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Donald R Gerke

Jeff Glotfelty

Maria Freshman

Julia Schlueter

Alex Ochs

See next page for additional authors

Authors

Donald R Gerke, Jeff Glotfelty, Maria Freshman, Julia Schlueter, Alex Ochs, and Katie Plax

Help Is Available: Supporting Mental Wellness Through Peer Health Navigation with Young Black Men Who Have Sex with Men with HIV

Donald R. Gerke, PhD, MSW,[1] Jeff Glotfelty, MPH,[2] Maria Freshman, MA,[2]
Julia Schlueter, MPH,[2] Alex Ochs, MSS,[1] and Katie Plax, MD[2]

Abstract

Young black men who have sex with men (YBMSM) with HIV experience disproportionate rates of trauma, incarceration, poverty, racial discrimination, and homophobia. The synergistic effects of these adverse experiences, along with increased rates of mental health disorders, increase their risk for poor health. To address this need, the study authors adapted a current HIV service model to include a peer-health navigation intervention (WITH U) to attend to behavioral health, health literacy, linkage to services, and psychosocial support for YBMSM with HIV. This longitudinal, mixed-methods, nonexperimental study reports on the mental health burden among participants and the association between participation in WITH U and mental wellness outcomes. Participants ($N = 65$) were an average age of 25–26 years (mean = 25.48, standard deviation = 2.51). Over 25% of participants reported clinically significant depression and/or anxiety symptoms and nearly half the participants reported experiencing post-traumatic stress symptoms that were at least moderately difficult to handle. Quantitative analyses indicated no significant positive association between intervention engagement and mental health symptoms; however, reporting a greater number of depression symptoms was associated with attending fewer intervention sessions. Qualitative data analysis revealed that participants' mental wellness was positively impacted by participating in the intervention and that participants preferred to receive mental wellness support from peer health navigators (HNs) rather than licensed mental health professionals. Yet, peer HNs did not feel adequately prepared to address participants' mental wellness concerns. Increased training for peer HNs and development of a linkage process to more formalized mental health services with community input may strengthen mental wellness support.

Keywords: HIV, mental health, MSM, peer support, health navigation

Introduction

YOUNG BLACK MEN who have sex with men (YBMSM) have the highest rates of HIV prevalence compared to all other demographic groups[1] and are three to five times more likely to be living with HIV than Latinx and White coun- terparts, respectively.[2] Moreover, many YBMSM also experience substantial adversity through disproportionate rates of trauma, incarceration, poverty, racial discrimination, and homophobia compared to young White men who have sex with men.[3] The synergistic effects of these adverse experiences, along with increased rates of mental health

disorders,[3,4] substance use, social risk factors (e.g., poverty, housing instability, unemployment), and racism[5,6] increase the risk for poor health among YBMSM with HIV.

These conditions necessitate further investigation, assessment, and intervention to determine how best to support this population in achieving more equitable outcomes. To address this need, the study authors adapted an HIV service model to include a direct, intensive peer health navigation intervention to attend to behavioral health, health literacy linkage to services, and psychosocial support for YBMSM with HIV.

Stigma, social support, mental health, and HIV

Stigma and social support are associated with mental health and HIV outcomes in YBMSM. The RADAR cohort study found that YBMSM with HIV reported higher levels of stigma and were also less likely to achieve viral suppression compared to their White and Hispanic counterparts.[4] Moreover, for young adults with HIV, HIV stigma is associated with higher levels of depressive and anxiety symptoms and lower rates of self-esteem.[7,8] In addition, a recent study of YBMSM with HIV found that participants with a positive depression screening and lower levels of social capital (i.e., fewer connections to people or organizations they can trust and who can provide help when needed) had 93% lower odds of achieving viral suppression than their peers.[9]

Findings from these studies highlight the relationships between stigma, social support, mental health, and HIV outcomes for YBMSM. Results of these studies also suggest potential benefits of helping YBMSM with HIV increase levels of social connections and improve access to depression treatment.

Peer health navigation

One method for addressing stigma, social connection and support, and mental health for YBMSM with HIV is connecting them to a peer health navigator (HN) program. The employment of peer HNs was initiated in 1990 to improve care outcomes for cancer patients.[10] By the early 2000s, HIV clinics implemented peer health navigation to aid HIV care coordination efforts.[11] Peer HNs have been studied in HIV care contexts to support patients' linkage and adherence to antiretroviral medication[12–15] as well as access to services across the HIV prevention and care continuum. For example, peers who have been trained to provide an education intervention have been utilized to support AIDS clinical trial recruitment efforts among African American and Hispanic participants.[16]

Peer-driven outreach was found to be significantly more successful in screening participants for AIDS clinical trials than those who received the control arm. Results from this study suggest that racial and ethnic minorities, who historically have lower rates of engaging in AIDS clinical trials compared to their White counterparts, may be more likely to participate when trials use peer-driven screening, leading to increased racial and ethnic equity in clinical trials.[16]

Multiple randomized control trials (RCTs) have compared HIV care outcomes between participants who receive either peer health navigation or other forms of peer-led intervention to those who do not.[12,16–18] Results of previous research has demonstrated that peer support for people with HIV is significantly associated with increased retention in care, antiretroviral therapy adherence, and viral suppression.[18] Similarly, in a peer-led HIV medication adherence RCT intervention study, 90% of the participants in the intervention arm attained viral load suppression at the 24-week follow-up compared to only 30% among the participants in the control arm.[17] Another study found that participants who received a peer intervention experienced fewer gaps in HIV treatment and suggested that peer intervention had strong empirical support to improve HIV care outcomes among racial and ethnic minorities.[12] However, studies have demonstrated conflicting findings regarding the association between receipt of peer support and viral load suppression.[12,13,17]

Although several studies have examined the association between peer interventions and HIV care outcomes, few have explored the role of peer support on mental health outcomes for people with HIV. A study investigating the role of peer intervention for participants who had fallen out of care suggests that peer support and intervention increased receptivity among participants to engage in care, who may have not responded as well to other forms of outreach or re-engagement strategies.[13] Brashers et al[19] found that participants who received a one-on-one peer intervention reported significantly better outcomes in illness uncertainty, depression, and satisfaction with social support than those who did not receive the peer intervention.

Findings from previous studies on peer support also highlight the positive role that social support and connection to individuals with shared identities can play in HIV care outcome attainment. For example, one study demonstrated that fewer missed appointments were significantly positively correlated with a sense of affirmation, belonging, and commitment to one's ethnic group.[20] Further findings from a separate qualitative study with 168 YBMSM suggested that mentors have a substantial impact on positive development and that the inclusion of mentors in health-related interventions may ''enhance the cultural relevance of interventions for this population.''[21(p. 962)]

Although peer interventions have been associated with increased HIV care outcome attainment for people with HIV, few studies have examined peer interventions for YBMSM with HIV. Moreover, there is limited research on the association between peer interventions and improved mental wellness for this population. Further research is needed to expand on the role of peer health navigation as a method of supporting social and emotional well-being and improved HIV care outcomes for YBMSM with HIV. This study seeks to address this gap through a mixed-methods evaluation of a peer health navigation program for YBMSM with HIV and at risk for poor HIV care outcomes.

Study aims

This study pursued the following aims: (1) describe the extent to which YBMSM in the WITH U program experienced mental health problems, participated in WITH U sessions, and engaged in mental wellness services; (2) examine the association between engaging in peer health navigation and experiences of mental health problems and mental wellness; and (3) describe the experiences of peer HNs addressing mental wellness with their clients.

Methods

Intervention description

WITH U was a 6-month, peer-based, health navigation program consisting of 12 one-on-one sessions between an HN and a participant. The first eight sessions were delivered weekly, and the final four were delivered monthly. Session duration was ~20–60 min, and was dictated by participant need and the time it took to discuss progress toward goals identified by participants during their initial session. Health navigation services complemented standard services provided by Ryan White-funded medical case managers (MCMs) within three infectious diseases clinics at one organization (the Washington University Medical School in St. Louis). HN sessions took place in-person, or by phone call, text message, in app messaging, and/or video conferencing.

The activities during these sessions were focused on health education (e.g., HIV infection and treatment, medication adherence), care navigation (e.g., linkage to clinical care, linkage to mental wellness), and support (e.g., stress management, emotional support). Specific session topics varied as they were tailored to the needs and goals of each participant. In addition, the WITH U program collaborated with the behavioral health team, known as the ''Mental Wellness'' program at the Washington University Medical School in St. Louis Department of Infectious Diseases, for active referrals and follow-up. Table 1 provides a full list of topic areas covered in health navigation sessions.

One primary goal of the WITH U intervention was to reduce barriers to behavioral health care for YBMSM living with HIV. To accomplish this, WITH U administered the Patient Health Questionnaire (PHQ-8),[22] the Generalized Anxiety Disorder screening (GAD-7),[23] an abbreviated version of the Post-Traumatic Stress Disorder Checklist-Civilian (PCL-C),[24] and the CRAFFT[25] screener for substance use problems at baseline, 6-month, and 12-month time points. Participants who screened positive on any of these instruments were referred to mental wellness services within the same agency, and results were shared with their peer HN to address in sessions. Participants were also offered immediate linkage to mental wellness services during their WITH U enrollment session.

The WITH U intervention was adapted from the youth-focused case management model of care,[26] which was designed to better engage and retain young black and Latinx men in HIV care. Adaptations for the WITH U program included the following: (1) expanding the age for inclusion from 18–24 to 18–29 years; (2) shortening the intervention from 24 to 6 months, with 2 months of weekly session and 4 months of monthly sessions; (3) using peer HNs to deliver the intervention; (4) focusing on identifying and addressing behavioral health barriers; (5) integrating HNs into an existing multidisciplinary team that included MCMs, mental wellness providers, and medical providers; and (6) providing the option for peer health navigation appointments to be conducted virtually (telephone, text messaging, or video conferencing) or in person depending on client preference.

Feedback on the feasibility of the intervention was provided by peer HNs, and members of a weekly MPowerment initiative for young gay and bisexual black men and volunteers from a previous intervention that had served a similar population gave feedback on the program logo and recruitment materials.

Adaptations to the intervention were based on reported findings from the evaluation of youth-focused case management, guiding theoretical frameworks, and feedback from peer HNs. Youth-focused case management evaluation results indicated that participants attended an average of seven sessions and that the intervention was most effective following intensive engagement in the first few months of the program.[27] As such, WITH U included intensive contact with peer HNs in the first 2 months and shortened monthly follow-up sessions by several months. The flexiblility of session modality (phone, video conference, text, and in person) was based on conclusions from the original evaluation, in which Wohl et al suggest that flexibility was an important factor for keeping participants engaged. The decision to use peer HNs rather than traditional MCMs to deliver the WITH U intervention was based on the theory of social proof[28] and social cognitive theory.[29]

The theory of social proof argues that individuals may prefer to work with someone who shares their identities to make important decisions, including decisions about health.

TABLE 1. PEER HEALTH NAVIGATION SESSION TOPICS

Health education	Support	Care navigation
HIV and treatment	Encouragement	Clinical care
HIV 101/Life cycle	Empowerment	Medical care
How the body works	Stress management	Pharmacy
How HIV works	Emotional support	Dental
How medications work	Disclosure	Specialty care
Understanding laboratory values		Behavioral health
Prevention		Mental health
Safer sex		Substance use/abuse
Safer drug use		Crisis hotline
U=U		Social services
PrEP		Food
Adherence		Housing
Medication		Utilities
Clinical care		Transportation
Mental wellness		Insurance

PrEP, pre-exposure prophylaxis; U=U, undetectable=untransmittable.

Social cognitive theory adds the principle of vicarious efficacy; if an individual learns of another person like them succeeding at a goal, that individual's self-efficacy for accomplishing their similar goals may increase. According to these two theories, peer HNs that share identities with intervention participants would likely be more effective at helping participants reach their goals.

Recruitment of WITH U participants and delivery of peer health navigation sessions were impacted by the COVID-19 pandemic. The first participant enrolled in WITH U in October 2019. However, in accordance with university policy, enrollment into the WITH U program was halted completely between March to June 2020. In addition, following the onset of the pandemic, all health navigation sessions were delivered virtually. Moreover, given the potential impact of the COVID-19 pandemic on participant stress and mental health, all WITH U participants were given the option to remain in contact with their peer HN past the planned 6-month completion date. However, formal engagement in and evaluation of the intervention ended after participants reached the 6-month endpoint.

This study was approved by the Institutional Review Board at Washington University in St. Louis.

Intervention procedures

This mixed-methods study collected quantitative data from WITH U participants and qualitative data from WITH U participants and peer HNs. Recruitment occurred by in-reach to teams within the three infectious disease clinic sites that were part of the same organization and served the same geographical region. Each week during the recruitment phase, potential participants with clinic visits were pre-screened for eligibility using medical record data and then approached during medical visits by WITH U staff.

The intervention team also recruited participants through collaboration with MCMs who focused on the clinics' linkage to care, lost to care, youth, and young adult services, as well as with quality improvement staff to identify clients who were persistently viremic. To enhance recruitment, WITH U staff educated all MCMs and medical providers across all three clinics about the program and encouraged them to refer potentially eligible participants. WITH U staff completed an eligibility screening tool with all interested participants identified during recruitment.

The two peer HNs received training before implementing WITH U and continuing education, while delivering the intervention. Training and continuing education topics included job-specific information (e.g., trauma-informed care, self-care), HIV-specific information [e.g., HIV lifecycle, undetectable = untransmittable (U = U)], human subjects research (e.g., research ethics), job skills (e.g., motivational interviewing, goal setting), agency-specific information (e.g., agency orientation, safety on the job), and social and racial justice (e.g., anti-racism). Table 2 provides a complete list of trainings completed by peer HNs.

Quantitative data were collected at enrollment and 2-, 6-, and 12-month time points using computer-assisted self-interview technology. In addition, viral load, medical appointment attendance, health navigation session attendance, and topics covered in health navigation sessions were extracted from medical records. Health navigation session data, including type and topics, were entered into charts by peer HNs and extracted by the WITH U project coordinator, who did spot-checks of data against text message exchanges between peer HNs and participants to ensure reliability of data entered.

Qualitative data were collected using semistructured interviews over HIPPA-compliant video conferencing software (i.e., Zoom) with a convenience subsample of 22 WITH U participants and both HNs. All WITH U participants who had completed at least 8 weeks of the intervention at the time we began qualitative data collection were contacted by text message and phone call to ask if they were interested in participating in qualitative interviews. Participants received an additional gift card incentive for participating in an interview. Interviews were audio-recorded and transcribed verbatim.

Participants

Eligible participants for the WITH U intervention were men (including transgender men and gender nonbinary persons assigned male at birth) who were 18–29 years old and who identified as Black, had sex with men in the last 5 years, and who currently received HIV care through one of three sites, including the Washington University Medical School in St. Louis Department of Infectious Diseases HIV clinic. In addition, eligible participants met at least one of the following criteria: (1) diagnosed with HIV within the past 12 months; (2) not linked to care following their HIV diagnosis;

TABLE 2. PEER HEALTH NAVIGATOR TRAINING TOPICS

Training module	Topics covered
Peer Navigation Job-Specific Training	Medication Adherence/Treatment, Social Determinants of Health, Setting Boundaries, Resolving Conflict, Burnout, Self-Care, Trauma-Informed Care, Building Blocks to Peer Success
HIV-Specific Training	Introduction to HIV, HIV Lifecycle, Prevention with Positives, Understanding U = U, HIV and Aging, HIV and Mental Health
Human Research Training	CITI Training, HIPAA/Privacy, Good Clinical Practice
Job/MOC Function Training	Motivational Interviewing, Mental Health First Aid, Administering Screening Tools, Health Literacy, Goal Setting, Case Conferencing
Agency-Specific Training	Agency Orientation, Code of Conduct, Safety on the Job, Ethics, Team Dynamics, Documentation Systems, Quality Improvement 101
Social and Racial Justice Training	Cultural Competency, Working Toward Racial Equity, Anti-Racism

MOC, model of care; U = U, undetectable = untransmittable.

TABLE 3. INTERVENTION PARTICIPANT DEMOGRAPHICS
AND RISK FACTORS AT ENROLLMENT ($N=65$)

	N (%)
Demographics	
Race (check all that apply)	
Black	65 (100)
White	3 (4.6)
American Indian/Alaska Native	1 (1.5)
Asian	1 (1.5)
Some other race	1 (1.5)
Ethnicity	
Not Hispanic, Latino, or Spanish origin	60 (92.3)
Unsure	3 (4.6)
Gender	
Man	64 (98.5)
Genderqueer/Gender nonconforming	1 (1.5)
Education level	
Finished Grade School	2 (3.1)
Some High School	1 (1.5)
High School Diploma of GED	16 (24.6)
Some college, professional, vocational, or trade school	18 (27.7)
Graduate college	3 (4.6)
More than college	1 (1.5)
Other	1 (1.5)
Current employment status	
Employed at a company	38 (58.5)
Self-employed	4 (6.2)
Unemployed	18 (27.7)
Unable to Work/Disabled	1 (1.5)
Student	2 (3.1)
Other	2 (3.1)
Income level-last 12 months	
$5000 or less	23 (35.4)
$5001 to $10,000	9 (13.8)
$10,001 to $20,000	12 (18.5)
$20,001 to $40,000	12 (18.5)
Viral supression	
Virally suppressed	45 (69.2)
Not virally suppressed	15 (23.1)
Newly diagnosed (within past year)	
Newly diagnosed with HIV	8 (12.3)
Diagnoses with HIV more than 12 months ago	56 (86.2)
Not sure	1 (1.5)
Unsure	9 (13.8)
Age, mean (SD)	25.48 (2.51)
Psychosocial risk factors	
Depression (PHQ-8 ≥ 10; last 2 weeks)	17 (26.2)
Anxiety (GAD-7 ≥ 10; last 2 weeks)	17 (26.2)
Post-truamatic stress (PCL-C ≥ 4; last month)	46 (70.8)
Possible Substance Use Problems (CRAFFT ≥ 2)	49 (75.4)
Used marijuana or other recreational drug in last 12 months	45 (69.2)
Engaged in binge drinking in last 12 months	45 (69.2)
Feels like alcohol or drugs are causing problems in life	12 (18.5)
Worried about food instability last 3 months	39 (60.0)

(continued)

TABLE 3. (CONTINUED)

	N (%)
Experienced food instability last 3 months	37 (56.9)
Unable to get utilities when needed last 3 months	17 (26.2)
Worried about losing housing	24 (36.9)
Feel physically and emotionally unsafe in current housing	4 (6.2)
Physically abused/attacked in past 3 months	6 (9.2)
Humiliated or emotionally abused last 3 months	17 (26.2)
Released from jail or prison in the last 12 months	5 (7.7)

GAD-7, Generalized Anxiety Disorder screening; PCL-C, Post-Traumatic Stress Disorder Checklist-Civilian; PHQ-8, Patient Health Questionnaire; SD, standard deviation.

(3) not fully retained in care, defined as not having at least two HIV medical visits at least 90 days apart in the last 12 months; (4) not virally suppressed, defined as having a viral load ≥200 at their most recent lab test; or (5) at risk of falling out of care due to substance use, diagnosis of a sexually transmitted infection (STI) in the last 12 months, housing instability, joblessness of at least 3 months in the last 12, a positive depression screen, having been releases from incarceration in the last 12 months, or self-reporting a negative experience with an HIV health care provider or clinic staff.

Participants ($N=65$) were an average age of 25–26 years [mean = 25.48 and standard deviation (SD) = 2.51]. All participants reported being assigned male at birth, and one participant identified as genderqueer or gender nonconforming. More than half of participants reported either worrying about or experiencing food insecurity in the last 3 months, over a third were concerned about losing their housing, and a quarter were unable to get their utilities paid when needed. Nearly three-quarters of participants screened positive for a substance use problem, and nearly 70% reported engaging in binge drinking in the last year. Complete demographics of WITH U study participants, including risk factors, are presented in Table 3.

A total of 50 of 65 enrolled participants completed the 6-month WITH U intervention. Twelve participants completed enrollment but did not attend a health navigation session and three participants were removed from the study because they moved out of the service area following enrollment. After computing bivariate Spearman correlations, no statistically significant difference was observed in age, viral suppression, recency of HIV diagnosis, depression, anxiety, or post-traumatic stress between those who completed the 6-month intervention and the 15 individuals who did not attend a session or were removed from the study after moving out of the service area.

Measures

Sociodemographic variables. Participants self-reported several sociodemographic characteristics at the time of enrollment, including age, race, ethnicity, sex assigned at birth,

gender, employment status, income, and education level. Frequencies of these variables are reported in Table 1.

Mental wellness variables. Participants completed screening instruments to assess for depression, anxiety, and post-traumatic stress symptoms at enrollment and at 6- and 12-month follow-ups. Depression symptoms were measured using the PHQ-8[22] and anxiety symptoms were measured using the GAD-7.[23] Scores of all items on each measure were summed. A score of 10 or higher on these screening instruments indicated moderate depression or anxiety, respectively. A two-item version of the PCL-C[24] was used to measure post-traumatic stress symptoms. After summing the score for each item, a total score of 4 or higher on the brief PCL-C was considered a positive screen for post-traumatic stress.[24,30]

Mental wellness engagement. Data from the above mental wellness variables and chart abstractions were used to measure mental wellness engagement along a continuum. Points along the continuum included screening positive for a mental health problem, receiving a referral to mental wellness services, having initial contact with mental wellness services, engaging in an initial mental wellness appointment, and engagement in four or more mental wellness appointments.

Additional psychosocial, behavioral, and environmental risk factors. Substance use screening was measured using the CRAFFT,[25] for which a score >2 indicated possible substance use problems.[31] Binge drinking was assessed with the question, "How many times in the last 12 months have you had five or more drinks in a day?" (0 times, 1 time, 2–5 times, or 6 or more times). Responses were dichotomized into 0 = no times and 1 = one or more times for this analysis. Participants were also asked about using marijuana or other street drugs, or recreational use of prescription drugs (Yes/No) and if they felt like drugs or alcohol were currently causing issues in their life (strongly agree, agree, somewhat agree, neither agree or disagree, somewhat disagree, disagree, or strongly disagree). Responses to this question were recorded into a dichotomous variable were 1 = strongly agree, agree, or somewhat agree, and 0 = all other response options.

In addition to substance use, participants were also asked (Yes/No) if they worried about having enough food, if they experienced not having enough food, if they were able to access utilities like electricity and heat, if they worried about losing housing, if they were physically attacked, and if they were emotionally abused in the past 3 months. Furthermore, participants self-reported (Yes/No) whether they currently felt physically and emotionally unsafe where they lived and if they were released from jail or prison in the last 12 months.

Intervention participation. The number of health navigation sessions and the types of topics discussed at each session were extracted from participant medical records. Types of topics covered included health education, care navigation, and support. Areas of education included medication, mental wellness, safer sex, U = U, understanding medical laboratory values, HIV treatment, how HIV impacts the body/HIV 101, clinical care, pre-exposure prophylaxis (PrEP), condom use, and drug use harm reduction. Subjects included under support included building rapport, encouragement, emotional support, stress management, empowerment, and HIV disclosure. Care navigation included linking clients to a variety of resources, including mental wellness, housing, support groups, transportation, employment assistance, utilities, insurance, education access, and multiple components of medical care.

Semistructured interview guide. During semistructured qualitative interviews, WITH U participants were asked how they became involved in the program, how things have gone with the program, how useful different elements of the program were to them, what they got out of being in the program, anything that they did not like or did not get out of the program that they were hoping to experience, and any suggestion for improving the program. Similarly, WITH U peer HNs were asked how they became involved as an HN, what changes the COVID-19 pandemic brought to the program, how things have gone overall in the program, how useful the program is to the participants, how helpful different elements of the program were to participants, how they think participants have benefitted from participating in the program, and suggestions for improving the program.

Data analysis

Quantitative analysis. Frequencies and means were used to describe the sample, including rates of mental health problems and other psychosocial, behavioral, and environmental risk factors, as well as engagement in the WITH U intervention. Bivariate Spearman correlations were used to examine the associations between number of sessions attended and expressed need to address social determinants of health and mental health status.

Qualitative analysis. Data were analyzed using a directed content approach as described by Hsieh and Shannon[32] using coding techniques based on Miles et al.[33] A directed content analysis approach was appropriate for this study as prior research suggested topics that were likely to emerge during analysis. In total, three coders participated in the analysis. The lead researcher was an expert in HIV care and prevention with young men who have sex with men, and a second researcher was an expert in qualitative research methods. A third coder was a mixed-methods data analyst at the university where this research was conducted and a former student of the qualitative researcher.

Analyzing these data involved an iterative process of coding, inter-rater reliability checking, conferencing, codebook revisions, and thematic analysis. Initial rounds of coding included a combination of on-paper coding and coding using NVivo Pro 12 software. Inter-rater reliability checks and coding conferences were conducted after each round of coding was completed. Inter-rater reliability was high overall and coding schemes were adjusted as needed to resolve any discrepancy. Coding conferences were held on Zoom and involved the use of the Lucidchart website as an effective substitute for wall displays as described by Maher et al.[34] Once the data were condensed into a final set of codes, any code containing 30 or more references was recoded as synthesized transcripts, allowing further nuances and patterns

to emerge. Finally, summaries of each thematic code were drafted, and representative quotations were selected.

Results

Frequency of participation in WITH U, mental health problems, and engagement in mental wellness services

Participants attended an average of 5–6 (mean = 5.69, SD = 3.05) of 12 possible health navigation sessions. Of session topics related to mental wellness, 41 sessions focused on mental wellness education among 19 participants, 37 sessions included encouragement among 20 participants, 41 sessions focused on emotional support among 19 participants, 19 sessions incorporated stress management among 11 participants, 24 sessions involved mental wellness care navigation for 14 participants, and 1 session contained psychiatric care navigation for 1 participant.

Participants were screened for depression, anxiety, and post-traumatic stress symptoms. At enrollment, 26.4% ($n = 17$) of participants screened positive for depression (PHQ-8 ≥ 10), 26.4% ($n = 17$) screened positive for anxiety (GAD-7 ≥ 10), and 70.8% ($n = 46$) screened positive for post-traumatic stress (2-item PCL-C ≥ 4).

All participants were screened for mental wellness services at enrollment. A total of 43 participants screened positive, all of whom were referred to mental wellness services provided by a licensed mental health professional on site. Of those referred, 79.1% ($n = 34$) made contact with mental wellness services (i.e., met with the mental wellness staff over the phone or in person and learned about the program) and 44.2% ($n = 19$) engaged in at least one therapeutic encounter with mental wellness services.

A total of 16.3% ($n = 7$) of participants referred for mental wellness services engaged in four or more therapeutic encounters during the intervention. Of note, some of the participants who participated in mental wellness services during WITH U were already receiving these services before joining WITH U. Eight of the 34 participants who made contact with mental wellness services and 5 of the 7 participants who engaged in 4 or more therapeutic encounters were existing mental wellness clients before enrollment in the WITH U intervention.

Associations between WITH U participation and mental wellness

Results of Spearmen correlations did not show a significant association between number of health navigation sessions attended and frequency of anxiety or post-traumatic stress symptoms at enrollment or 6-month follow-up. A significant negative association between number of sessions attended and frequency of depressive symptoms was noted at baseline, indicating that those with a great number and severity of depressive symptoms attended fewer HN sessions [$rs(54) = -0.32$, $p < 0.05$]. No significant association between depressive symptoms and number of health navigation sessions attended was observed at the 6-month follow-up.

Results of the qualitative analysis indicated that, in general, WITH U participants found the intervention helpful in improving their mental wellness. One of the primary themes that emerged around program helpfulness was emotional support. Nearly half of participants interviewed said that the WITH U program provided them with a sense that they were "not alone" and that they had someone who was "in [their] corner." As one participant described, "it's a beautiful thing to know that you're not alone in this." Moreover, more than one quarter of participants mentioned being "checked on" as one way in which their HN helped them feel not alone. Check-ins from HNs often came in the form of text messages or phone calls. One participant described the support he received from his HN:

> When I got [my health navigator], I was doing bad. So I needed some real support—he called me three times a day. He stuck his neck out on the line. I don't even think he was supposed to do the things that he did, you know, with doing as much as he did … it was like he was with me the whole time."

Other participants described knowing that there is always someone there to support you.

> Your navigator is that person that you can always count on that will be there for you. It's like a breath of fresh air when you know that you have somebody that you can call and count on the help you when you need it.
> He's just been there, always.
> He's just very good with just being there … to reach out to if I needed an extra ear to vent to.

Participants also described emotional support through reassurance from their HNs. This included reminders of the availability of mental health resources as well as resources to address instrumental needs like housing and paying utility bills. As one participant stated:

> [My health navigator] definitely always made sure to let me know, "If you do randomly get maybe depressed, we do have services. We can talk to [therapist name]. We can get those referrals." So they were always making sure that I knew that there were resources available, even though at the moment I didn't need anything.

HNs also helped participants develop greater feelings of self-efficacy and well-being. Specifically, some participants described the program as preparing them to cope with difficulty in the future. As one participant said, "you're going to have moments when you're down, but [participating in the program is] going to help you get through those very small moments where you still do get down." Other participants noted that the availability of their HN increased their self-confidence, explaining,

> [My health navigator] helped me with self-esteem, like confidence, attitude—having a different outlook on life and approach. Just having a good sense of well-being because I knew that I have people that will help … someone that understands what you need to be human.
> I was always self-conscious, even though nobody knows what's going on with me … [my health navigator] pretty much helped me understand it—like I'm still normal, you know? That's honestly the best feeling out of all of it.

Participants who worked with a mental health therapist were asked about the difference between working with their HN and working with a therapist. Half of these participants reported that they did not see a notable difference in the support they received from either provider. Participants explained:

[My therapist and my health navigator] they're not really different to me because I'm comfortable talking to both of them about everything that's going on within my life.
[My therapist] is just like [my health navigator]. They're both very helpful …. Like, they're neck and neck when it comes to their jobs.

However, two participants noted that gender was an important difference between their mental health therapist and HN. Specifically, they explained that having an HN who was a man was more helpful when discussing certain topics. They stated:

I think honestly, I feel like it was easier with [my health navigator] because communicating with someone who I consider a male peer, as opposed to a female who is a little bit older than me, there's a different dynamic there. There was still like a little comfortability with [my health navigator] that wasn't there [with my therapist].
By me being a gay man, it tends to come off that you are more comfortable with another male. He can understand things a little bit better than talking to a woman can. So, that's one thing that I absolutely loved. I would never want to change that (laughs).

Experiences of HNs in addressing mental wellness

HNs explained that providing emotional support was a key element of the WITH U program. As the HNs explained,

So one thing that a lot of clients … most of the clients, if not all of them … really just needed support. And by support, it's not even support about anything specific. They just needed somebody to talk to. And sometimes we would have sessions and not have conversations about HIV or medication. They just really wanted somebody to listen.
Support was really the bulk of the WITHU program. That is pretty much the backbone of this program, to be honest.

When asked to describe what support meant in the context of WITH U, one HN said that it included active listening, encouragement, and ultimately:

it just really is being there for the client in whatever way they need you to be. But most of the time, they just need a listening ear. They just want somebody to talk to them. Sometimes it's not about sex, sometimes not about HIV. It's, "I had a crappy day at work today." Or "My mom is just not supporting me the way that I need." And they're not asking you to say anything about that … they just want to get that off of their chest.

Although the HNs described support as a critical component of the WITH U intervention, they explained that they did not feel prepared to offer the same level of mental wellness services as a trained therapist. However, the HNs explained that some participants were reluctant to follow through with a referral to mental wellness services because they preferred to receive support from their HN. One HN stated:

… what I'm sad about is the fact that sometimes when clients get linked with HN, they're more reluctant to go to mental wellness. Because like I said before, a lot of our clients are looking for their person. And so once they find their person, they're more reluctant to go outside of that person for any other type of support.

When describing feeling unprepared to offer mental wellness services, the HNs explained:

A lot of the issues that clients have rooted from family issues that they have not unpacked yet. And it's caused them to do drugs and it's caused them to seek love in other places. It's caused them to be rebellious. It's things that happened to a lot of my clients as children growing up, that's traumatized them. And a lot of my clients need to unpack that. And I can't unpack that shit. One day eventually … cause being in this field, I said, "You know, maybe I do want to be a counselor or a therapist, just a little bit." But right now, I'm only your big brother … They really, really, need some mental health specialist.
So one thing that we learned is that some clients … well, a lot of our clients…didn't engage in mental wellness services, because they felt that the HN were filling that void for them, which is kind of … I think it's good, but it's also kind of unfortunate, because there is … We're not trained in the way that the therapist is. And so like, I can give you my opinion about how I feel about something or I can kind of respond in a way to help you to hear what you want to hear, but I'm not necessarily changing the way that you think. I'm not … I can't offer them what a therapist can offer them.

When asked for suggestions to improve the WITH U program, both HNs reported a need for peer support, given the emotional toll that the job can have on an individual. He explained that HNs often use their past traumas and stressors to support participants.

Other team members that don't necessarily operate with clients in the way that we do may not understand. And they may not understand the very high potential for burnout that we have of doing this job with multiple clients, day in and day out. You're giving yourself and talking about your past traumas. You're talking about your HIV diagnosis. You're talking about how you have some of the same problems that they have.

HNs also expressed interest in deeper, more frequent, theoretically grounded training to enhance their work with participants. One HN suggested using health behavior theories like the Theory of Planned Behavior[35] or change theories rooted in mental health counseling like Cognitive Behavioral Theory[36] or Dialectical Behavioral Theory[37] to guide HN's actions. Regarding more frequent training, one HN stated:

So when we come in onboarding, we go and we talk about motivational interviewing, we talk about Narcan, we talk about drug abuse. We had a training on these things, maybe twice …3 times, if I'm lucky. And so I just don't think that what the clients require and what we are trained to give them, I don't think that it's on the same level … I don't feel like they're sufficient. I would actually like to have some type of quarterly trainings, to be honest, because it's not a thing where you learn something, it just sticks. I think we need refresher courses.

Discussion

This is one of the first studies to examine the association between participation in a peer health navigation program and mental wellness outcomes for YBMSM with HIV. Qualitative findings indicated that access to empathetic and supportive listening was associated with greater feelings of mental wellness among WITH U participants. This is consistent with recent research that demonstrated statistically significant reductions in depression, anxiety, and loneliness among adults who received regular phone calls during the COVID-19 pandemic from laypersons trained in empathetic conversational techniques.[38]

Moreover, our results suggest that peer health navigation may be more effective when the peer shares multiple identities with program participants. In the WITH U program, peer HNs matched participants on race, sexual identity, and HIV status. There is theoretical support for this finding in the literature. The theory of normative social behavior posits, in part, that an individual is more likely to engage in a behavior if that individual perceives the behavior as desired by important others in their social network and beneficial to themselves and others in their social network.[39] Diffusion of innovation theory adds that if the desirability of a behavior is communicated by a popular opinion leader in an individual's social network, the individual is even more likely to engage in that behavior.[40]

Furthermore, the theory of social proof[28] argues that individuals prefer to work with people that are most like them to make important decisions, including decisions about their health. The HNs in the WITH U program likely served as popular opinion leaders for WITH U participants, many of whom likely did not have other known YBMSM with HIV in their social networks to influence their health behaviors. Engaging with their HN may have been the first time WITH U participants had the opportunity to receive support and advice from someone like them, which many reported as important during qualitative interviews.

In addition, in this study, we found high levels of mental health needs among participants, especially related to post-traumatic stress symptoms. However, despite a high level of need, engagement in more formal mental wellness service among WITH U participants was low. This finding is aligned with results of a recent retrospective study of mental health care utilization among YBMSM in HIV care, in which the authors posited that high-effort coping and masculine self-reliance, two strategies black Americans have developed in response to structural barriers, may serve as barriers to engagement in mental health care.[41] Moreover, these findings may be partially explained by the high frequency of post-traumatic stress symptoms experienced by participants.

Individuals with post-traumatic stress symptoms may choose not to engage in mental wellness services as a means of avoiding negative thoughts and feelings about their past traumas.[42] Indeed, avoidance is a common symptom of post-traumatic stress disorder.[43] Low engagement in mental wellness services may also be partially explained by perceived stigma among black men associated with accessing mental health services. Previous research has demonstrated that stigma and social norms that associate seeking mental health services with weakness[44,45] lead to lower engagement in mental health services for black men. One study also found that black men may be more likely to seek support for their mental health problems through informal support networks rather than formal mental health service providers.[46]

Although we found a low level of engagement in mental wellness services among WITH U participants, participants did commonly seek mental health support from their HN. Several participants reported a preference for receiving mental health support from an HN rather than a licensed mental health professional. The theory of social proof[28] and previous research findings regarding black men's preference for finding mental health support among informal support networks[46] may partially explain this finding. However, despite this preference, we also found that WITH U peer HNs did not feel adequately prepared to address participants' mental health concerns. Those who plan to use this intervention in the future may benefit from added training for peer HNs regarding addressing participant mental health concerns. In addition, peer health navigation program developers and managers could consider working with a community advisory board to improve the referral process to mental health services.

Future efforts may draw suggestions from emerging literature on HIV-focused community health workers in the United States that suggests that more informal intermediaries can effectively empower people with HIV to access needed resources.[47] Moreover, perhaps stronger encouragement and deeper involvement by the HN in the linkage process would increase engagement in more formal mental health services. Engagement in mental health services may also be improved through identity matching between participants and licensed mental health professionals,[48] when possible. Another consideration is that traditional mental health services are not a fit for this population, and alternative forms for delivery of mental health services may need to be explored to better meet the mental health needs of YBMSM with HIV.

Limitations

Findings from this study should be interpreted in the context of several limitations. First, the generalizability of our findings is limited by a small sample from a specific geographic area. In addition, our findings related to peer HN experiences in the program are limited to two individuals. We also cannot draw any causal inference from this study because we did not use a randomized control or comparative effectiveness design. Finally, this study was conducted during the COVID-19 pandemic, which created several constraints for WITH U program staff and participants.

This study demonstrated that peer HNs can provide needed mental wellness support for YBMSM, who report high levels of need for mental wellness services and a desire to receive support from someone with similar identities and experiences. Increased training for peer HNs and development of a linkage process to more formalized mental health services with community input may strengthen mental wellness support that can be provided by peer health navigation programs.

Authors' Contributions

Acknowledgments

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Address correspondence to:
Donald R. Gerke, PhD, MSW
University of Denver
Graduate School of Social Work
2148 S. High Street
Denver, CO 80208
USA

E-mail: donny.gerke@du.edu