

A Qualitative Investigation of Engagement in Mental Health Services Among Black and Hispanic LGB Young Adults

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Objective: Little attention has been paid to engagement in mental health services among racially and ethnically diverse youths who identify as a sexual minority, despite research indicating that they face significant mental health disparities. In this study, the authors assessed the service use experiences of black and Hispanic lesbian, gay, and bisexual (LGB) young adults to identify factors that promoted or hindered their engagement.

Methods: Semistructured interviews with 38 young adults regarding past and present experiences with mental health services were analyzed thematically for perceived challenges to and support for engagement. Participants' service use histories were reviewed for significant interruptions in services reported over the past year.

Results: Seventeen participants (45%) reported disengagement despite continuing to need services. Factors that influenced engagement were identified across four domains: personal, social environment, accessibility, and provider

characteristics. Stigma related to sexual orientation and cultural attitudes presented engagement barriers, whereas providers who were knowledgeable about sexual-minority issues were important engagement promoters. Additional barriers to engagement were ambivalence about treatment efficacy, lack of family support, and difficulty finding suitable and affordable care. Peers who identified as a sexual minority helped participants locate LGB-affirming services. Rapport with providers and health care autonomy assisted participants to manage barriers to engagement.

Conclusions: These findings offer insights about factors that can influence engagement with treatment among black and Hispanic LGB young adults. The findings reveal important provider competencies and can inform interventions to improve engagement and reduce mental health inequities among these youths.

Psychiatric Services 2020; 71:555–561; doi: 10.1176/appi.ps.201900399

Young adults between the ages of 18 and 25 are less likely to engage in needed mental health treatment than any other age group in the United States (1). Common barriers to mental health service engagement during this developmental period include lack of access to services and prohibitive cost (2, 3), difficulties navigating the adult health care system (4, 5), lower perceived need for treatment (3, 6), as well as social and emotional factors such as stigma and mistrust (3, 5). Young adults from black and Hispanic racial-ethnic groups (7) and those who identify as lesbian, gay, and bisexual (LGB) (8) have some of the lowest rates of mental health service utilization because additional barriers related to culture (9, 10) and providers' lack of knowledge about their needs (11, 12) further complicate their help-seeking experiences.

Even when LGB young adults from racial-ethnic minority groups use mental health treatment, they may not receive adequate care. LGB young adults are more likely to report unmet need for services compared with heterosexuals

(13, 14). Unmet needs (15, 16) and premature discontinuation of treatment (17, 18) are often related to perceived discrimination because mental health professionals may lack the necessary understanding of sexuality-based discrimination

HIGHLIGHTS

- Young adults from black and Hispanic racial-ethnic groups and those who identify as sexual minorities have low rates of engagement in mental health services.
- Qualitative interviews were used to explore factors that influence engagement from the perspectives of these youths.
- Major themes were ambivalence about treatment; stigma related to ethnic, racial, and sexual identity; autonomy; accessibility; and LGB-affirmative providers.

(19) and competencies for treatment of LGB young adults (20, 21). Experiences of heterosexism and antigay attitudes in health care settings are associated with nondisclosure of sexual orientation to providers (22), which can further reduce the quality of care received by LGB young adults (23). In addition, services designed to enhance engagement with mental health treatment among black and Hispanic populations are scarce (24) and are rarely adapted for young adults (25). Individualized care has been linked to treatment engagement among young adults who are difficult to engage (26). However, when there is limited provider knowledge and strategies for engaging black and Hispanic LGB young adults in treatment, personalized care that incorporates their cultural, developmental, and sexual-identity needs can be challenging to obtain.

LGB young adults in the United States have a disproportionate risk of experiencing mental illness (27, 28), specifically depression (8, 29), suicidal ideation and attempts (30, 31), anxiety (14, 29), and substance use (8, 29). Experiences of stigma and discrimination related to having more than one minority status (29, 32), when combined with the documented stressful developmental tasks of transitioning to adulthood (13, 31), contribute to these outcomes. Meanwhile, receipt of inadequate services (13, 17, 18), lack of provider knowledge about the needs of LGB young adults (19–21), and lower rates of mental health service use (7, 8) lead to significant disparities in mental health care.

This study was designed to address these gaps in knowledge and uncover the ways in which black and Hispanic LGB young adults experienced engaging with mental health treatment to identify and contextualize barriers to and facilitators of their service use. Although quantitative studies of mental health service use among LGB young adults have been conducted (14, 33), this study homes in on a key missing voice in the research: the point of view of LGB young adults. This approach has the potential for identifying novel targets for intervention and providing rich detail to help interpret and contextualize quantitative findings. Furthermore, this study attends to the service use experiences of LGB young adults specifically from black and Hispanic racial-ethnic groups, a focus that is currently absent from the literature (18).

METHODS

Sample

The sample was drawn from a larger study examining both ethnic identity and mental health service use in young adults with one or more minority identities. The larger study was conducted between November 2016 and March 2017 in New York. This study involved a purposive sample of young adults who were ages 18–25, identified as black-African American or as Hispanic-Latinx and as a sexual minority (including LGB), reported they had received mental health services (i.e., assessment or treatment from a mental health professional), and endorsed symptoms of mood or anxiety disorders within the past year. In addition to ensuring that

participants had experiences consistent with the research objectives, inclusion criteria confirmed that all participants had expressed a need for treatment.

Recruitment

Participants were recruited through community-outreach (i.e., fliers, e-mails, and social media posts) and venue-based (i.e., schools, nonprofit organizations, and health care agencies) methods in settings likely to have contact with young adults. Fliers were also provided to respondents for distribution to others who they thought would meet study criteria and be interested. Potential participants who contacted the first author were given information about the study and screened for eligibility either in person or by phone. Young adults were eligible for the larger study if they were between ages 18 and 29, identified as a racial-ethnic minority, and had used mental health services. They were excluded from participation if they had used services only for neurodevelopmental disorders, if they appeared actively psychotic or intoxicated at the time of the interview, or if they could not communicate sufficiently to consent or answer questions for any reason.

Interview Procedures

Informed consent was obtained in writing from all individuals included in the study. Face-to-face interviews were conducted by the first author, a licensed social worker with extensive clinical and research experience. Interviews were audio recorded, with notes taken by the interviewer throughout, and lasted from 30 to 60 minutes. They were conducted at various sites that offered privacy and were convenient to participants (e.g., private offices, community-based agencies, university offices). Participants received \$40 for their participation. The institutional review board at Columbia University approved all study protocols.

In this study, we used a semistructured interview protocol, the Service Assessment for Children and Adolescents (SACA) (34), to capture lifetime, past-year, and current use of mental health services. Open-ended questions based on the SACA were used as prompts for the interview protocol. Examples include the following: What were the reasons you went to that service? What were the reasons you stopped going? What was it like going to that service? Participants were also asked to describe any challenges that affected seeking help and to reflect on how their minority identities affected treatment experiences. Along with participant demographic characteristics, the Brief Symptom Inventory (35) was used to measure severity of current psychiatric symptoms. Written data (i.e., notes and measures) were reviewed by participants at the end of each interview to ensure accuracy.

Data Analysis

We transcribed interviews verbatim, and we coded transcripts using an inductive coding approach, following guidelines for thematic analysis described by Braun and

Clarke (36). The first author and a trained research assistant (L.L.) independently identified emergent codes related to barriers to and facilitators of service engagement across all interview transcripts. This process resulted in initial coding categories such as “knowledge about services,” “treatment will-won’t help,” and “family involvement.” Next, two co-authors (D.C. and M.R.M.) who are experts in substantive areas of the present research reviewed coders’ interpretations of the data and identified potential biases, unclear and redundant codes, and discrepancies. Reliability in the initial coding phase was achieved through multiple discussions and refinement of the codes until consensus was reached between coders (37). After coding differences were resolved, the first author identified themes that emerged in the interviews on the basis of the incidence and prominence of topics across participants. Participant responses that were coded with these themes were extracted for further description. Last, themes were sorted into four distinct domains. ATLAS.ti, version 7.1 (38), was used to track coding notes, changes, categories, and frequencies of codes and quotations.

Data from the SACA were used to characterize participants’ engagement with services in the past year. Participants who reported no significant interruptions in their treatment since initiating services, or between initiation and discharge when they no longer needed treatment, were categorized as continuous. Those who reported discontinuation of treatment despite a continuation of need were categorized according to the number of treatment interruptions between initiation of services and the time of interview.

RESULTS

Participants

Sixty-three percent (N=38) of the young adults from the larger study met inclusion criteria for this study. Table 1 provides a summary of sample characteristics. Most participants (N=26) reported lower incomes, with annual household incomes of less than \$54,000, and several participants (N=24) had symptom severity scores at the time of interview that were greater than the average for adult psychiatric outpatients. Table 2 presents information on participants’ treatment engagement and a summary of all settings where they reported having received mental health services. Most (84%; N=32) received some services from a mental health professional in the past 12 months, and 45% (N=17) reported at least one major interruption in treatment despite continuing need.

Domains

Factors influencing treatment engagement that were robustly represented in the interview data emerged across four domains: personal (233 quotes from 30 participants), social environment (214 quotes from 30 participants), accessibility (105 quotes from 29 participants), and provider characteristics (204 quotes from 34 participants).

TABLE 1. Demographic characteristics of 38 black and Hispanic LGB young adults who reported having received mental health services

Characteristic	N	%
Age (M±SD)	22.1±1.8	
18–21	12	32
22–23	16	42
24–25	10	26
Gender		
Female	16	42
Male	22	58
Sexual orientation		
Lesbian	13	34
Gay	15	40
Bisexual	10	26
Race-ethnicity		
Black, non-Hispanic	21	55
Hispanic, any race	17	45
Household income		
Low, lower middle	26	68
Middle, upper middle	12	32
Education		
Some high school	8	21
High school graduate or GED	22	58
Some college or college graduate	8	21
Symptom severity (M±SD) ^a	1.4±.7	
GSI>1.32 ^b	24	63

^a Measured with the Global Severity Index (GSI) of the Brief Symptom Inventory (BSI). Possible scores range from 0 to 4, with higher scores indicating greater severity.

^b GSI score was higher than the average for adult psychiatric outpatients (1.32) (35).

Personal Factors

Participants described personal beliefs and emotions that influenced their engagement. Ambivalence about the need for and efficacy of mental health treatment presented barriers to service use. Most participants (N=29, 76%) said that they had hesitated to initiate or had disengaged from services because they did not believe treatment would help. Participants related this behavior to not knowing what to expect from treatment and to lacking insight about their own mental health needs. They described believing that their problems were not severe enough for treatment and that they could handle their problems on their own, including by using substances to manage symptoms. One participant described ambivalent thoughts about treatment “not helping” and how those thoughts interfered with consistently engaging in treatment. He said, “Kid, teenager, adult, they always offered it to me, I’d just never go. I just personally knew it wouldn’t help. It’s just talking to a random guy that probably, at the end of the day, it’s not like you take the curse away or something. I just felt stress every day. It’s not pleasant, but I did it for so long that I was just used to it.”

Young adults in the study also described challenges to engagement related to stigma (N=27, 71%), indicating that they had delayed seeking or continuing with treatment

TABLE 2. Mental health service use patterns among 38 black and Hispanic LGB young adults

Variable	N	%
Mental health visits: past year		
0	6	16
1–24	14	37
≥25	18	47
Treatment engagement: past year		
Multiple interruptions	9	24
Single interruption	8	21
Continuous treatment	21	55
Service settings: lifetime		
Faith-based counseling	5	13
Private practice	11	29
School-based	12	32
Emergency room	14	37
Inpatient or residential	17	45
Community mental health center	35	92

because they felt shame about both their symptoms and their LGB identity, which has been pathologized and linked to mental illness. One participant explained, “It was hard to admit that I needed to go because of my sexuality. Some nuances might have to do with that part of my life, but that’s not the reason why I’m going to get help.” Developing an understanding of the interplay between symptoms and societal discrimination (i.e., heterosexism) assisted their engagement with treatment. As one participant described it, “When I was more open with being queer and realizing that it’s connected with these other mental health issues, I thought then maybe that [treatment] is something that I should probably pursue.”

Participants also discussed engagement as prompted by feeling responsible for their own well-being (N=21, 55%). As one participant expressed, “I knew that I was not really doing too well. But I have to maintain employment and stuff, so before I did anything stupid, I wanted to know that I had exhausted all my options. I think that’s a responsibility for myself.” Many participants related this decision to maturing. As one explained, “When I was younger, I didn’t really care for it. Now I can see where it helps me.” For others, seeking treatment was associated with wanting to attain goals in life. “I’m going back to college,” said one, “and I don’t think I would be in the situation I’m in right now if I didn’t stick with the medication.”

Social Environment

Participants also described how their engagement in mental health services was influenced by others in their social environments. Young adult peers who were also LGB were significant facilitators of service use by helping participants to locate identity-affirming providers (N=20, 53%). “Just knowing other queer people,” one said, “you see there are resources everywhere and that made me feel more comfortable going.” Some participants (N=14, 37%) reported that their family members were helpful with accessing services and with providing ongoing support to stay engaged. However, many (N=21,

55%) described family as discouraging their service use. Cultural attitudes and religious beliefs held by family members presented barriers to engagement. As one young adult explained, “I’ve been told multiple times by my family that mental health issues are an excuse and just talk to the pastor. In our culture, we don’t believe in it.”

Relatives who had negative experiences with mental health care were also described as having discouraged engagement. One participant said of his mother, “She was medicated when she was younger. She would always respond with what she went through, so that gave me a predetermined idea that mental health treatment was bad.” Participants discussed the importance of autonomy in their help seeking when families seemed unlikely to accept and be supportive of service use and, especially, when families held antigay attitudes and beliefs. One participant discussed how transitioning to adulthood and being able to access treatment independent of family could facilitate engagement. She said, “Once I was 18 I got to talk to my doctor in private, so my mom wouldn’t be in the room, and I felt like I could finally tell somebody what I was feeling and what I was going through.”

Accessibility Factors

Accessing services as a young adult brought several challenges to engagement. Participants said they had delayed seeking or disengaged from services because they did not know how to locate appropriate providers and navigate the health care system on their own (N=19, 50%). As one explained, “I had no clue so knowing different places that you can go to get services or how the whole system works would’ve been easier for me.” Lack of insurance was a barrier, and finding low-cost providers promoted service use among participants (N=23, 61%). However, they reported drawbacks to low-cost providers. As one participant explained, “Because they service so many people, it’s hard to get someone to really sit down with you. It’s not like I have a regular doctor that I go to . . . it’s a see ‘em when you can see ‘em kinda deal. But I would say it’s better than not having anything.”

Competing responsibilities such as school or work (42%; N=16) and a lack of transportation (N=12, 32%) were also barriers to engagement for some participants, who said these factors interfered with attending regular appointments with providers.

Provider Characteristics

Participants discussed experiences with individual providers who influenced their engagement with services. They said that providers who developed rapport and who seemed genuinely invested in their treatment improved their engagement (N=22, 58%). “He actually got to know me and what happened to me, how I was feeling, and he took the time to explain to me what I was taking and what it’s for,” said one. Participants also identified the importance of providers being “nonjudgmental” and being knowledgeable about the lesbian, gay, bisexual, and transgender (LGBT) community (N=26, 68%), including a preference for

providers who had marginalized identities. As one participant explained, “The place where I get therapy now is very LGBT friendly, but at the program that was just supposed to be for youth, I was uncomfortable because they didn’t get that part of my story there. . . . The doctor showed some very stereotypical ideas.”

Speaking about how provider identity affected his engagement, another participant said, “I feel Latinos are very in tune with their culture, and it definitely did help to have a person of color who understood what I was going through culturally and that [LGB] experience. I feel like it should be people that have dealt with it because it’s such a personal-ized thing.”

Participants also discussed withholding information or avoiding topics related to marginalized identities when meeting with nonmarginalized identity providers. One said, “I don’t talk about that part of my life with her. I can tell she wouldn’t understand so I’m not gonna waste my time.”

DISCUSSION

Findings from this study build knowledge about experiences among black and Hispanic LGB young adults with mental health treatment engagement and have several implications for services. It is important to note that having more than one minority identity had a significant influence on engagement for these young adults. Sexual identity-related stigma and cultural attitudes presented engagement barriers, whereas “LGB-friendly” and culturally competent providers were described as important for facilitating participants’ treatment engagement. These findings support previous studies linking provider behaviors that are LGB affirming (e.g., demonstrating knowledge, respect, and comfort with LGB issues) (20, 39, 40) and culturally competent (e.g., self-awareness, active attempts to understand and acquire skills appropriate to patients’ worldviews) (39–41) with establishing and sustaining therapeutic relationships among racially and ethnically diverse LGB young people.

Provider behaviors that are culturally competent can establish rapport and build trusting relationships with these young people and overcome emotional barriers related to ambivalence and shame about the need for mental health treatment. Providers can seek additional training and resources such as those offered by the National LGBT Health Education Center (42, 43) to develop these skills and to become proficient at displaying them on first contact with young adults to foster help seeking and to prevent disengagement. Given the variety of service settings visited by participants, displaying Pride flags and using patient forms that contain inclusive language and ask about sexual identity might act as important cues that disclosing sexual orientation and any related psychosocial information is welcomed and encouraged (23). Study results also support research indicating that concordance between provider and patient in sexual orientation (17, 44), gender (45, 46), or racial-ethnic background (47, 48) may be an important consideration for

increasing service utilization among black and Hispanic LGB populations. Matching young adults to a provider who has a similar marginalized identity may be another useful approach for improving engagement (47, 49).

Participants experienced interrupted treatment along with many of the barriers to engagement common among young adults in general, such as lower perceived need for treatment (3, 5, 6) and structural barriers (e.g., cost, complexities of health care systems) (2–5). In addition, many lacked the support from family that could help them manage these barriers, which is unfortunately common among LGB youths because of real or feared rejection from family (50). This lack of support left them assuming greater responsibility for their own mental health care and experiencing disengagement because of a lack of information about when or how to access needed services. The unique interplay of multiple minority identities in these youths’ experiences indicates that a multilayered approach to engagement strategies is needed. Outreach and psychoeducation should incorporate developmentally and culturally targeted strategies to reach black and Hispanic LGB youths and their families (25, 51), such as mental health messaging that normalizes help seeking and aligns with cultural values and faith traditions (9, 52), along with education on the risks related to family rejection for LGB youths (51).

Targeted outreach delivered in informal settings that are already serving these populations (e.g., churches, community centers) might improve the chances of seeking formal mental health services (47, 53). One additional avenue for social support that emerged to counter the lack of family assistance was other supportive LGB peers. Peers were credited with having mental health literacy and even helping to locate culturally competent providers. Social media platforms that connect young adults with their peers, such as Instagram and YouTube, may be more effective than traditional methods for improving mental health literacy and health system navigation for this age group (54, 55). Community mental health providers should consider having a social media account and being listed by geographic location in online directories that are LGB friendly (49) to reduce barriers to finding LGB-competent care.

As is true in all research, our results had important limitations to consider. First, information about participant service use relied on self-report, without comparison to clinical records, which may present inaccuracies because of recall. Future research should consider service use and engagement experiences across diagnostic categories to examine the potential relationship between diagnosis and engagement with services. Additionally, this study sampled young adults in a large urban city with a culturally diverse population. The significance of minority identity statuses in service use experiences may differ from those in suburban and rural places depending on demographic makeup and representation. We also did not assess for possible unique barriers to treatment for substance use among participants. Last, there are many free and low-cost mental

health care providers where the study was conducted, as well as providers who specifically serve the LGB population. This accessibility may have contributed to greater ease of service engagement for study participants. Despite these limitations, this study contributes important perspectives from a largely invisible population of young adults and adds to the qualitative literature on engagement in mental health services among black and Hispanic LGB youths. Findings can inform survey development for quantitative studies, offer contextual information needed to understand quantitative results, and point to innovative approaches to improving engagement in this population.

CONCLUSIONS

This study highlights the need for improved provider knowledge and strategies for engaging young adults with multiple minority identities in mental health treatment. The challenges to seeking and maintaining care during the transition to adulthood occur within a key period of development and identity formation that can be more complicated for youths from multiple minority groups compared with their same-age peers, which can contribute to mental health disparities. More research is needed to understand how to appropriately tailor services to engage young people from minority groups, particularly when minority identities are marginalized and prompt fears of discrimination.

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This study was supported by a grant from the Columbia University School of Social Work. Drs. Moore and Munson are supported by National Institute of Mental Health grant 3-R34-MH-111861-02S1. Dr. Camacho is supported by a T-32 training grant at Weill Cornell Medicine.

The authors report no financial relationships with commercial interests.

Received August 5, 2019; revision received November 4, 2019; accepted December 2, 2019; published online January 21, 2020.

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