned providers.

Additionally, participants felt it would be helpful if their employer offered more information about how to access mental health services with their company's insurance. One recommendation was for employers to mention that sick leave or paid time off can be used for mental health appointments in the same way it's used for medical illness or appointments.

> *"If I can start from the top and say, listen, I'm gonna make a work environment that's supportive in helping them with whatever's going on rather than an environment that's gonna make whatever's going on worse. And I think that's what we should be training our employees to."*

> *"Why do we have to wait? Why do we have to wait to get mental health? That is a crisis situation. Why can't we go and get mental, get, get help before there's a crisis?"*

> *"Why aren't there any walk-in mental health clinics? Like there are for when you are sick?"*

> *"If I as a provider can learn to accommodate rather than push away."*

## Subgroup Populations

When reviewing the data provided by specific subgroups (older adults, veterans, LGBTQ+), some common themes emerged among these groups (e.g., need to be understood by their provider and accessibility to services) as well as several differences (see Figure 1: Special Populations Response Frequencies). Notably, individuals within the LGBTQ+ population expressed significantly more stigma-related experiences and fears than their veteran and older adult counterparts, with four times as many responses. Several LGBTQ+ participants felt shamed and/or offended by their providers, which is unique to this subgroup population and speaks to the need for improved competency training and appropriate provider designation as LGBTQ+ allied.

> *"It was very frustrating to me. And for a period of time really made me not trust mental health professionals cause they weren't really listening to what I was saying to them."*

> *"I think also the like, intersection of different identities also plays a role being a trans woman. I think most people think I'm crazy already. So then like, uh, PTSD or depressed, you know, add other things on top of that."*

> *"…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."*

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."*

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."*

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."*

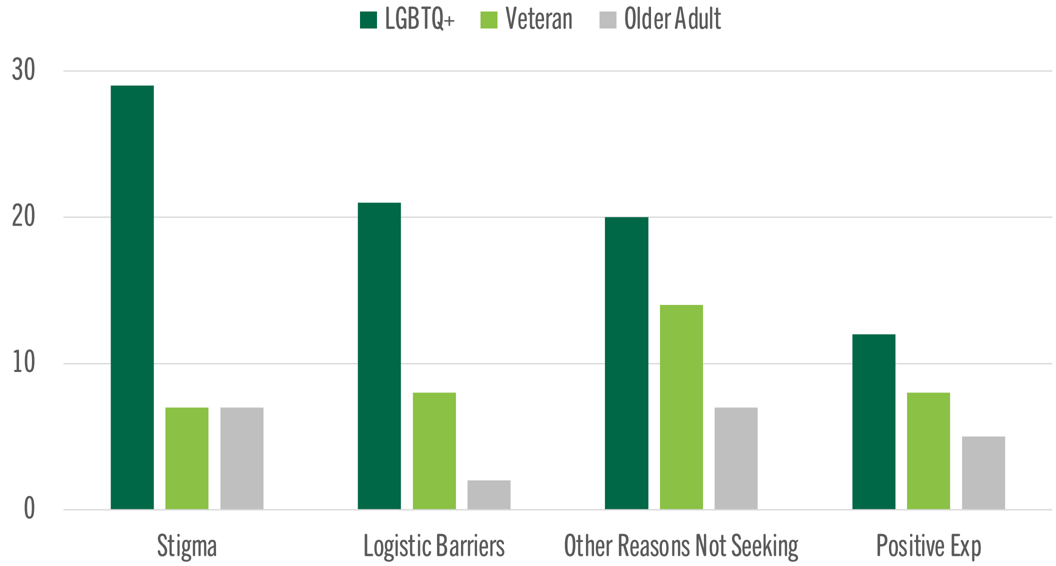
Interestingly, suicide was mentioned among the subgroups more often than any other participant group. This aligns with the research on the impact of stigma, veteran suicide rates, and the incidence of completed suicide being highest among older, white males. The veteran participants expressed more awareness 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."*

Figure 1. Special Populations Response Frequencies



## Summary

The data collected in this qualitative evaluation reflect the pervasive nature of stigma and its impacts on the way a person perceives their own mental health, the behavioral health care system, and views on accessing care for themselves or someone close to them. Within the sample, generational, cultural, and lifestyle influences guided their perceptions of mental health and their behaviors related to accessing care. Their fear of facing stigmatized responses and judgment from family members and friends, co-workers, and the general population discouraged these community members from being emotionally vulnerable and seeking necessary care. Further, significant logistic barriers make accessing care difficult, even for those seeking treatment. Some unmentioned barriers include lack of insurance coverage, out-of-pocket fees, scheduling, provider matching, and a general lack of awareness of available services and how to find them to stop individuals from accessing the care they want and need. The following recommendations address additional contributing factors related to stigma and accessing care behavioral healthcare within the Tampa Bay Region.

# Recommendations

## Destigmatization

Similar to our findings in the Hillsborough County report, and 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. To combat these stigmas, a call for anti-stigma or destigmatization education and awareness is needed within the Tampa Bay Region. To address this concern, the following are recommended:

- Implementing anti-stigma programming across counties, 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 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, 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

Similar to our findings in the Hillsborough County report, 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. Recommendation include the following:

- 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.
- Promoting inclusivity and diversity within marketing campaigns for mental health. Community members want to see other seeking care that looking like them (e.g., age, sexual orientation, cultural background, racial/ethnic background, and field of employment).
- 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.

## Education for Family and Friends

Educating family and friends 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. Recommendations include:

- 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.

## Special Population Training for Providers

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 members seeking 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. Recommendations include:

- 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.

## System Navigation Assistance

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. Recommendations include:

- Integration of 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.

## 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 style of treatment. Additionally, focus group participants spoke of a desire for expansion of the type of support services offered while seeking treatment. Some examples of additional and alternative supports include the following:

- Stress management groups
- Parenting support
- Childcare and care for aging parents
- Educational materials in managing substance use with teens and adolescents
- More telehealth options or 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 was dependent on the representativeness of our sample population. Therefore, the first limitation and most impactful was lack of racial and ethnic representativeness and the need for more diversity among participants, specifically in non-white racial backgrounds and the underrepresentation of Hispanic participation. In addition, although this evaluation study captured more of the male voice than the prior evaluation, gaining a larger male perspective on these topics would be beneficial to balance findings. Future focus groups should expand recruitment strategies to reach these populations as the literature reports they're most likely to encounter barriers to accessing behavioral healthcare services. Additionally, there was a lack of representation within Pasco County.

The next 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, which 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 = 73 | *"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"* |
| Reasons for Not Seeking Help | Named reasons or examples of why participants negated seeking assistance with their mental health. | N = 119 | *"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"* |
| Examples of Lived Experience (Positive Results to Services) | These are examples of participants' positive lived experiences associated with seeking treatment or accessing services. | N = 59 | *"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."* |
| Examples of Lived Experience (Public Stigma) | Personal or witnessed experiences of being judged, labeled, or avoided due to mental health. | N = 55 | *"… 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."* |
| Cultural Differences Related to Mental Health | Personal or witnessed experiences of having one's culture (e.g., geographic region, subgroup population) | N = 76 | *LGBTQ+*<br>*"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*<br>*"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*<br>*"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,"* |

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# Notes

Tampa Bay
THRIVES
A MENTAL WELLNESS COALITION

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