Mental Health Outreach in Men: Focus Group Analysis

Background:

This is a qualitative analysis of 3 focus groups pertaining to mental health, treatment, and outreach preferences in Shasta County men. Its purpose is to identify the mental health needs and challenges faced by this population, as well as generate preferred strategies and directions for future mental health outreach campaigns.

During the focus groups, participants were asked their opinions of 3 different mental health outreach campaigns which aimed to reach men who are at risk for suicide. The 3 campaigns are Man Therapy, which is a humorous campaign developed in Colorado by the Carson J. Spencer Foundation, Man Up, which is Man Therapy's Australian counterpart, and Up2Us, which is a community-based campaign from San Francisco. The goal in asking participants about these campaigns was to identifiy the advantages and disadvantages of each, and use it to build a local outreach program in the future.

Methods:

Participants were recruited from a number of sources, including the HHSA Facebook page, the Redding Facebook page, the suicide prevention workgroup email list, and CPR training. Attempts were made to reach participants through gun shops, but no one responded through that channel.

Participants included 10 men and 5 women, including mostly agency employees and spouses of employees. The focus groups lasted 1.5 to 2 hours, and asked a number of questions pertaining to men's perception of mental health, mental health treatment services, preferences for maintaining good mental health, and preferences regarding outreach programs.

Analysis Methods:

Definitions:

For the purposes of this analysis, Mental Health Treatment was differentiated from non-professional care activities by using the following mutually exclusive definitions. These terms are also used throughout this document.

TERM:	DEFINITION:
Treatment	Refers to medical or psychiatric treatment provided by a licensed professional only. (Does not include support from friends or family, self-care, or non-medical activities such as yoga or sports.)
Care	Refers to non-medical care for mental health problems, including self-care, non-medical activities such as yoga, seeking support from loved ones etc. (Does not include negative behaviors such as drug use or self-harm.)

Research Questions:

The project coordinator provided the evaluator a list of preliminary hypotheses, which were reframed into the following 5 research questions prior to the analysis:

1. How do men seek out care or treatment for mental health? How does this behavior differ from other groups?
2. What is the perception among men of mental health and mental illness?
3. What barriers do men face when seeking mental health treatment or reasons for delaying treatment?
4. What preferences do men have regarding mental health awareness messages?
5. What preferences do men have regarding mental health care or treatment?

Coding

During the analysis, each statement which was relevant to the analysis was coded into one of nine preset categories, eight of which were used (see table). Each statement was assigned only one code. If a statement included multiple major themes, it was broken into separately coded segments. If a statement included a key theme which was not included in the preset codes, it was assigned a new [emergent] code, which were used to identify unexpected emergent themes.

Code	Research Question	Definition
Treatment or Care Seeking Behavior (Descriptive)	1	Participant provides a description of male treatment or care-seeking behavior, whether it be different or similar to care-seeking in women or other groups. Statement does not include an explanation for the behavior.
Perception of Mental Health or Mental Illness	2	Participant provides a description of male perception of mental health or mental illness. Statement does not include a connection with seeking, delaying, or decision not to seek treatment.
Perception of Mental Health Treatment Services	3	Participant provides a description of male perception of professional mental health treatment services. Statement does not include a connection with seeking, delaying, or decision not to seek treatment.
Barriers to Seeking Treatment	3	Participant makes a cause and effect statement describing a reason for choosing not to seek mental health treatment.
Reasons for Seeking Treatment (Causal)	3	Participant makes a cause and effect statement describing a reason for seeking treatment.
Preferences for Mental Health Awareness Messages (Positive)	4	Participant describes preferences for mental health messages. Includes things they liked about the presented options, and positive ideas for messages.
Preferences for Mental Health Awareness Messages (Negative)	4	Participant describes preferences for mental health messages. Includes things they didn't like about the presented options, and ideas of what they wouldn't like to see in messages.
Preferences for Mental Health Care or Treatment	5	Participant describes preferences for mental health care or treatment (refer to definitions above).

Note: Unused Code was “Reasons for Delaying Treatment.”

Results:

Participants

In total, 15 participants were recruited. They were placed into 3 separate focus groups. Focus Group 1 included 5 men ages 36-64. Focus Group 2 included 5 women ages 39-63. Focus Group 3 included 5 men ages 54-71. Demographics for each participant are described in the table below.

Group/Participant "(G#P#)"	Gender	Age	Occupation	Marital Status	Parent	Education
G1P1	Male	64	Certified Shorthand Reporter	Married	Yes	High school/trade school
G1P2	Male	71	Retired	Single	Yes	BS
G1P3	Male	43	Management	Single	No	BA
G1P4	Male	57	Self employed	Married	Yes	12th
G1P5	Male	36	Engineer	Single	No	Some college
G2P1	Female	61	Community Worker/Advocate	Married	Yes	BA/Teaching credentials
G2P2	Female	63	Program coordinator/hypnotist	Married	Yes	Graduate degree
G2P3	Female	40	Hospice social worker	Married	Yes: step-children	Masters
G2P4	Female	58	Writer/on disability	Married	Yes	Some college
G2P5	Female	39	Social Worker	Single	No	Masters
G3P1	Male	70	IMAM	Married	Yes	Some college
G3P2	Male	71	Engineer/retired	Married	Yes	BS, MS, MBA
G3P3	Male	59	Program Coordinator	Married	Yes	Masters
G3P4	Male	54	Courier	Married	Yes	BS
G3P5	Male	70	Community Orgnanizer	Married	Yes	Some college

1. Mental Health Treatment or Care Seeking Behavior

The female respondents (Focus Group 2) described male treatment and care-seeking behavior in more general terms and at greater length than the male respondents. Many said that their male loved ones frequently don't talk about mental health issues, had an easier time talking about issues besides mental health, or would shut down or numb-out when asked about mental health issues. Most of them described needing to encourage men before they would open up about feelings.

Male respondents described men (themselves or others) who "plow through" emotional pain, experience stigma against showing feelings, and either refuse to seek mental health treatment or who are slow to uptake treatment.

2. Perception of Mental Health and Mental Illness

There is no one cohesive statement that can be made to summarize participants' feelings on mental illness. Participants varied so widely in their perceptions of mental illness that some participants even appeared to directly contradict themselves. Some of the more common themes are discussed below:

All or nearly all participants agreed that anyone would be susceptible to mental illness in some form, but they disagreed about what makes a person vulnerable. Some of the specific reasons that were mentioned included head injuries, military deployments, feeling unneeded, life stressors, aging, unemployment/economy, self-blame, and living in a rural area. The below quotes demonstrate the wide variety of responses:

> "You think, "I'm indestructible and strong". And then you have problems. You have to realize it. We're human, we have mental problems." [This represents the most common answer.]
>
> Participant 2, Focus Group 3
>
> "It's definitely true, you are [vulnerable to mental illness]. Anything can happen in your life that changes your opinion. Heck, you could take a fall and hit your head and next thing you know, you have a mental issue. It happens to quite a few people."
>
> Participant 4, Focus Group 1
>
> "For me, it was a bad business dealing. I got screwed in a business deal. And then some other things that were less consequential to it, seemed a lot bigger. So, it can be physical, or it can be that marriage falling apart, bad break-up, you know there's lots of triggers out there. So I would say that no one's invincible to it. I think there are some people who are less prone to it."
>
> Participant 5, Focus Group 1
>
> "The tears of joy, the tears of pain, the tears of sorrow – all that, but we're still supposed to just be stone-faced, and what you say displayed in American society is it's okay for men to be angry, but it's not okay for men to be crying and sad because something's happened. Or, tears of joy and, so, to me this ability, or the acceptability of showing anger is something that could also, well, feeds into violent society, but also feeds into higher rates of suicide."
>
> Participant 3, Focus Group 3

Mental illness was commonly connected with homeless people and veterans. All three groups mentioned concerns about the mental health needs of homeless populations. No one felt that those needs were being adequately met, and in some cases this view contributed to a poor opinion of the mental health system (see perception of mental health treatment, below). Focus Groups 1 and 3 spent a significant amount of time discussing how to improve services for homeless people. Veterans were connected to their high rates of PTSD, suicide, and level of mental health stigma in the military (see Barriers, below).

Other, less common opinions about mental illness included: it is difficult or impossible to treat, treatable, connected with violence, and runs in families. Participants also noted a societal preference for treating mental illness with a pill, which they viewed as insufficient to fix the problem.

3a. Perception of Mental Health Treatment Services

Perceptions of Mental Health Treatment Services were more negative than positive, with negative statements primarily focusing on limited access to services and the system's inability to address the needs of local homeless populations. In contrast, positive statements focused primarily on quality of treatment. Some people spoke in a strongly positive way about personal experiences with mental health treatment, and a few offered nuanced opinions, noting both positive and negative elements and experiences.

Negative assessments often centered on the idea that mental health treatment in Shasta County was available, but that access was limited. Many people mentioned that there were not enough services available to meet the needs of the local community, and provided a variety of reasons and examples. They mentioned a lack of services for veterans, needing to drive out of the county for services, the past closure of a mental hospital, needing to access services through the local court system, and lack of adequate funding.

Many people also connected the quality of mental health treatment services with homelessness. The general perception was that with such a common and highly visible problem with homelessness, the mental health system cannot be addressing the community's need effectively. This topic was brought up spontaneously in all 3 focus groups. The following response is typical:

> "I don't see mental health here in Redding as being effective, because every day driving up and down the street I see people, men and women, that need to have their situation addressed. They're talking to telephone poles, to, I don't know, invisible people that you can tell they have mental health problems. But there's nowhere to go here. I think they even, they even closed down the, my late wife used to work at the mental health over here, they closed down the hospital they had over there."
>
> Participant 1, Focus Group 3

Another common finding was that while services were available in the county, residents (or the respondents themselves) were often unaware of available services.

> "I would take a completely different tack and say what mental health services? I don't know what's available. The private services are easy to access if you have a credit card that has a positive balance, someone's gonna see you. Fortunately for me, I had financial means when I was dealing with my stuff. But, to this day, I wouldn't know what services are out there and available."
>
> Participant 5, Focus Group 1

Positive feedback on mental health treatment services focused around quality of care. Some respondents mentioned themselves or loved ones having good experiences with therapy, and a few mentioned having had both good and bad experiences. Those who mentioned good experiences with therapy frequently described getting different benefits out of treatment than what they expected:

> "The experience I had didn't save my marriage. That was the reason we went, but it didn't save our marriage. Where it helped me was it made me realize that my first marriage ending was not the end of the world. And there was nothing wrong with me. That's the benefit I got out of it.

> And the therapist helped prepare me for the possibility that this marriage might not survive. He made me face that. And then helped me realize that there was nothing wrong with me…"
>
> Participant 1, Focus Group 1

3b. Barriers to Seeking Mental Health Treatment

Stigma was overwhelmingly identified as the most common barrier to seeking out mental health treatment. Participants mentioned external sources of stigma, such as being called "crazy" or "shell shocked" by peers. They also mentioned internal sources of stigma, such as wanting to be a "tough guy" or not wanting to feel like a failure.

> "My ex-boyfriend was a severe alcoholic. He still didn't think mental health was valid, even when his life was at stake. He reached out to his friends, played golf, drank alcohol. He 'powered through,' which was a common philosophy of his friends around here: 'We're tough, we don't need help.'"
>
> Participant 5, Focus Group 2

Participants also mentioned high levels stigma present in specific professions: members of the armed forces, military police, veterans, first responders, and police officers were all identified as having heavy stigma against mental health problems. Some types of stigma mentioned by participants could have professional consequences.

> "They are the hardest to get in to talk to somebody. Beyond what we're talking about, they have to be afraid of their fellow officers. If I am perceived as having a mental problem, will they feel safe being my partner? Am I somebody they can rely on? I don't want to jeopardize that because there's a real brotherhood."
>
> Participant 1, Focus Group 1
>
> "I have friends and family in defense contract, the military police. You can guarantee they don't say anything, which can lead to some bad situations, because the moment you do, you lose your security clearance, now you don't have a job, you don't get a promotion. So there's some major consequences, just by coming out that you have an issue."
>
> Participant 3, Focus Group 1

Apart from stigma, participants also mentioned lack of awareness of mental health issues, services, or the importance of seeking treatment, having bad previous experiences with therapy, insufficient access to services because of living in a rural area, or hearing second-hand stories about bad mental health treatment.

> "Well, a lot of guys like me, I've fixed things my whole life. And some things you can't fix no matter how hard you try. You need help and we don't know how to go out and ask for help sometimes."
>
> Participant 2, Focus Group 3
>
> "My father, the first and only time he engaged in mental health service is when his first marriage started to degrade. And it continued to degrade. They got divorced and, from that point

forward, he had a very negative opinion of mental health in general. And he won't talk about it much but my impression is that he feels like it failed him once, so not again."

Participant 5, Focus Group 1

3c. Reasons for Seeking Treatment

Some participants mentioned specific reasons for choosing to seek out mental health treatment. The most common reason was experiencing some kind of crisis, such as losing relationships (marriage counseling was common), extreme anger, or becoming homeless. Female respondents described actively persuading their loved ones to enter therapy. One participant was referred to counseling by social services.

4. Preferences Regarding Mental Health Awareness Messages

None of the three programs presented to participants emerged as a clear favorite in all three groups. Generally, Focus Group 1 favored Man Therapy, followed by Up2Us San Francisco, with Man-Up as their least favorite. Focus Group 2 preferred Man-Up, followed by Up2Us San Francisco, with Man Therapy being their least favorite. Some members of focus Group 3 preferred Up2Us San Francisco, but others did not like any of the materials and the group continued to discuss past ads that had resonated with them and potential areas of improvement.

Man Therapy

Advantages: Man therapy was seen as very engaging. Many people said they would want to click on many things before making a decision about the site. Participants also mentioned that it was funny and disarming, confronted stereotypes, and could engage multiple groups of people. Participants preferred the Duct Tape print ad over the one that described the smell of grilling meat.

Disadvantages: Some participants thought that man therapy was unrealistic/hokey, not politically correct, or that it might not connect with younger men. Those who preferred the duct tape ad felt that the other one "smell of grilling meat," would not connect with the local audience.

It's Up2Us San Francisco ("Comebacks" and "Garage")

Advantages: These two ads were viewed as touching/sentimental and highly relatable by participants. Participants also liked that the campaign was based locally, and had a stronger basis in reality compared to Man Therapy. They felt that the sports and car themes of the two commercials would be able to connect with the target audience. More participants preferred the Garage ad over the Comebacks ad.

Disadvantages: Some participants thought that the commercials came across as unclear or unfocused. Those who preferred the Garage ad mentioned that team sports are not as popular in Shasta County, and so Comebacks may be less effective.

Man-Up (Australia)

This campaign generated the least amount of discussion of any of the programs among participants in Focus Group 1 and 3, and was mentioned in an exclusively negative way in those groups. In Focus Group 2, it received the most discussion and was strongly favored over the other programs.

Advantages: Participants in Focus Group 2 liked the slogan "It takes guts to show pain." They also liked that it came across as raw and uncensored, and that it would give men permission to express and channel their anger.

Disadvantages: Man-Up was viewed negatively in Focus Group 1 and 3, but it was also barely discussed at all in those groups. Therefore it is difficult to pinpoint a reason why it was not discussed or not favored. However, there was some issue with the slogan "it takes guts to feel pain" and the title of the program. One participant said:

> "For me, the "Man Up" does not work at all. It's the source of the problem with American men.."
>
> Participant 3, Focus Group 3

Other preferences:

Participants frequently emphasized the need to use multiple outreach approaches to reach different groups of people. They also had a number of suggestions on the best ways to advertise to reach different populations. They suggested outreach on advertisements on television, internet, Spotify, billboards, buses, and at the Mission (homeless shelter).

For outreach and intervention, participants suggested person-to-person, through churches, phone, and text messages. Participants also felt that outreach materials should be focused and easy to understand, and contain brief videos and webpages that were not overly cluttered. They felt that outreach materials should be able to be reached anonymously.

Several participants mentioned mentorship as a good strategy for reaching men. They felt that being called to leadership would be a benefit to the mental health of older men, and that younger men would benefit from learning from older male role models.

5. Preferences Regarding Mental Health Care or Treatment Practices

Participants showed an overwhelming preference for "care"-based activities, as opposed to mental health treatment services. The most common responses for how to maintain good mental health included maintaining physical health (mostly through exercise), activities that create a sense of accomplishment (projects, volunteering, helping others), talking to trusted people (older male mentors was most common, but women, friends, a boss, and a wife were also mentioned), and prayer or meditation. Less common responses included making goals to change life circumstances, outdoor vacations, avoiding stressors, laughter, and staying away from drugs and alcohol. The following were mentioned only once: maintaining good relationships, reading self-help books, taking an occasional sleeping pill, and watching TV.

Participants also mentioned that the mental health of homeless people could be improved with access to showers, clean clothes, and a place to sleep. (Note: while participants were very clear on the need for better access to better professional treatment for homeless and other groups, they were not clear on the type of treatment that they needed access to).

Preferences regarding professional mental health treatment were rare overall, but came up most often among all-female Focus Group 2. They mentioned that their loved ones would not prefer support groups, psychiatrists, or medications, but would prefer female over male counselors, directive/practical therapy, and psychologists. Male respondents mentioned that treatment should be anonymous, and one man had a care/treatment preference for therapy.

Discussion

Limitations

This is a qualitative analysis of mental health, treatment, and outreach preferences in Shasta County men. It is not meant to be interpreted as a reflection of public opinion in Shasta County. Its purpose is to identify the mental health needs and challenges faced by this population, as well as generate preferred strategies and directions for future mental health outreach campaigns.

Due to technical difficulties, the audio for Focus Group 2 was lost before a transcript could be made. Analysis was conducted on Focus Group 2 based on the moderator's notes. The moderator's notes were recorded during the focus groups session, and consisted of documentation of each key statement by participants in as much detail as was possible. However, because they were not compared against the audio, it is likely that the notes missed details and statements by the participants. To mediate this effect, results from Focus Group 2 were stated more generally and interpreted with more caution in the analysis.

Findings

The results indicate that men face a number of challenges and barriers related to seeking professional treatment for mental health problems. Men frequently don't talk about mental health issues, attempt to "plow through" emotional pain, experience stigma against showing feelings, have an easier time talking about issues besides mental health, or shut down when asked about mental health issues. They may refuse to seek mental health treatment or delay treatment until they experience a crisis.

Perception of mental health and mental illness varied, but had a few common themes. Participants frequently connected mental illness with homeless people and veterans, though they also mentioned other groups. Perceived risk factors for mental illness included head injuries, military deployments, feeling unneeded, economy/unemployment, self-blame, life stressors, aging, and living in a rural area.

When men were asked about mental health treatment services, they thought almost exclusively of therapy. Other potential treatments, such as medications, support groups, psychologists, and psychiatrists were barely mentioned and generally recommended against when they came up. Feedback about mental health treatment was more negative than positive. Negative assessments centered on insufficient access to mental health treatment in the county, or lack of awareness/advertisement of services. Positive assessments centered on good experiences with therapy, though there were also a few bad experiences.

The strongest barrier to seeking out mental health treatment for men was stigma. This included both fears of being mocked or shunned by peers, as well as internal feelings that equated seeking mental health treatment with failure. Some of the external stigma mentioned included workplace discrimination, indicating a strong structural, as well as social, barrier to treatment. Lack of awareness, either of available services or the importance of treatment, also played into the decision not to seek treatment.

None of the presented campaigns (Man Therapy, Up2Us, or Man-Up) emerged as a clear favorite among participants. Participants liked that Man Therapy was highly engaging and humorous, but some thought that it came off as hokey. They liked that Up2Us was touching, sentimental, and relatable, but some thought that the ads were unclear as to their meaning or unfocused. Some liked Man-Up for its slogan

and its free expression of male anger, but a few disagreed with the slogan/title. Many participants emphasized the need to use multiple advertising and outreach approaches in order to reach different groups of people, and that outreach materials should be accessible anonymously.

Results demonstrated a strong male preference for non-professional "care"-based approaches to mental health, as opposed to professional treatment. Common ways to improve mental health included maintaining physical health, activities that create a sense of accomplishment, talking to trusted people, prayer or meditation, making goals to change life circumstances, outdoor vacations, avoiding stressors, laughter, and staying away from drugs and alcohol.

Recommendations

Efforts to improve male uptake of mental health treatment services should include education about the importance of seeking mental health treatment, as well as information about the availability of services in Shasta County. Reduction of internal and external sources of stigma against entering mental health treatment or expressing mental health needs will need to be addressed.

Future outreach programs and advertising campaigns aimed at men should use a variety of approaches to reach different groups (e.g. young men, old men, homeless, veterans). Participants showed preferences for outreach programs that were engaging, locally based, with relatable themes that were specific to the local community. Outreach to homeless communities was of particular importance to all 3 groups.

The strong male preference for care-based approaches to mental health suggests that men could benefit from community-based approaches to mental health, as opposed to direct referrals to treatment. Evidence also suggests that a mental health mentorship program could be acceptable in the community.