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“I can literally spill my guts and be 100% honest and it helped”: Narratives of Mental Health Service Utilization Among Young Black Gay and Bisexual Men Living with HIV

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Thesis Committee Chair: Sophia Hussen, MD, MPH

An abstract of

A thesis submitted to the Faculty of the

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in partial fulfillment of the requirements for the degree of

Master of Public Health

in Global Health

2022

Abstract

"I can literally spill my guts and be 100% honest and it helped": Narratives of Mental Health Service Utilization Among Young Black Gay and Bisexual Men Living with HIV By Zoë Johnson

Young, Black, gay, bisexual, and other men who have sex with men (YB-GBMSM) living with HIV, experience a high burden of mental health concerns, yet underutilize mental health care services. This study qualitatively explored mental health care pathways, including motivations, experiences, and barriers to care, to understand why mental health care service utilization and engagement remain low. We conducted a secondary analysis of 23 in-depth interviews with YB-GBMSM who previously utilized mental health care services using a narrative approach. We found that YB-GBMSM follow different pathways to utilize mental health care service. YB-GBMSM in our study were motivated to seek care due to several life stressors and events and reported overall positive experiences with the care they received. However, they faced significant barriers related to stigma, financial constraints, and logistics (housing and transportation) which influenced utilization and continued engagement in mental health care services. Our conclusions discuss implications for future research and suggestions for improving mental health service utilization and engagement among YB-GBMSM.

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Acknowledgements

Thank you to all interview participants for their willingness to share their stories for the OPENMIND study. My thesis would not have been possible without you.

Thank you to my thesis chair, Dr. Sophia Hussen, for your invaluable support in the design and execution of this thesis. Your mentorship, encouragement, knowledge, and uncanny ability to always keep it real, have been tremendous in helping me reach the finish line. To Dr. Michael Curtis, thank you for your mentorship and guidance throughout the thesis process, I have learned indispensable tools for academic writing, qualitative research, and analysis that I will continue to use in the near future. To my mom and sisters, thank you for always giving me something to laugh about and encouraging me to press forward no matter what.

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Chapter 1: Introduction and Literature Review

The next section will introduce the topic and review pertinent literature.

Mental Health and HIV

The relationship between mental health and HIV outcomes is well researched. A large body of work focuses on identifying the effect of mental health on components of the HIV care continuum, from transmission to retention and engagement, towards improved HIV outcomes. Poor mental health is associated with all aspects of the HIV continuum. Mental health issues, including substance use, may increase risky behaviors for HIV (Batchelder et al., 2017; Turpin et al., 2021), potentially increasing transmission. PLWH with co-occurring psychiatric symptoms experience significant disruptions in treatment due to missed visits, poor adherence to medical appointments, and low engagement in HIV care (McLean et al., 2017; Pecoraro et al., 2013; Zuniga et al., 2016). Similarly, mental health comorbidities are associated with decreased retention in HIV care (Saag et al., 2018). Finally, mental health symptoms, like depression, are associated with low ART adherence and viral suppression (Gokhale et al., 2019; Hightow-Weidman et al., 2017; Hussen et al., 2018). If individuals are unable to obtain and remain in care and adhere to antiretroviral therapy, this may contribute to increased mortality from and transmission of HIV.

Synergies between the effects of mental health and HIV outcomes are hypothesized to be mutually occurring, interacting epidemics, or also known as a syndemic (Singer & Clair, 2003). A syndemic is characterized by 1) diseases occurring at the same time or place due to harmful social conditions and 2) disease interactions produce mutually enhancing or deleterious health outcomes for populations or individuals (Tsai & Burns, 2015). While mental health outcomes have been shown to affect HIV outcomes and vice versa, no research has shown viable empirical results that

indicate an additive interaction characteristic of a syndemic (Tsai & Burns, 2015). Hence, more evidence is needed to define exactly how the two diseases interact. However, despite a lack of empirical evidence to support a syndemic, existing evidence shows that they do indeed co-occur (Tsai & Burns, 2015).

Young, Black, gay, bisexual, and other men who have sex with men (YB-GBMSM), are disproportionately affected by HIV in the US (Prevention, 2019a, 2019b, 2020). Black, gay and bisexual men represent over a quarter of new infections, with 75% of these cases occurring among young men between 13-34 (Prevention, 2019a, 2019b). Given the co-occurrence of mental health concerns and poor HIV outcomes, research, and public health interventions for YB-GBMSM have targeted mental health outcomes to improve HIV care engagement and overall well-being.

Mental Health of YB-GBMSM

In addition to high rates of HIV infection, YB-GBMSM suffer a high burden of mental health disorders and decreased wellbeing (Hussen et al., 2021). Despite the high burden of mental health disorders, most literature has focused on evaluating the mental health burden among MSM and PLWH, often of adult age, more generally or the effect of mental health on specific HIV outcomes, and risky behaviors.

Recent literature specific to the mental health concerns of YB-GBMSM focus on quantifying the magnitude of the mental health burden among YB-GBMSM and identifying psychosocial correlates. A 2022 study, suggests that depression, anxiety, substance use, trauma, and distress, are highly prevalent among YB-GBMSM (Hussen et al., 2022). A 2021 study of 435 YB-GBMSM, identified 43% of participants with mental health concerns, with depression and substance use as the two most common (Hussen et al., 2021). Other studies evaluating HIV

infected youth, more broadly, also estimated 42% of their sample had untreated mental health concerns (Whiteley et al., 2014).

Multiple mental health conditions and other life stressors further exacerbate the mental health burden among YB-GBMSM. A sample of YB-GBMSM recruited in Atlanta, reported a high number of mental health concerns and screened positive for one or more mental health issues related to anxiety, depression, and trauma at once (Hussen et al., 2022). In the same sample, HIV stigma and substance use was associated with higher depressive symptoms, while full time employment and lower HIV stigma was associated with lower depressive symptoms (Hussen et al., 2022). YB-GBMSM may also have more adverse experiences which increase their risk for mental health issues. Young MSM may experience more victimization, intimate partner, sexual, and physical violence than young heterosexual men (Turpin et al., 2021). In particular, young, Black MSM may experience greater stigma, victimization, and trauma than other young non-Black MSM (Mustanski et al., 2019)

Published mental health interventions for YB-GBMSM to date target informal and formal support to address their complex needs. The Youth to Telehealth and Texting for Engagement in Care (Y2TEC) intervention provided 12 weekly counseling session and utilized text messaging to identify barriers to HIV care, mental health, and substance use (Saberi et al., 2021). This intervention, where most participants had never received mental health or substance care despite a need, found improved ART adherence and HIV education, depression and anxiety symptoms, and stigma (Saberi et al., 2021). Another intervention, WITH U, utilized peer health navigators in place of licensed mental health providers to address behavioral, social, and psychosocial needs of YB-GBMSM living with HIV. Although no results were statistically significant, participants self-reported a positive experience with the intervention.

In Atlanta, multiple organizations provide interventions and mental health support for YB-GBMSM living with HIV, including Thrive SS, NAESM, Grady Infectious Disease Program (IDP), and the Center for Well Being. However, this may not be the case in other place of the United States.

Mental Health Service Utilization Among YB-GBMSM

Based on available data, YB-GBMSM living with HIV underutilize mental health care services, despite a high need (Hussen et al., 2021). In a retrospective cohort study, Hussen et al. (2021) found low service utilization, even when mental health care services were co-located with HIV care (Hussen et al., 2021). Study findings showed a gap between YB-GBMSM being diagnosed with a mental health concern and engaging in treatment (Hussen et al., 2021). Despite nearly 80% of those with mental health concerns being referred to mental health care, only 40.5% attended an initial visit and 19.6% continued in care (Hussen et al., 2021) . Study findings suggest a need to identify why YB-GBMSM engage and discontinue mental health care services.

Several studies investigated the mental health care service utilization of sexual minorities, with no particular focus on age or gender. Published studies suggest that lesbian, gay, and bisexual (LGB+) identifying individuals utilize mental health care services more than their heterosexual counterparts (Flentje et al., 2015). In a San Francisco study of 1,441 LBG+ substance treatment admissions patients, persons identifying as a sexual minority showed a higher likelihood of having a mental health diagnosis and utilizing mental health services (Flentje et al., 2015). Specifically, gay and bisexual men were more likely to receive mental health treatment or have a recent mental health assessment than their heterosexual counterparts (Flentje et al., 2015). Gay men were also more likely to have a recent psychiatric hospitalization (Flentje et al., 2015). These findings

suggest that service utilization is higher among sexual minorities. However, the average age of participants was 38 years old, with Black men making up about 36% of the sample. Hence, the study did not conduct analyses to look for potential differences within group based on race or age.

Other studies suggest a high unmet need when race, age, and HIV status are accounted for. Burns et al. (2015), in a study of 449 young gay and bisexual men, found most participants with a mental health diagnosis, had never received treatment (Burns et al., 2015). More specifically, 67.5% of young men had 12 month diagnoses, and 82.8% did not receive treatment in the last year (Burns et al., 2015). Similarly, Whiteley et al. (2014) investigated mental health care service utilization among 1,706 HIV infected youth between the ages of 13-26 years old (Whiteley et al., 2014). The exploratory study found that Black youth were less likely to receive mental health services and medication than non-Black youth, indicating a potential disparity among Black youth who are living with HIV(Whiteley et al., 2014).

Perceptions and Barriers

Internal and external factors influence engagement in care. Given that YB-GBMSM may identify with multiple stigmatized identities (i.e., gay, bisexual, Black, male), a few studies have investigated how this impacts engagement in mental health care. Literature about barriers highlight how perceptions about care, provider and institutional factors, and logistics pose potential challenges. Most studies focused on engagement in HIV care, although a few studies looked at mental health service utilization.

Perceptions of Care

YB-GBMSM, navigate their health at a complex intersection of race, sexuality, gender, and for those affected, HIV status (Harper et al., 2013, Fields et al., 2016). Literature investigating

this phenomena suggests that having one or more socially stigmatized identities may lead to lower engagement in healthcare and health outcomes among YB-GBMSM (Fields et al., 2016). Harper et al. (2013) showed that how one views their identity may also influence how they engage in care. In a study of 200 gay and bisexual youth living with HIV, positive ethnic identity, negative attitudes/emotions towards one's sexuality, and HIV positive identity salience were associated with a greater risk for missing a medical appointment (Harper et al., 2013). While the study did not categorize the specific type of appointment missed or focus on YB-GBMSM specifically, the results point to how different identity categories influence gender and sexual minority youth's engagement in care and can be used to inform both care management, and interventions. Similarly, Hussen et al. (2015) investigated what influences YB-GBMSM's engagement in HIV care (Hussen et al., 2015). Research findings showed negative self-image was associated with decreased care seeking and engagement, while positive ethnic identity, and employment were associated with higher appointment adherence (Hussen et al., 2015). Hence, for YB-GBMSM, identity, in addition to socioeconomic factors, may facilitate engagement in care.

While ethnic identity has showed a positive relationship with mental health care utilization, race may contribute to decreased mental health care utilization. Black men, specifically, are commonly purported to underutilize health services, including mental health, due to an array of system level (racism, discrimination, inaccessibility) and individual level factors (medical mistrust, stigma and masculine ideologies) (Eaton et al., 2015; Gaston et al., 2016; Mays et al., 2018; Sarah Clement et al., 2015). Other studies also suggests that black men are open to care, but the care they receive is not tailored to their personal needs or appropriately targeted for their help-seeking patterns (Keating, 2021; Lindsey & Marcell, 2012).

Barriers to Care

Stigma (related to HIV care or mental health), individual perception of need, provider characteristics and institutional relationships can serve as barriers to care (Arrington-Sanders et al., 2020; Doraivelu et al., 2022). Two qualitative studies explored what providers viewed as barriers to service utilization. Arrington-Sanders et al. (2020) conducted key informant interviews with HIV service providers for young, Black and Latinx MSM and transgender youth (Arrington-Sanders et al., 2020). Key informants reported an interaction between societal marginalization and HIV stigma which hinders youth engagement in HIV care (Arrington-Sanders et al., 2020). Specifically, informants noted how clinic providers lack cultural competence and understanding about their patients' intersectional identities challenged care engagement (Arrington-Sanders et al., 2020). Though the study focused on HIV care, this concept may also apply to how YB-GBMSM engage with other health care services. In a 2022 study, providers noted mental health as a number one priority for their patients (Doraivelu et al., 2022). However, in addition to stigma, and perceived need, their patients also expressed concerns about confidentiality and trust between providers (Doraivelu et al., 2022). For example, they did not want information that they shared with their mental health provider to be shared with their HIV provider, since both services were co-located (Doraivelu et al., 2022). While data collected is valuable to understanding barriers, both studies are from the provider perspective. Therefore, it is important to conduct interviews with individuals with the lived experience to gain the most accurate view.

Logistic barriers, including transportation, affordability of care, and insurance coverage were also noted as barriers to care (Doraivelu et al., 2022; Hightow-Weidman et al., 2017; Pecoraro et al., 2013; Saag et al., 2018) . If participants are unable to get to services, they will be unable to utilize services. Hence, understanding how to make mental health care services more accessible will be important to investigate.

Experiences in Care

One study looks specifically at the experiences in mental health care for LGB+ youth. Moore et al. (2020) conducted a qualitative study of 38 racially diverse LGB+ youth between the ages of 18-25 (Moore et al., 2020). Young adults in the study identified personal factors (thoughts, feelings, and beliefs about mental health care utilization), social factors (peer, family, and social support), accessibility and provider characteristics which influenced their experience in care and subsequent continuation or discontinuation of services (Moore et al., 2020). Ambivalence about needing mental health support, lack of family support, including negative cultural attitudes and religious beliefs about service use, knowledge about how to connect with providers, cost of care, lack of transportation, and competing responsibilities interrupted participants appointment attendance (Moore et al., 2020). Participants noted gaining autonomy (i.e. turning 18), taking more responsibility for their own well-being, and wanting to attain specific goals, like going to college, as facilitators to their engagement and continuation in care (Moore et al., 2020). Having supportive family and peers helped participants access low cost services, however, they note difficulty in scheduling low-cost providers due to the high demand (Moore et al., 2020). In regards to providers, participants noted increased engagement when providers seemed invested in their personal well-being, were non-judgmental, and well-informed about LBG+ issues (Moore et al., 2020). Participants expressed preference for providers with similar identities due to feeling the provider understood their point of view(Moore et al., 2020).

Problem Statement

YB-GBMSM living with HIV in the US contend with social, structural, and cultural factors that influence how they engage and maintain their health. Mental health concerns and disorders disrupt

engagement with life-saving HIV treatment and threaten general well-being. The literature on mental health care service utilization is limited and does not include the direct perspective of YB-GBMSM.

Purpose Statement

The purpose of this study is to explore the pathways of mental health care service utilization among YB-GBMSM living with HIV, including their motivations, experiences, and barriers.

Definition of Terms

YB-GBMSM *Young, Black, Gay, Bisexual and other Men who have sex with Men*

HIV *Human Immunodeficiency Virus*

PLWH *People Living with HIV*

US *United States of America*

LGB+ Lesbian, Gay and Bisexual

Chapter 2: Manuscript

Author Guidelines (for submission to Culture, Health & Sexuality)

Checklist: What to Include

1. **Author details.** All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
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9. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.

Contribution of Student

All data collection, coding, and initial analysis for the OPENMIND study occurred prior to the start of this thesis. The project is currently in the analysis and dissemination phase. My contribution to this project focused on exploring the narrative experiences of YB-GBMSM who utilized mental health care services. I conducted a secondary analysis of all transcripts meeting the inclusion criteria and determined themes to achieve this goal. 9 themes and 4 subthemes were identified during analysis representing motivations, experience, and barriers to mental health care service use. I also lead authorship of the draft manuscript reporting findings of this analysis.

"I can literally spill my guts and be 100% honest and it helped": Mental Health Service Utilization Among Young Black Gay and Bisexual Men Living with HIV (7500 words)

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Funding Details

This work was supported by the National Institute of Mental Health under Grant [R21 MH121164]; National Institute of Allergy and Infectious Diseases under Grant [T32AI157855 and P30 AI050409]. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Disclosure statement

There are no relevant financial or non-financial competing interests to report.

Mental Health Service Utilization Among Young Black Gay and Bisexual Men Living with HIV: A Qualitative Study

Young, Black, gay, bisexual, and other men who have sex with men (YB-GBMSM) living with HIV, experience a high burden of mental health concerns, yet underutilize mental health services. This study qualitatively explored mental health care pathways, including motivations, experiences, and barriers to care, to understand why mental health care service utilization and engagement remain low. We conducted a secondary analysis of 23 in-depth interviews with YB-GBMSM who previously utilized mental health care services using a narrative approach. We found that YB-GBMSM follow different pathways to mental health care service utilization. YB-GMSM in our study were motivated to seek care due to several life stressors and events and reported overall positive experiences with the care received. However, they faced significant barriers related to stigma, financial constraints, and logistics (housing and transportation) which influenced utilization and continued engagement in mental health care services. Our conclusions discuss implications for future research and suggestions for improving mental health service utilization and engagement among YB-GBMSM.

Keywords: mental health care utilization, mental health services, YB-GBMSM

Introduction

Young, Black, gay, bisexual, and other men who have sex with men (YB-GBMSM) living with HIV experience a high burden of mental health challenges. Depression, anxiety, and trauma-related stress are prevalent among YB-GBMSM and are related to declining well-being (Hussen et al., 2022). Mental health concerns for YB-GBMSM living with HIV are even more concerning given their consequences for HIV-related outcomes. Poor mental health undermines adherence to HIV care and treatment, decreasing the likelihood of favourable HIV outcomes like viral suppression (Gokhale et al., 2019; Hightow-Weidman et al., 2017; Hussen et al., 2021; Hussen et al., 2018).

In addition to the high burden and consequences of mental health symptoms, YB-GBMSM also have an unmet mental health care service need. Several studies suggest Black and sexual minority youth are less likely to receive treatment for mental health concerns than other groups (Burns et al., 2015; Whiteley et al., 2014). Similarly, YB-GBMSM may be less likely to utilize mental health care services or remain engaged in mental health care. A retrospective cohort study in Atlanta found that, among YB-GBMSM living with HIV who were referred to mental health care, 56% set an appointment, 40.5% attended an initial visit and just 19.6% continued in care (Hussen et al., 2021). This pattern of service utilization and engagement persisted, despite mental health and HIV care services being co-located (Hussen et al., 2021). Exploring YB-GBMSM's mental health care pathways, may provide evidence for why their utilization and engagement remain low.

There is a small body of research which focuses on the mental health service utilization of YB-GBMSM, specifically (Doraivelu et al., 2022; Hussen et al., 2021; Hussen et al., 2022). To date, however, most of these studies do not include the direct perspectives of YB-GBMSM or explore their mechanisms of engagement in mental health care services. Research which includes YB-GBMSM's perspectives may not only provide a holistic understanding of how they utilize mental health care services but may also help identify impediments or facilitators to service use and engagement. Therefore, to investigate the pathways to and experiences in care, we qualitatively explored the motivations, experiences, and barriers from the direct perspective of YB-GBMSM who have experienced mental health service use, as a step towards improving mental health care services utilization and engagement.

Methods

Qualitative Approach and Study Population

This paper represents a secondary analysis of data from the OPENMIND study, a mixed method study to explore influences on mental health service utilization among YB-GBMSM (ages 18-29) living with HIV in Atlanta, Georgia, USA. As a part of this study, 40 qualitative interviews were conducted to explore how YB-GBMSM conceptualize mental health services, including sociocultural, demographic, and clinical influences. This paper will analyse a sub-set of the qualitative interviews, with focus on the narrative experiences of YB-GBMSM who have previously utilized mental health services.

Sampling and Recruitment Strategies

Study participants were recruited from a large HIV clinic, community-based organizations, individual/community referrals, and other settings in Atlanta, GA. Recruited participants were screened for eligibility using a self-administered REDCap survey. Participants were eligible if they self-reported: living with HIV, between 18-29 years of age, male gender identity, and being gay, bisexual or having had consensual sex with a male partner. The study team utilized purposeful sampling to ensure diversity in ages between 18-29 and prior utilization of mental health services.

Data Collection

Forty qualitative interviews were conducted from July 2020-January 2021. Interviews were conducted via videoconference or in-person, as COVID-19 protocols permitted. At the start of each session, verbal consent was obtained by trained study staff, and participants completed a brief demographic survey on REDCap. A semi-structured interview guide, informed by Anderson’s Behavioural Model of Health Services Use and feedback from youth advisors, facilitated conversation about participants' utilization and need for mental health services.

Interview questions were open-ended to understand how participants viewed mental health (ex. ‘how would you describe good mental health?’ and ‘how does being [gay/bisexual/Black/HIV positive] influence your mental health, if at all?’). To understand mental health service utilization and experiences specifically, participants were asked if they ever sought support for issues related to their mental health from a series of mental health providers (psychiatrist, psychologist, counsellor, religious leader, or other). Follow-up questions asked participants how they learned about care, likes, dislikes, improvements, and reasons for ending care, if indicated. These questions were asked for each provider type indicated by the participant. Participants were also asked to describe any barriers they faced in seeking care. Participants who did not seek care were asked why and if they would consider going in the future.

Interviews were conducted by four masters’ degree-level staff and students, all of whom had experience and training in qualitative methods as well as shared identities with participants (e.g., Black and/or gay identities). Interviews lasted 60-90 minutes and were digitally recorded. Study staff kept field notes and recorded a debriefing summary at completion of each interview. Interviews and debriefs were transcribed verbatim by a professional service.

Procedures

Interviews were sorted to identify participants with prior mental health service utilization and to prepare the data for secondary analysis. Interview participants who indicated no mental health care service utilization in their lifetime were excluded. REDCap screening surveys, which included a question about prior mental health service use, were cross-referenced to ensure accuracy. After excluding transcripts of those who had not utilized mental health care, as well as those with transcription errors, 23 transcripts were identified for this analysis.

Data Analysis

Given the rich experiences shared by participants in the study, a narrative approach was most appropriate to accomplish the research aims. Narrative inquiry allows researchers to use stories to describe human action (Polkinghorne, 1995). As a first step, the first author (ZJ) read all 23 transcripts to become familiar with the data, with special attention to interview segments that discuss mental health care utilization. Next, holistic descriptive summaries were created for each. Summaries noted all aspects of participants mental health utilization including the type of provider(s) seen, reason for seeking care, experience in care (likes, dislikes, improvements), and reasons for discontinuing care, if applicable. Each summary was cross-referenced with transcript data to ensure accuracy. Categories based on the main plot points in participants' stories (i.e. type of professional seen, reasons for seeking care, experiences, barriers) were created to facilitate analysis. Next, we created a matrix in Excel to facilitate comparisons of participants across categories and identification of themes and patterns. Themes were validated by revisiting transcripts, analysing representative quotes, and through discussions with other study team members who conducted the interviews. Study team members met on a weekly basis to report progress, key findings, and results. Notes, memos, and a reflexivity journal were utilized throughout all stages of data analysis to enhance analysis and to account for subjectivity.

Results

The average age of participants in our sample was 25.1. Their median household income range was $10,000-$19,000, 50% were employed full-time at the time of interviews, and 77% had a high school diploma/GED or completed some college/tech school.

Themes and subthemes represent motivations for seeking mental health care (Formal Evaluation, Catharsis, Navigating Adversity (Sub-themes: Interpersonal Relationships, HIV Diagnosis, Suicide Attempt, Alcohol and Substance Use), experience in care (Free from Judgement,

Confidentiality and Trust) and barriers to care (Overcoming Stigma, Low Perceived Need , Financial Constraints and Logistics).

Motivations for Seeking Mental Health Care

Formal Evaluation

Formally evaluation for mental or behavioural disorders motivated some participants to seek care. Our study participants discussed formal evaluation for sex addiction and ADHD. Across cases, participants described wanting to verify if they had an underlying condition after noticing what they thought were atypical thoughts or behaviours.

> I felt as though I was kind of going crazy for the way that I felt and I didn't know if my feelings were of an addiction based or were they just something that I wanted to explore and you know, desire myself. By the end of that whole counselling sessions, it basically determined these were desires. (003, Age 27)

This desire for formal evaluation was often not related to feelings of depression or other more typical mental health diagnosis, but rather to learn more about themselves or overcome personal challenges.

> …I knew that certain things is hard for me to focus…so it made me seek out help to…get a mental evaluation… it wasn't even because of my mental health as far as like if I'm happy or depressed in a way. It was more so due to things that had a lot to do with ADHD traits and I couldn't understand why certain things were a little bit more difficult for me to do…I was like 'Okay, I'm gonna actually go so I can know myself… (007, Age 24)

After undergoing such an evaluation, participants felt a peace of mind from knowing and a deeper understanding of how to navigate these feelings in the future, whether or not their suspected diagnosis was confirmed. After a recent diagnosis with ADHD, one participant was curious if they were also bipolar and began to use the internet to self-diagnose themselves. Although they were not diagnosed, mental health services provided answers and potential solutions. They shared,

> I liked the self-discovery cause there was … questions that I've always you know, thought to myself… So with knowing I was able to…do my own research and figure out how to either prevent these things or navigate through them when I'm in these mind states. (007, Age 24)

In reference to not being diagnosed with a sex addiction, one participant shared the following:

> … by the end of it all that was determined…and I'm like alright, I'm not crazy for feeling this way. And no, my feelings are normal. I'm not even the only one that thinks like that…overall the conversation was healthy and beneficial and helped me progress in my own relationship with my boyfriend and yeah, I'd do it again. (003, Age 27)

Catharsis

Sometimes participants pursued mental health care because they simply wanted to talk. Although this was a relatively uncommon explanation among our study participants, participants 'just needing someone to talk to' motivated them to seek care.

> It was good…I just wanted somebody to talk to…She listened to me and she helped me understand my pain and stuff so it was good. (033, Age 27)

Others expressed feeling negative emotions and seeking care to let go.

> I: You said you have to let go of a few things. What do you think it's going to take … to let go of those things?
>
> P: These therapy sessions that I just started, um, just talking about it basically and just learning what to accept and what to take responsibility of, as to why I was in certain situations, and forgiveness. I have to learn how to forgive. (065, Age 21)

Navigating Adversity

Participants discussed a number of adversities as motivations to seek care. The following describes the circumstances our participants discussed.

Interpersonal Relationships

With Partner

Interpersonal relationships with a partner motivated participants to seek care. Participants used couples counselling to navigate complex or difficult conversations with their partner. One participant, who identified as pansexual, described using counselling to navigate discussions in his open relationship,

> …in my current relationship that's kind of like a challenge. Like how I would want to maneuver about my desires … and also catering to … what he's not okay with or what he is into. It gets … hard to communicate that sometimes or have him understand what you want in a relationship. (003, Age 27)

Others went to process claims of infidelity.

> My ex when he was cheating on me with one of my friends, made me feel like I was crazy. He went and brought me to a psychiatrist to talk to. I'm not crazy. I know what's going on. I know what's going on. I know what I see. I know what I feel. I know what I hear. You can't call me dumb cause I know what's going on. You don't see what I see. (020, Age 25)

Whether self-initiated or forced by a partner, participants felt optimistic that couples therapy could improve their relationship or resolve conflict with their partner. However, participants expressed mixed outcomes in their couples counselling sessions. Some gained skills that improved their relationship,

> We are learning new tools on how to communicate effectively. Um, active listening or how to practice active listening. Both of us have already like told each other things that we've never told each other before … I feel like that is, it's of course ripping the band aid off but it's also like, it feels good. It feels good to be able to like, express things to each other that you know, we've held in for however long and to do it in a controlled

> environment where it's not going to blow up into an argument … it's a better method of having healthier discussions. (003, Age 27)

For other participants, insights learned from couples therapy may have actually caused their relationship to end.

> I went because I was still in love and I thought maybe if I went it would make it better but it really it didn't … And then he had the nerve to bring the new boyfriend in there. (020, Age 25)

Couples therapy was not always well-received by our participants. For one young man, when asked how sessions could have been better, he remarked,

> I feel like honestly because…the therapist, was on their side. I was like, see we can't do this… (020, Age 25)

With Self

Personal check-ins, or "self-checks", motivated some participants to seek care. Self-checks were initiated in the context of wanting to be in a relationship or exiting a bad relationship.

> I wanted to be in a relationship, which I still am not in one. And I figured going to see a psychiatrist would be the adult thing to do. If I want to be in a relationship, let me go seek mental health to make sure that I'm good and I'm making the steps to ensure that I'm actually ready to be in one and I'm not just jumping into a relationship (002, Age 27)

Another participant described their mental health decline after a bad relationship,

> I was in a really bad mental place…because … I was in a relationship and my relationship was not good … But I was really trying to make it work actually my relationship impacted my mental health really critically…I had good things…that were happening in the physical plane. But in my mental scape, dealing with my emotions and trying to cope with being in a relationship with somebody that - and I have never experienced the type of person he was…I was very mentally stunted…. I had to seek outside help. (014, Age 20)

With Family

Family was a pain point for some participants and motivated them to seek care. Participants described self-isolating from unsupportive family members or in some cases, their entire family network, once it was in their power to do so.

> …you go through a certain period .. Where you're tired of feeling not wanted, you just do something about it, so those family who have a problem with my lifestyle, I just… don't be around you… I don't want to be around nobody who don't want me…It's sad to be like that, but…I don't want to be around people like that. (032, Age 28)

Although it was described as necessary for self-preservation, this type of self-imposed isolation from family caused a heavy mental burden. Some participants described turning to alternative forms of support like, drugs or alcohol, to cope in this situation.

> I: When you went that year… without communicating with your family, where did you get support from during that time?
>
> P: Drugs. Yeah, so that's when I like, yeah, that's when I went through a whole phase of drugs and alcohol and all that good stuff. (032, Age 28)

Participants described engaging with mental health care to process feelings towards their family or feelings caused by not having their family's support.

> When I got diagnosed with my condition [HIV], there were times where my dad, my biological dad wasn't there and it was just, it bothered me…I didn't want to hate him or I didn't want to put this thing in my mind to where I was just, like I had this pain. I kind of just wanted to get rid of it because I just had a lot of stuff that I had to deal with. I didn't want that weighing over me. (015, Age 19)

Another participant expressed a similar sentiment,

> I went through a little phase with my mother, well, just my whole family. I was not talking to them. It was like two or three months and in that time I realized that I kind of didn't like some things about my family that I wanted to discuss. (032, Age 28)

Finally, loss of support, due to the death of an integral family member, also motivated participants to seek care.

> I do get overwhelmed with the thought that not only did I have to lose my mom, but I'm battling something such as HIV and I don't have the support that I know I would have, had she been living…I had been balling up my emotions internally…it just created this overwhelming effect of emotions…I could be out in public and just have these outbursts of crying and just feeling really down, really emotional… I sought support not to lose myself. (001, Age 28)

HIV Diagnosis

When it came to their mental health, participants reported varying levels of perceived influence of HIV, if any at all. These levels of influence changed over time and often depended on where the participant was in their personal HIV journey. Participants discussed a combination of negative emotions following their HIV diagnosis: shame, mistrust of others, feeling "dirty"/unclean, depression, loneliness, paranoia, anxiety, and isolation. Depression was commonly expressed as an initial feeling after being diagnosed. One participant reflected,

> When I was diagnosed, I kind of went into depression and I went to go see a therapist… (023, Age 23)

Factors like level of personal acceptance of their diagnosis, and length of time since being diagnosed/ time spent living with HIV, also influenced how participants felt HIV impacted their mental health and, consequently their mental health service utilization.

> It had already been about a year since I had been diagnosed and I wasn't properly doing everything I was supposed to be doing. Because like I said, I was still in this denial stage and I just couldn't accept it and it was taking a toll on me mentally because I felt like my life was over. You know, at 20 years old I felt like, 'Damn, I have this virus. My life is over…I actually told that to my doctor at the time and he recommended me seeing her so

> that's how I ended up…and I honestly have to say I don't regret it. I'm glad I asked for that help… (025, Age 29)

Another participant remarked,

> Really like, it was recommended for me to go because that was back when I first got diagnosed with having HIV. So really, I was just going because you know, everyone said that I should go. I always felt like I could you know, handle myself or carry myself so I didn't really need one…it was really working in the beginning… I felt like back then, I was going every 2 weeks and then I scheduled it every week cause I felt like something would happen in that week and I would need to talk to somebody. But like now to be honest, I'm not gonna say that I put all my problems on my friends and stuff but like I have a very good support system now. (013, Age 21)

Some participants also expressed feeling like 'their life was over' after their diagnosis. Mental health care services helped them realize they were in control of their life and map out tangible ways to move forward.

> I thought that once I was HIV positive, it's over. It's done. You have no life. You have no true career… And being a Black gay man who is positive… I'm thinking to myself when…going to interviews… they know you're positive… the counselor...let me know saying, 'That's one of your long-term goals to be in the sports industry in some fashion or form. You can do that. Your HIV is not plastered on your face…they gave me just kind of a road map of what I need to do to get to where I am today and helped me to understand that I can do this. (080, Age 29)

It is important to note participants who did not receive mental health services earlier, expressed they wished services were offered when they were first diagnosed.

> I think if I had someone to kind of walk me through what the hell HIV was at 16 years old, instead of just dragging me to a doctor's office with my mom and some doctor giving her all the information, and I'm just taking medication and not knowing what I'm dealing with. Regardless of how old I am, I have the - not one time did anyone offer me any psychiatric

> help, or anything. I wasn't until years later, my first time going to see a psychiatrist was last year, and I was 26. And they had made it available, but not in [name of city], where I'm from.. Or not when I was 16 ,17, 18 years old and it was at its peak. (002, Age 27)

However, as participants learned more, they took more control of their own health and agency in how and if they utilized services.

> I: So when your doctor recommended it, was it an easy decision to decide to go or difficult?
>
> P: Yeah, it was easy then cause it was like I came in here and I didn't know. I was learning a lot of stuff so I was trying to go wherever she was sending me…But now that I know the ropes I'm like, 'No, I don't want to go and do that.' Well now I can make my own decisions but first I was learning everything when I first came here.
>
> I: So what…
>
> P: Cause just because she recommended me to somewhere doesn't make me feel like I need to go, like especially like that. At that time [when I was first diagnosed] I did need it…
>
> I: Okay. And now you don't feel as though you do?
>
> P: Uh-uh. (016, Age 27)

Involuntary or Mandated Treatment

Several participants were involuntarily enrolled in mental health services due to attempted suicide or drug or alcohol use. Despite being forcefully enrolled at the beginning of services, most participants discussed having a transformative experience in care and even wanting to continue services after the mandatory sessions ended. One participant described his experience recovering from bullying,

> Because I was going through depression. Like I said, I had gotten my jaw broken for being gay. I had gotten jumped in middle school or whatever, and I had my mouth wired shut for seven months and it put me in a depression state. I tried to commit suicide twice. My mom reached out and got me some help…At first I was like, I'm okay, I don't think I'm crazy, I don't need to talk to anybody. But she [the therapist] ended up finding ways to…trail through my emotions in ways, and instead of being angry and shutting in, she gave me ways to kind of express myself. She gave me other resources to calm my brain…I liked it. (044, Age 26)

One participant, who was admitted into a program after an arrest for driving under the influence (DUI), expressed similar reluctance at the beginning of his mental health treatment program,

> P: … [T]he DUI court program. It's a five-phase program. It was changing when I left it, but it's a five-phase program and it's 12 weeks per phase. Um, you have group meetings anywhere from three times a week ending off to one time a month about your alcohol and drug usage and the different ways to stay off of them, basically.
>
> I: Okay, so through the program that's where you…were forced into the counselling?
>
> P: Yup.
>
> I: …okay, so tell me about your experience seeing the psychiatrist.
>
> P: … so when COVID went down, that's when … I can't remember the name of it. But they were having a transition because a lot of the student therapists weren't allowed to talk to their patients. So I… talked to my social worker/case worker in the program and she referred me out to the community service board. So a part of being enrolled is meeting with the psychiatrist so you can be assigned to a therapist. I didn't ask for a psychiatrist but that's what they assigned me to be fully enrolled in the community service board.
>
> I: Okay, was it an easy or difficult process, especially since you were forced into it?
>
> P: It was [difficult] at first because I wasn't used to the idea of therapy. After I saw it helped and how talking about some of the things that I had going on was kind of relieving the stress from it, then I liked it. (028, Age 29)

Participants also described building connections with others while hospitalized. These connections helped the participant feel like they weren't struggling by themselves.

> …I kind of just felt like I was a disappointment to my family and to just everyone. I just felt like you know, my life was just not going anywhere and everybody would be better off without me. So I was in a really dark place to where I just felt like everything would just be better without me here. So I had like a plan to do something to myself and then my dad brought me to the hospital because I had I guess, tried to do something but it didn't really go as planned so they brought me to the hospital and then the doctor admitted me into…I forget the hospital that it's called, but I was admitted into there…So…when I was admitted, I was in a wheelchair so the whole time you know, I just kind of just…I had to kind of just deal with it and understand that you know, it's not over and that other people that were there were kind of not going through the same thing but they were dealing with other stuff as well so I wasn't alone. And you know, like the people that were there were very nice and I met a lot of friends through people. I don't really communicate with but I kind of you know, just I guess, if they contact me or something but it just kind of showed me a lot like you know, I'm not alone and I mean you know, that's it's not worth taking my life over it so that was kind of the experience I got there. (015, Age 19)

Contrastingly, some participants described how forced rehabilitation was counterintuitive to their mental health progress. One participant noted,

> …they was trying to push me to stop doing drugs… I know it's their job but that's what I didn't like when I was doing it… I think that's probably why I don't like to go and talk to them…sometimes. Because the more I start talking about drugs and stuff like that – I mean not now but then when I was on it, it just made me want to go do it. (016, Age 27)

This participant described being in and out of care up to three times before deciding to stop using drugs. However, when they were ready to make the change, not only did they know where to find resources, but also were able to re-enrol and fall back on supportive relationships at their centre. Speaking about the staff at the rehab centre, one participant stated:

> It makes you happy when other people are really happy for you. Like it's made me see that they really are not just here doing…like just here for a paycheck. They are really caring about their patients… I'm just proud that they're proud of me. (016, Age 27)

Experience in Care

Despite their motivations for seeking mental health care, participants had overall positive experiences. Participants overwhelmingly reported liking services because they felt free from judgement. Confidentiality and trust were also important to their experience.

Freedom from Judgement

Multiple participants shared they had positive experiences because they felt like therapy was a judgement free space where they could openly express themselves or be their whole self, one participant described,

> I: …[W]hat did you like about therapy?
>
> P: The fact that I wasn't being judged. (013, Age 21)

Another participant described how they felt being in a non-judgmental environment,

> I could literally be just 100% open and honest and there was no bias, there was no - I didn't feel the shame and I could literally speak. Because even when you're talking to family and friends and trusted people, there's always that bias, like do I really want my mom to know this? Do I really want my best friend to know that? What if they view me differently? It was such a relief, like no, you're paid to listen, and that's it. So I can literally spill my guts and be 100% honest. And it helped, it helped. That's the big thing, to be able to talk openly and honestly. (031, Age 29)

Confidentiality and Trust

Participants explained how confidentiality and trust were important to their experience in care. Confidentiality and trust made participants feel comfortable sharing personal experiences. However, participants also needed to establish trust with their provider first to begin feeling comfortable sharing.

> I was like a little reluctant cause I was like, I don't…am I gonna be forced to like divulge all this personal private information that I don't even feel comfortable or haven't shared with close friends and family and all of a sudden like I have this random stranger that I'm gonna like you know, share my life with? And then it was like, it's not gonna be that bad…I guess my experience but I felt so comfortable being able to confide in a stranger. (009, Age 24)

> I: Okay. So what did you like about that experience, being able to speak with a counselor?

> P: I liked the fact that I could tell her stuff that I knew she wouldn't go tell anyone else. I kind of could trust her and just being able to talk and vent and getting stuff off my chest that I was going through and her understanding and just being someone I just really could talk to. It just felt good talking and just someone that kind of understands and just venting. I liked that. It helped a lot, I would say. (015, Age 19)

Barriers to Care

Participants noted stigma, low perceived need, financial constraints, and logistics as barriers to care.

Stigma

Participants discussed internal and external stigma as a barrier to care. Participants described not wanting to tell people that they were enrolled in mental health care or being anxious about being labelled as 'crazy'. A participant stated:

> So initially, going to see the psychiatrist actually was a big deal. I didn't want to go because of the stereotypes and the stigma, of course. And it, and it, that did in itself, create a little bit of anxiety because not everybody wants to say that they had to see a psychiatrist. It has it's negative connotations but I felt that if I did not go see a psychiatrist, I was gonna lose myself. (001, Age 28)

Another participant remarked,

> So it was difficult because you know, you don't want to be labelled as "crazy" or you know, the first thing that you kind of hear in a lot of ways is um, Black men got mental

> issues. You know, it's that whole thing of that so it wasn't as easy. It took a lot of confidence and it took a lot of battling with myself. (007, Age 24)

Low Perceived Need

Participants also discussed personal doubt regarding their need for help as a barrier to care. Many participants noted positive experiences once in care but described needing to overcome their personal doubts first.

> I: And what has stopped you from admitting that you need to seek help?
>
> P: My own thoughts in my head telling me, 'Oh, you don't need help. You're okay.' When in reality like, you do need help. You do need to talk to somebody. You do, because you can't keep everything in. I try to keep it all in but eventually, you're gonna call them all out. I'd say that's one boundary or just admitting to myself that I need help. (033, Age 23)

Another participant remarked,

> …I never really believed in it like that. I had to mentally believe that it will be beneficial to me before I'm even able to put myself into it. So it took about a month. (050, 27)

Financial Constraints

Financial constraints were discussed frequently as a barrier to mental health care. One participant discussed his concerns with costs of care,

> …things like that are super expensive so I kind of felt like…it was by luck, in a sense. I went through my doctor – her wife is the psychiatrist, so she was able to get me you know, an appointment for free luckily but you know, if I was seeking out this stuff on my own, not having insurance and being without insurance and being HIV positive, it makes a lot of things kind of like, okay. Yeah, I don't have a $1,000, $2,000 to just drop and try to figure these things out and maybe it's something and maybe you're being honest and not just doing a job for a check or whatever. You know, it's just a lot of worries. (007, Age 24)

Another participant noted,

> Like you know, you can exhaust resources or you can go online and like try to figure out like where to go and Google it but it's like I don't necessarily have you know, hundreds if not thousands of dollars to like go to some random retreat or speak to this you know, licensed professional for like an hour and a half and pay all this, like pay this exorbitant amount of money that I don't have. But knowing like there is this resource [subsidized mental healthcare through the HIV clinic] where you know, I can pay this small amount of money or nothing at all and like have this resource afforded and available to me or readily available to me at that is…was incredible to know that so I jumped at the opportunity. (009, Age 24)

Logistics

Logistics, like transportation, also created a barrier to care for some participants. One participant noted feeling embarrassed about rescheduling so many times, that they stopped going to their mental health appointments:

> …I stopped going because it was around the time that I couldn't really necessarily get there. It was like a hard time for me to get there so I was just embarrassed about the whole thing and I didn't want to have to keep rescheduling on her, keep flaking, so ultimately I just stopped going. (013, Age 21)

Another participant described how housing instability prevented them from starting care despite wanting to, stating,

> …my mind was already made up. It was just my situation that I was going through wouldn't allow me to start [engaging with mental healthcare] sooner than I did…I was experiencing homelessness. (023, Age 23)

Discussion

Our findings suggest that YB-GBMSM living with HIV are motivated to seek mental health not necessarily by overt or classic psychopathology, but by wanting help understanding self, navigating relationships with familial and romantic relationships, or adjusting to HIV diagnosis. Further, our participants nearly uniformly described positive experiences with mental

health services, once enrolled in care. However, significant barriers related to stigma, personal doubts about need for services, financial constraints, and logistics (transportation and housing) create obstacles to mental health care engagement.

Young men in our study showed various motivations for seeking MH care services, with several participants involuntarily admitted. Formal Evaluation and Catharsis represented a less frequently mentioned motivation for seeking MH care. However, participants liked learning about themselves and having someone there to listen. Young men who sought care for a formal evaluation also noted how learning about their diagnosis, or lack thereof, helped them better respond and navigate challenges that may arise later. YB-GBMSM in our study may be motivated to mental health service use to both talk and be listened to, and to gain new information. Both findings are consistent with studies showing how youth value talking and see MH care services like therapy as an opportunity to develop new capacities and skills (Gibson et al., 2016; Midgley et al., 2016). Emphasizing the skills-based nature of MH services may improve engagement in services for YB-GBMSM.

Interpersonal relationships, specifically with partners and family, represented a common challenge prompting YB-GBMSM in our study to seek mental health services. Some young men utilized couples therapy to navigate conflict, communication, and personal needs in their partnered relationships, while other young men utilized individual therapy to conduct "self-checks", due to wanting to enter a relationship or after exiting a relationship. Family relationships also created significant challenges. Young men in our study noted a loss of family support due to their sexuality/identity and increased self-isolation. This self-isolation led to adoption of other coping strategies like drugs and alcohol. Other young men in our study were motivated to care to discuss negative emotions towards their unsupportive family, the impact

lack of family support had on their mental health, or the death of a family member who was integral to their support system. Social support, including family and partners, is important to overall well-being (Mavandadi et al., 2009; McDowell & Serovich, 2007) and YB-GBMSM may lack some of these important networks. Therefore, providers should be equipped to recognize signs of relationship issues and connect young men with resources.

Some young men in our study were motivated to care due to their HIV diagnosis. Often, the impact of HIV on the participants mental health varied with different factors such as level of personal acceptance of their diagnosis and length of time since being diagnosed/ time spent living with HIV. Young men felt MH support was most needed when they were first diagnosed. In this period, most of our participants noted feeling depressed and seeking care. Similarly, denial about their HIV status, lack of acceptance, and fear of 'life being over' after their diagnosis, created a mental health burden which motivated them to care. Our participants also discussed naivete about their HIV diagnosis as a motivation to care. However, as they learned more about their diagnosis and gained external emotional support, the less need they saw for MH care. This finding suggests that YB-GBMSM may seek care when they are dealing with new, unfamiliar, or life altering situations. Our findings support a previous study showing that time of diagnosis can be a particularly vulnerable, and traumatic for Black MSM (Mgbako et al., 2020). Therefore, diagnosing providers can help mitigate mental health concerns by offering young men mental health resources and counselling when diagnosed. Mental health providers should also focus on addressing young men's emotional concerns while helping them to understand how to create paths forward despite their diagnosis.

Although not motivated to care by themselves, young men who were involuntarily admitted expressed enjoying their experience. Young men admitted for suicide attempts

expressed a change in their mindset that allowed them to better express themselves or have a different outlook on harming themselves. These young men also expressed making connections with other individuals at the facility that helped them feel less alone. Older participants in our study who were admitted for substance use noted resistance to change before they were ready. These participants emphasized the importance of autonomy in their decision to stop using drugs. This finding is consistent with other studies which note how young people value autonomy, choice, and control in their forms of support (Gibson et al., 2016). Despite mandatory supervision, young men should still have the flexibility to choose how and if they engage in MH services. For example, allowing young men who are hospitalized to choose their therapeutic activities including if they participate in group or individual therapy, may improve engagement. Similarly, a focus on building a relationship, instead of pushing a behaviour change, may help youth feel comfortable coming back when they are ready to change.

Most young men in our study had an overall positive experience in care. They highlighted how providers created a non-judgmental environment where they felt free to express themselves openly and honestly. Additionally, they felt they could trust their providers due to the added layer of confidentiality. A previous study also highlighted concerns about confidentiality and trust among YB-GBMSM as a barrier to MH service utilization (Doraivelu et al., 2022). After starting services, young men in our study felt MH services were helpful. In fact, many felt speaking to someone in a non-judgmental environment with guaranteed confidentiality was a strength of service utilization. Contrary to other studies investigating the experiences of sexual minorities in MH care (Filice & Meyer, 2018; Rees et al., 2020), our study participants showed an overall satisfaction with the mental health services that they were provided. Additionally, none of our participants mentioned experiences of perceived racism, homophobia, or

discrimination from their MH provider. These finding may be due to providers having shared identities with participants, extensive experience with and knowledge of issues facing YB-GBMSM living with HIV, and/or training in culturally competent care delivery (Moore et al., 2020; Rees et al., 2020; Rutherford et al., 2012; Williams et al., 2020).

Young men in our study identified stigma regarding mental health service use, personal doubts, financial constraints, and logistic barriers, like transportation and housing instability, as barriers to MH care utilization. Previous studies have highlighted how pervasive negative attitudes in the Black/African American community about mental health may contribute to stigma and the underutilization of services, particularly among Black/African American men (Gaston et al., 2016). Creating culturally appropriate care environments, which ensure confidentiality, may help mitigate the stigma experienced by YB-GBMSM and make them feel more comfortable seeking help (Harper et al., 2013). Additionally, social norming campaigns may be helpful to reduce public stigma around mental health (Wohl et al., 2013). Finally, structural barriers including, cost, and lower perceived need have been linked to low engagement in MH care services among young adults (Cadigan et al., 2019; Munson et al., 2012). However, many of our participants seemed to recognize that they needed help and were open to receiving mental health care. Instead, financial constraints were noted as a substantial barrier to care for most of our participants and they often implied they would have better engagement if they could afford the full cost. As such, advertising low, to no cost services for YB-GBMSM who indicate mental health concerns may improve engagement (Moore et al., 2020). Additionally, utilizing informal social networks of YB-GBMSM to promote low, to no cost services may facilitate greater knowledge about help that is available (Moore et al., 2020)

Our study is not without limitations. Young men in our study may have a unique experience in MH services given that Atlanta, Georgia is more friendly, and aware of LGBT+ issues and the provision of services for Black gay/bisexual men. YB-GBMSM throughout the US, particularly in South, may experience more barriers to MH service utilization due to stigma, homophobia, and discrimination than our participants reported. Additionally, our sample only included YB-GBMSM who indicated prior MH service utilization, and therefore does not report on those whose barriers were insurmountable. Analysing the reasons why other YB-GBMSM did not engage in MH services may provide information about additional barriers faced by this population.

In conclusion, we learned that YB-GBMSM living with HIV take varied paths towards engaging in mental health care. Providing mental health services which are accessible and cost effective may address a significant barrier to young men's engagement and utilization of services. Future programs may build on our findings by advertising low to no cost services, and offering alternative formats like video conferencing, to address logistic and accessibility issues for YB-GBMSM living with HIV. Additionally, further research which investigates the influence of cultural and public perceptions about mental health on YB-GBMSM's service utilization, will be important to improving engagement.

Acknowledgements

This work was supported by the National Institute of Mental Health under Grant [R21 MH121164]; National Institute of Allergy and Infectious Diseases under Grant [T32AI157855 and P30 AI050409]. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Declaration of Interests

There are no relevant financial or non-financial competing interests to report

Chapter 3: Conclusion and Public Health Implications

Mental health care utilization and engagement among YB-GBMSM living with HIV is understudied, despite evidence of an unmet need. Current strategies focus on integrating mental health services with HIV care to improve accessibility and knowledge of services available. Our findings showed that YB-GBMSM are utilizing services, and enjoy their experience in care, but face social (stigma and personal doubts) and structural(financial constraints, transportation, and housing) barriers to care. It is imperative that public health interventions address the unique socioeconomic challenges faced by YB-GBMSM in accessing mental health to improve utilization and engagement in services. It is not only a matter of having care available, but YB-GBMSM must be able to get to and afford to stay in care. Efforts should focus on promoting low-no cost mental health services available, removing logistic barriers, like offering transportation assistance (i.e. bus or Lyft/Uber vouchers) or virtual visits, and incentivizing engagement. For example, a provider may re-structure a session to help their client build skills for finding housing or employment. Future research should investigate the feasibility and acceptability of these recommendations, how cultural and public perceptions influence stigma regarding mental health service utilization, generally, and the mechanisms by which stigma discourages mental health service utilization among YB-GBMSM.

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