

## **Healthcare engagement among gay and bisexual men with recent suicide ideation or attempts**

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## **Abstract**

**Objective:** Gay and bisexual men experience elevated rates of suicide ideation and attempts, as compared with heterosexual men, but face unique barriers in accessing health services. In this context, the present study sought to describe rates of healthcare engagement among gay and bisexual men with a recent history of suicide ideation or attempts.

**Methods:** An anonymous online survey was conducted with 7872 Canadian gay and bisexual men in 2014-15. The sample was restricted to characterize patterns of mental healthcare engagement among respondents who reported suicide ideation or attempts in the previous 12 months. 'Engagement' was defined as having discussed mental health concerns (depression, substance use, or suicide) with a provider in the previous 12 months. Rates and correlates of engagement were estimated.

**Results:** Nineteen percent of men reported suicide ideation or attempts in the previous 12 months, of whom 58% had discussed mental health concerns with a provider. Older age, larger social support networks, and being out to a healthcare provider about one's sexuality were all positively associated with mental health care engagement. Among those who had not engaged with the healthcare system, 88% had some contact with a provider in the previous 12 months. One third of these men accessed care through a provider other than their family doctor.

**Conclusions:** Drawing on lessons learned from the HIV crises, collaborations between gay and bisexual community organizations and decision-makers within the health system are needed to address elevated rates of suicide ideation and attempts affecting sexual minorities.

**Public policy relevance:**

Gay and bisexual men are at increased risk of suicide but have unique healthcare usage patterns that in turn require specific healthcare and community networks to reach those at risk. This study demonstrates that 88% of recently suicidal gay and bisexual men have had contact with a healthcare provider in the previous 12 months, but 1/3 of them sought care from an alternative site (other than a family doctor). Broad intersectoral networks can be mobilized to prevent suicide in gay and bisexual communities.

## Introduction

Gay and bisexual men experience 2-4 times the rate of suicide ideation and attempts as compared with heterosexual men, with as many as 20% of adult gay and bisexual men attempting suicide during their lifetimes (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; King et al., 2008). Rates of suicide ideation and attempt additionally vary *within* the population of gay and bisexual men, with higher rates reported among Indigenous men, those living with HIV, men with lower income or educational attainment, and those with lower social support (Ferlatte et al., 2017; Salway et al., 2017). Relatively few studies have examined suicide deaths among sexual minorities, though at least two studies have substantiated a similarly elevated risk of suicide mortality among gay and bisexual men relative to heterosexual men, using two distinct epidemiologic designs (Mathy, Cochran, Olsen, & Mays, 2011; Plöderl et al., 2013). Much of the excess burden of suicide behavior and mortality is attributable to a stress process particular to gay and bisexual men's social status as sexual minorities (Hatzenbuehler, 2009; Meyer, 2003). Social stigma manifests in various forms ranging from overt homophobic and biphobic violence to subtle reminders that non-heterosexual orientations are unwelcome or unwanted (Herek, 2004). In response to pervasive stigma, gay and bisexual men develop adaptive behaviors, most notably concealment of their sexual minority identities (Pachankis, 2007).

This inequity in suicide-related outcomes is compounded by a scarcity in social and healthcare resources that may help to identify and respond to precursors to suicide (i.e., mental distress, crises, suicide ideation, etcetera) (Eaton, Badawi, & Melton, 1995; Klonsky, May, & Saffer, 2016). Social resources that are typically available to heterosexual men (e.g., childhood familial/friend networks, wife, children) are less reliably available to gay and bisexual men (Herek, Norton, Allen, & Sims, 2010). The distinct pattern of social resources for gay and

bisexual men is in part a consequence of exposure to minority stress during adolescence and subsequent social-avoidant behaviors (Branstrom, 2017; Hatzenbuehler, 2009). Many gay and bisexual men are estranged from their families, and those who maintain contact often find these relationships to be less supportive than chosen families and gay and bisexual friends (Brennan-Ing, Seidel, Larson, & Karpiak, 2014).

Emerging evidence suggests that minority stress-related social avoidance also extends to healthcare settings (Neville & Henrickson, 2006). In one study of lesbian, gay, and bisexual (LGB) patients' experiences with disclosing their sexuality to healthcare providers, participants reported it was "easier... to disclose to their parents (often reported as the most stressful event in the coming out process) than to healthcare providers" (Eliason & Schope, 2001). In Canada, gay and bisexual men are less likely to have a regular family doctor, more likely to have consulted alternative care providers (e.g., acupuncturist, homeopath, massage therapist), and more likely to report having unmet healthcare needs (Tjepkema, 2008). These results highlight both distinct healthcare usage patterns of gay and bisexual men—less reliant on family doctors, more reliant upon alternative care—and a lack of effectiveness of existing healthcare services to address the particular needs of gay and bisexual clients (i.e., higher reports of unmet needs).

The effectiveness of healthcare encounters in addressing suicide risk and underlying mental health concerns in gay and bisexual populations is further limited by structural barriers. Many healthcare professionals lack sufficient training to respond to gay and bisexual patients with culturally competent and sexual minority-affirming care (Parameshwaran, Cockbain, Hillyard, & Price, 2017). Access to mental health interventions is particularly difficult for users of healthcare systems that rely upon a centralized gatekeeper model, such as the publicly funded Canadian healthcare system and healthcare management organizations in the US (Forrest, 2003).

In these systems, primary care providers are a first point of contact for health system referrals, including those to scarcely funded mental health resources (Aggarwal & Hutchison, 2012). We define primary healthcare as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (Institute of Medicine, 1996), while mental health providers include psychiatrists, psychologists, social workers, and counselors, who are typically accessible only through referral or hospitalization for severe episodes of mental disorder (Kirby & Keon, 2006). Once gay and bisexual individuals manage to navigate the mental healthcare system, it remains unclear whether those individuals effectively respond to traditional healthcare interventions, or whether tailored approaches, such as LGB-affirmative cognitive-behavioral therapy, would be more beneficial (Blosnich, Nasuti, Mays, & Cochran, 2016; Meyer, Teylan, & Schwartz, 2014; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015; Plöderl et al., 2017).

Gay and bisexual men are at increased risk of suicide; and, the degree to which the traditional primary healthcare system can reach those gay and bisexual men at greatest risk remains uncertain. Several studies of suicide in the general (predominantly heterosexual) population have found that contact with primary care providers prior to suicide deaths is common (Leavey et al., 2016; Luoma, Martin, & Pearson, 2002). However, similar studies have not yet been conducted among gay and bisexual men, who have distinct healthcare usage patterns. The present analysis therefore draws upon existing community survey data from Canadian gay and bisexual men with a history of recent suicide ideation or attempts in order to characterize their patterns of healthcare utilization and discussion of suicide, depression, and substance use with healthcare providers.

## Methods

### Sample

*Sex Now* is the largest Canadian survey of gay and bisexual men. Participants are recruited from sex-seeking and dating sites and apps, gay and bisexual community organizations, social media, word-of-mouth, and an existing database of previous survey participants. Eligible participants are Canadian residents, 16 years of age or older, who identify as gay or bisexual, or are men who have sex with men.

Recruitment for the 2014-15 cycle of *Sex Now* began in October 2014 and ended in April 2015, producing a sample of 7,872 eligible participants. All participants gave informed consent. The survey was offered in Canada's two official languages, English and French, and responses were anonymous. The survey protocol was approved by the independent research ethics board of Community-Based Research Centre in Vancouver, British Columbia, Canada. For the present study, the data were restricted to those who reported suicide ideation ("*Have you considered suicide—ending your own life?*") or attempts ("*Have you attempted suicide—ending your own life?*") in the previous 12 months. We conceive of this sub-group of gay and bisexual men as those most at risk for suicide, acknowledging that it is often not possible to predict suicide attempts before they happen, and that those who have a recent history of ideation or attempts are more likely to attempt suicide in the future (Ribeiro et al., 2016; Wasserman et al., 2012).

### Measures

The *Sex Now* survey includes self-report questions to assess socio-demographics, physical health, sexual health, mental health, healthcare access, and social aspects of the lives of gay and bisexual men. In order to address the current research objectives, the following variables

were selected from the data-set, based on previous theoretical and empirical research about mental health status among gay and bisexual men (Blosnich et al., 2016; Hatzenbuehler, 2009; Salway et al., 2017).

*Outcome measure: mental healthcare engagement*

A dichotomous outcome, hereafter referred to as ‘mental health care engagement’, was constructed from the following question: “*Have you discussed any of the following topics with a healthcare professional, in the last 12 months?: suicidal thoughts; depression; alcohol or drug use.*” Discussions regarding depression and substance use were included in the primary outcome, given that both are precursors (clinical correlates) to suicide ideation and attempts in both general and sexual minority populations (Klonsky et al., 2016; Nock et al., 2008; Salway et al., 2017). In the absence of effective tools for clinical prediction of suicide risk, most healthcare guidelines recommend treating depression and substance use disorders as proximal/secondary suicide prevention strategies (Carter et al., 2017; US Preventive Services Task Force, 2014; Zalsman et al., 2016). We note that these discussions may or may not have occurred before the onset of suicide ideation and attempts, but that the discussions may nonetheless be expected to aim to reduce ongoing risk of suicide in those individuals who have expressed suicidal thoughts to their healthcare providers (Wasserman et al., 2012).

*Potential correlates of mental healthcare engagement*

Three categories of correlates of mental healthcare engagement were identified. (1) Socio-demographic categorical variables included age (categorized as <30, 30-49, and ≥50 years), sexual identity (gay, bisexual), living environment (urban, suburban, rural), education (high school, some college/university, college/university degree), income (<\$30,000 CAD, \$30,000-59,999 CAD, ≥\$60,000 CAD), indigeneity (binary), and immigration (binary), each of

which has been found to be associated with suicide ideation/attempts or with limited access to healthcare services, among gay and bisexual men (Buchmueller & Carpenter, 2010; Ferlatte et al., 2017). (2) HIV status (dichotomized as positive or negative/unknown), history of suicide attempts (more than 12 months ago), and social support network (measured as number of people available for support if something goes wrong: 0, 1-3,  $\geq 4$ ) were examined as “co-morbidities”, or co-occurring conditions that may either promote or limit access to prevention or care for suicide ideation and its clinical correlates (depression, substance use). Healthcare contact following a previous suicide attempt (distinct question asked of those with a history of attempt: “*Did you see a health professional following that attempt?*”) was also summarized, among respondents with a history of suicide attempts (>12 months ago). (3) Finally, the following specific clinical and community resources were studied: access to family doctor, access to a mental health professional (psychiatrist, psychologist, social worker, or counselor), HIV and sexually transmitted infection (STI) tests in previous 12 months, and participation in volunteer activities at a gay community organization. Acknowledging the importance of social stigma in limiting sexual minorities’ interactions with the healthcare system, two additional variables were constructed to examine patient-provider interaction histories as potential correlates of mental health care engagement. First, respondents reported whether they were ‘out’ (i.e., disclosed their sexuality) to at least one healthcare provider. Second, respondents rated their primary healthcare provider’s “respect for [their] sexuality”, and were asked whether they ever experienced a negative reaction from a healthcare provider when discussing their sexuality or sexual health needs.

## **Analysis**

Analysis was conducted in three steps, using R statistical software, version 3.3.3. First, the percentage who reported mental healthcare engagement was described for the total sample of men with recent suicide ideation or attempts, and across sub-groups corresponding to the explanatory variables above. Second, associations between explanatory variables and the outcome were assessed using univariate and multivariable logistic regression. Odds ratios with 95% confidence intervals excluding 1 were treated as statistically significant.

Third, the data were restricted to those who reported suicide ideation or attempts in the previous 12 months but had not discussed suicide, depression, or substance use with a provider during the same period of time. Access to clinical and community resources was then described within this sub-sample, to indicate opportunities for future suicide prevention activities targeting gay and bisexual men. Specifically, the percentage of men with a recent suicide ideation/attempt who had not discussed a mental health concern with a provider *but had* visited a family doctor, walk-in clinic, or mental health professional (psychiatrist, psychologist, social worker, or counselor), received an HIV test, volunteered for a gay organization, or  $\geq 1$  of the above (in the previous 12 months) was estimated.

## Results

Of 7,872 men surveyed, 1,480 (19%) reported suicide ideation or attempts in the previous 12 months; specifically, 3% had attempted suicide, and 15% reported suicide ideation without an attempt. Among these 1,480 men, 58% had discussed a mental health concern with a provider: 38% discussed suicide, 54% depression, and 17% substance use.

Mental health service engagement ranged from 52% among men <30 years of age to 62% among men 50+ years of age. No other socio-demographic characteristics were significantly associated with mental health service engagement (**Table 1**).

Individuals with a history of suicide attempts (>12 months ago), and in particular, those who had contact with a healthcare provider following a previous suicide attempt (>12 months ago), were significantly more likely than those with no history of suicide attempts to have recently engaged with a healthcare provider about a mental health concern (67% versus 54%). Mental health service engagement was also positively associated with size of one's support network: 49% among those reporting no available social supports had engaged with a health care provider, versus 61% among those reporting 4 or more social supports (**Table 2**).

Six of the eight clinical and community service-related determinants tested were significantly associated with mental health service engagement in univariate analysis (**Table 3**). Fewer than half of the following sub-groups had discussed mental health concerns with a provider: those without access to a mental health provider (30% had engaged), those without a family doctor (45%), and those not out about their sexuality to any provider (50%).

In multivariable analysis, suicide attempt history, access to a family doctor, access to mental health services, and HIV testing all remained positively associated with mental health service engagement (**Table 4**).

Among those who had not engaged with the healthcare system (N=621), 88% had some opportunity for engagement with a clinical or gay community provider in the previous 12 months (**Figure 1**). 59% had access to a family doctor, and an additional 29% indicated some contact with health or community care providers, including walk-in clinics, HIV testing locations, and community organizations. 55% were out about their sexuality to a healthcare provider.

## Discussion

In the context of a pervasive disparity in suicide ideation and attempts and healthcare access barriers related to social stigma, we investigated the degree to which Canadian gay and bisexual men reporting recent suicide ideation or attempts have discussed mental health concerns with healthcare providers. Nineteen percent of men surveyed reported suicide ideation or attempts in the previous 12 months, of whom 58% had discussed mental health concerns with a provider. Older age, larger social support networks, and being out to a healthcare provider about one's sexuality were all positively associated with mental health care engagement. Among those who had not engaged with a healthcare provider to discuss mental health concerns, 88% had some contact with a provider in the previous 12 months, though one third of these men accessed care through alternative sites (i.e., outside of a family doctor).

Given that the gay and bisexual population includes men with multiple and diverse intersecting identities related to socio-economic status, race, and geography—among others—we tested for associations between socio-demographic characteristics and discussion about mental health concerns. Mental health service engagement, however, remained <60% across nearly all of these sub-groups examined, including those with the highest levels of income and education. Only age was significantly correlated with engagement.

Most of the men who reported a history of suicide attempts more than 12 months before the survey did not have any contact with a healthcare provider immediately following their previous attempt (>12 months ago), and only 55% of these men had engaged with a provider about mental health concerns in the 12 months preceding the survey. This finding underscores the need to find opportunities beyond conventional acute care, primary care, and mental health

service settings for suicide prevention interventions that will reach gay and bisexual men with a history of suicide attempts. The positive association between size of social support networks and mental health care engagement is consistent with other research, including a longitudinal Canadian study, showing that greater social support predicts future mental healthcare utilization (Fleury, Ngui, Bamvita, Grenier, & Caron, 2014). This finding reinforces the need for simultaneously bolstering opportunities for building supportive social networks. Given ongoing social stigma in many gay and bisexual men's communities of origin, these structural approaches to improve social support need to be specifically tailored to gay and bisexual men (Pachankis, 2015). Such interventions already exist, though may not traditionally be regarded as 'suicide prevention' (Kegeles, Rebchook, Tebbetts, Arnold, & TRIP Team, 2015).

Structural factors related to clinical and community service access were consistently associated with mental health system engagement. Of the three categories of explanatory factors evaluated, only these variables remained associated after adjustment for underlying socio-demographic factors and co-morbidities. These factors included access to a family doctor or mental health professional as well as to LGB-specific venues, such as those providing HIV and STI tests, and LGB community organizations. A vast majority (88%) of respondents who had not engaged with a healthcare provider regarding mental health concerns did report having access to a primary health care provider or a LGB organization. This points to the need for collaboration across a variety of service settings, including those which are already targeted to gay and bisexual men (e.g., clinics related to HIV or STI treatment and prevention), as well as those situated within a broader suite of primary care services.

This study has both strengths and limitations. We used a large sample of 7,872 gay and bisexual men, which in turn enabled us to examine relatively infrequent characteristics of the

sub-sample who recently experienced suicide ideation or attempts (18%). In addition, the community-based approach of *Sex Now*—measurement embedded within the lives of gay and bisexual men—allowed us to study aspects of care that would not be typically measured in general population surveys (e.g., being out to healthcare providers, participation in gay community organizations).

Our results are limited, however, by the following aspects of sampling and measurement. First, most *Sex Now* respondents are recruited through online social networks and sex partner-seeking sites. LGB community samples, including *Sex Now*, tend to comprise individuals at higher risk of suicide than randomly selected population surveys (Hottes, Gesink, et al., 2016; Hottes, Bogaert, et al., 2016), though this sampling bias would presumably work in the favor of our present study objective, by getting closer to the population at-risk of suicide. There may be other selection factors associated with this online recruitment method that induce bias—for instance, perhaps individuals who are recruited from online social networks and sex-seeking sites are more likely to be connected to the LGB community and therefore have larger social networks. With regard to measurement, we were limited to the questions available to us within the broader gay and bisexual health survey, *Sex Now*. Data-sets that identify the sexual minority status of suicide decedents are rare, and limited by small sample sizes (Plöderl et al., 2013). We therefore studied suicide ideation and attempts as a proximal marker of suicide risk. However, we acknowledge that most individuals with suicide ideation do not go on to attempt suicide (Klonsky & May, 2014), and many suicide attempts are not fatal, making suicide attempts an imperfect predictor of subsequent suicide mortality (Ribeiro et al., 2016).

Moreover, our study design was unable to assess whether healthcare utilization and discussions with providers are able to effectively mitigate the risk of suicide among gay and

bisexual men—an important question for future, prospective studies; we acknowledge that in the present study, we are unable to know whether discussions with healthcare providers occurred before or after the onset of recent suicide ideation or attempts. We combined suicide ideation with suicide attempts to enable a large enough sample size to characterize the target population's healthcare utilization patterns in detail; however, these are distinct outcomes, with suicide attempt being rarer, more severe, and potentially revealing distinct correlates from the those of suicide ideation (Klonsky et al., 2016). Finally, while we chose markers of a variety of points of clinical and community service access, future studies will need to more precisely characterize these settings where suicidal gay and bisexual men could be reached (i.e., types of clinics, services, etcetera).

The present results support several recommended actions on the part of LGB health researchers, public health administrators and service planners, and clinicians, respectively. First, while evidence is gradually emerging to suggest a unique profile of LGB adults' patterns of healthcare access, more detailed data are required. Specifically, the following research questions remain unanswered. Several population health surveys have demonstrated that LGB adults access more mental health services than heterosexual adults (Bakker, Sandfort, Vanwesenbeeck, van Lindert, & Westert, 2006; Tjepkema, 2008); however, other studies suggest that conventional mental health services are not meeting LGB patients' needs (Meyer, Teylan, & Schwartz, 2015; Tjepkema, 2008). Reconciling these seemingly oppositional findings will require in-depth evaluations of LGB patients' experiences with healthcare providers regarding mental health concerns. In addition, research is needed to identify specific barriers to mental health care access that are experienced by LGB patients (e.g., those related to sexual identity stigma; cost or insurance; mental health stigma; knowledge of services; comfort with services).

Our results suggest that public health administrators and health systems planners should begin to identify networks or coalitions of clinical and community health providers who may be able to effectively reach LGB adults who do not have access to a regular family physician—these individuals notably constituted 41% of the gay and bisexual men with a recent history of suicide ideation or attempts in our sample. Such networks could be beneficial for the purposes of suicide prevention and for addressing numerous other health inequities experienced by LGB people, including those related to sexual health (HIV, STI, intimate partner violence), mental health (depression, anxiety, substance use), and physical health (Institute of Medicine, 2011). These networks may have the greatest reach if they are broad and inter-sectoral; e.g., our results point to the importance of sites like sexual health clinics (which provide HIV prevention services, often targeted to gay and bisexual men) and LGB health community organizations, as suggested by the varied distribution of sites of clinical and community service access displayed in **Figure 1**.

Finally, as only 55% of the final analytic sample (those who had not discussed mental health concerns with a provider) were ‘out’ to at least one healthcare provider, we echo calls by others recognizing the need for increased training and support for clinicians in sensitively and respectfully responding to perceived sexual (anti-LGB) stigma within healthcare interactions (Eliason & Schope, 2001; Lee, Oliffe, Kelly, & Ferlatte, 2017; Mayer et al., 2008; Neville & Henrickson, 2006; Parameshwaran et al., 2017). Stigma remains a powerful and pervasive force - even in healthcare interactions where the providers themselves do not espouse stigmatizing attitudes; clients may be reluctant to seek help due to histories of stigmatization, or general perceptions of healthcare provider attitudes toward sexual minorities. We point health care provider to best practice guidelines offered by the Fenway Institute, the Substance Abuse and

Mental Health Services Administration, the Centre for Addiction and Mental Health in Ontario, and the recently updated psychological practice guidelines provided by the American Psychological Association (American Psychological Association, 2016; Barbara, Chaim, & Doctor, 2007; Fenway Institute, 2017; Substance Abuse and Mental Health Services Administration, 2012).

Pervasive social stigma against sexual minorities and structural barriers within the healthcare system exacerbate the already heavy burden of suicide and associated risk factors (e.g., depression and substance use) among gay and bisexual men. Whereas public health and gay and bisexual communities have historically worked together to develop a broad network of secondary prevention interventions in other areas, such as HIV testing (Trapence et al., 2012), working together on suicide prevention opportunities should be a priority (World Health Organization, 2014). For example, lessons learned from the development and provision of ‘combination prevention’ tools (e.g., HIV testing; PrEP) (Beyrer, 2014; Beyrer et al., 2012; Branson et al., 2006; Pollack, Woods, Blair, & Binson, 2014) have established the importance of providing services across an array of healthcare and community settings, including primary care offices and hospitals, specialized sexual health clinics, and LGB community organizations, gay bars, clubs, and bathhouses. We propose a similar collaborative strategy between public health and LGB community organizations to address the epidemics of suicide ideation and attempts and other mental health outcomes that affect sexual minorities today.

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## Tables and figures

**Table 1.** Socio-demographic characteristics and engagement with healthcare providers about depression, substance use, or suicide, among a sample of gay and bisexual with recent suicide ideation or attempts, N=1480

Characteristic	Subgroup	n (% of N)	% (of row) who discussed MH concern with HCP	OR (95% CI)
Age, years	<30	496 (33.5)	52.4	Referent
	30-49	576 (38.9)	60.1	<b>1.37 (1.07, 1.74)</b>
	50+	408 (27.6)	62.0	<b>1.48 (1.13, 1.93)</b>
Sexual identity	Gay	1097 (74.1)	58.2	Referent
	Bisexual or other	383 (25.9)	57.7	0.98 (0.78, 1.24)
Living environment	Urban	867 (58.6)	59.3	Referent
	Suburban	233 (15.7)	58.4	0.96 (0.72, 1.29)
	Rural	380 (25.7)	55.0	0.84 (0.66, 1.07)
Education	High school	272 (18.4)	53.7	Referent
	Some college or university	686 (46.4)	59.3	1.26 (0.95, 1.67)
	University degree	522 (35.3)	58.6	1.22 (0.91, 1.64)
Income	<\$30,000	656 (44.3)	58.5	Referent
	\$30,000-59,999	414 (28)	57.5	0.96 (0.75, 1.23)
	\$60,000+	410 (27.7)	57.8	0.97 (0.76, 1.25)
Indigeneity	Indigenous	92 (6.2)	58.7	Referent
	Not indigenous	1388 (93.8)	58.0	0.97 (0.63, 1.49)
Immigration	Immigrant	225 (15.2)	52.4	Referent
	Not immigrant	1255 (84.8)	59.0	1.31 (0.98, 1.74)

**Note.** MH = mental health (including depression, substance use, and suicide); HCP = healthcare provider; OR = odds ratio; CI = confidence interval.

**Table 2.** Co-morbidities and engagement with healthcare providers about depression, substance use, or suicide, among a sample of gay and bisexual with recent suicide ideation or attempts, N=1480

<b>Co-morbidity</b>	<b>Subgroup</b>	<b>n (% of N)</b>	<b>% (of row) who discussed MH concern with HCP</b>	<b>OR (95% CI)</b>
HIV status	Positive	154 (10.4)	64.9	Referent
	Negative or unknown	1326 (89.6)	57.2	0.72 (0.51, 1.02)
History of suicide attempts <sup>a</sup>	One or more prior attempts	440 (29.7)	66.8	Referent
	No prior attempts	1040 (70.3)	54.3	<b>0.59 (0.47, 0.75)</b>
HCP visit after prior attempt <sup>b</sup>	HCP contact after prior attempt	205/440 (46.6)	81.0	Referent
	No HCP contact after prior attempt	235/440 (53.4)	54.5	<b>0.28 (0.18, 0.43)</b>
Support network <sup>c</sup>	No one	170 (11.5)	49.4	Referent
	1-3	680 (45.9)	57.6	1.39 (0.99, 1.95)
	≥4	630 (42.6)	60.8	<b>1.59 (1.13, 2.23)</b>

**Note.** MH = mental health (including depression, substance use, and suicide); HCP = healthcare provider; OR = odds ratio; CI = confidence interval; <sup>a</sup> reported a suicide attempt >1 year ago; <sup>b</sup> among those with a prior suicide attempt (>1 year ago); <sup>c</sup> number of people available for support “if something goes wrong”.

**Table 3.** Access to clinical and community resources and engagement with healthcare providers about depression, substance use, or suicide, among a sample of gay and bisexual with recent suicide ideation or attempts, N=1480

<b>Resource</b>	<b>Subgroup</b>	<b>n (% of N)</b>	<b>% (of row) who discussed MH concern with HCP</b>	<b>OR (95% CI)</b>
Family doctor <sup>a</sup>	Yes	1017 (68.7)	63.9	Referent
	No	463 (31.3)	45.1	<b>0.46 (0.37, 0.58)</b>
MH provider <sup>b</sup>	Yes	711 (48)	88.9	Referent
	No	769 (52)	29.5	<b>0.05 (0.04, 0.07)</b>
HIV test <sup>c</sup>	Yes	832 (56.2)	62.7	Referent
	No	648 (43.8)	52.0	<b>0.64 (0.52, 0.79)</b>
STI test <sup>c</sup>	Yes	870 (58.8)	62.2	Referent
	No	610 (41.2)	52.1	<b>0.66 (0.54, 0.82)</b>
Gay organization	Involved	279 (18.9)	63.8	Referent
	Not involved	1201 (81.1)	56.7	<b>0.74 (0.57, 0.97)</b>
Out to HCP <sup>d</sup>	Yes	927 (62.6)	63.0	Referent
	No	553 (37.4)	49.7	<b>0.58 (0.47, 0.72)</b>
Sensitivity of HCP <sup>e</sup>	High	193 (13)	56.0	Referent
	Low	1287 (87)	58.4	1.10 (0.81, 1.50)

**Note.** MH = mental health (including depression, substance use, and suicide); HCP = healthcare provider; OR = odds ratio; CI = confidence interval; <sup>a</sup> access family doctor for routine medical care; <sup>b</sup> accessed psychologist, psychiatrist, or counselor in previous 12 months; <sup>c</sup> received test in previous 12 months; <sup>d</sup> told your/a HCP about sexuality; <sup>e</sup> based on rating primary HCP as having “low respect for sexuality”, or reporting a negative reaction from a HCP when discussing sexuality or sexual health needs (ever).

**Table 4.** Correlates of engagement with healthcare providers about depression, substance use, or suicide, among a sample of gay and bisexual with recent suicide ideation or attempts, N=1480

Variable	Subgroup	OR (95% CI)
Age, years	<30	1.40 (0.99, 1.97)
	30-49	1.20 (0.81, 1.78)
	50+	Referent
Sexual identity	Gay	1.21 (0.87, 1.69)
	Bisexual or other	Referent
Living environment	Urban	0.87 (0.59, 1.29)
	Suburban	0.93 (0.68, 1.29)
	Rural	Referent
Education	High school	0.95 (0.66, 1.37)
	Some college or university	0.78 (0.52, 1.18)
	University degree	Referent
Income	<\$30,000	0.83 (0.59, 1.17)
	\$30,000-59,999	0.76 (0.53, 1.09)
	\$60,000+	1.40 (0.99, 1.97)
Non-indigenous		0.80 (0.46, 1.39)
Non-immigrant		1.07 (0.74, 1.55)
HIV negative/unknown		1.21 (0.76, 1.92)
No prior suicide attempts <sup>a</sup>		<b>0.71 (0.52, 0.95)</b>
Support network <sup>b</sup>	No one	Referent
	1-3	0.95 (0.61, 1.47)
	≥4	1.02 (0.65, 1.60)
No family doctor <sup>c</sup>		<b>0.45 (0.33, 0.61)</b>
No MH provider <sup>d</sup>		<b>0.05 (0.04, 0.07)</b>
No HIV test <sup>e</sup>		<b>0.64 (0.48, 0.85)</b>
Not involved with gay organization		1.03 (0.72, 1.48)
Not out to HCP <sup>f</sup>		0.79 (0.57, 1.08)
Low sensitivity of HCP <sup>g</sup>		0.97 (0.65, 1.45)

**Note.** MH = mental health (including depression, substance use, and suicide); HCP = healthcare provider; OR = odds ratio; CI = confidence interval; <sup>a</sup> >1 year ago; <sup>b</sup> number of people available for support “if something goes wrong”; <sup>c</sup> for routine medical care; <sup>d</sup> psychologist, psychiatrist, or counselor, in previous 12 months; <sup>e</sup> in previous 12 months; <sup>f</sup> never disclosed sexuality to a HCP; <sup>g</sup> based on rating primary HCP as having “low respect for sexuality”, or reporting a negative reaction from a HCP when discussing sexuality or sexual health needs (ever).

**Figure 1.** Access to clinical and community resources among gay and bisexual with recent suicide ideation or attempts who have not discussed mental health concerns\* with a healthcare provider, N=621 (Note. \* mental health concerns defined as depression, substance use, or suicide.)

