How can sexual health clinics meet their clients' mental health service needs?

Interviews with 22 providers from British Columbia

Why did we do this study?

Sexual health clinics are unique healthcare settings. They provide low-barrier, non-stigmatizing care to people with a number of different sexual health and related concerns. Sexual health clinics are also trusted places where lesbian, gay, bisexual, transgender, queer, and two-spirit (LGBTQ2) people can seek care without fearing judgment.

In 2016-17 we surveyed 1,115 clients—65% of whom were LGBTQ2—at 6 sexual health clinics in Greater Vancouver. We found that 40% of these clients self-reported a mental health or substance use-related healthcare need. As a next step, we wanted to understand how providers in sexual health clinics in British Columbia address these needs in their current practice, and what could be done in the future to support this work.

Who participated?

Between January and July of 2018, we visited 6 sexual health clinics in Greater Vancouver and Victoria, including 4 public health clinics and 2 non-profit clinics. A total of 22 people participated in interviews:

- 14 nurses
- 3 physicians
- 3 administrators
- 1 educator
- 1 counselor

What did we learn?

Clinician background & context:

The providers we spoke with had a wide range of backgrounds, from labor and delivery nursing to harm reduction to transplant and surgery. Despite this breadth of experiences, we found that sexual health providers are a unique group. Most were particularly motivated to do the community-oriented work of sexual healthcare because it enabled them to address 'upstream' health issues and the determinants of health for their clients.

> "I always loved sexual health. For nurses it's a great role, because we get a lot more autonomy than we would in other areas because, we have this kind of certified practice where we can see patients for a complete visit start to finish, and we have time with people. Because I think sexual health is so big, right? I think we act like it's just STI testing and birth control and whatever, but it's so tied to everything else for people."

What did we learn (continued)?

Clinician background & context:

All of the participants affirmed for us that the sexual and mental health of their clients were interconnected.

> "So, they're in crisis because they've been named as a contact of syphilis, or they have a rash in the genital area and they're sure that it's a sexual infection, but they're also about to get evicted from their home, and they've been struggling with chronic depression, but they're not enrolled in MSP, so they can't get medication or care."

While we heard about a wide range of mental health and substance use-related issues that come up in the sexual health clinic—depression, suicide, relationship struggles, self-esteem—the most prevalent concern articulated by participants was anxiety. In some cases, this anxiety was directly tied to their sexual health concern, e.g., worry about a specific sexual encounter or the possibility of testing positive for HIV or an STI. In other cases, this anxiety reflected a more general worry or preoccupation.

> "[For example, I saw] a young man probably in his early twenties, mid-twenties, and his risk was really low and he knew that, and he hadn't had any major risk event. But he was coming in because he was really worried about his HIV results. And I think when he had initially tested he still wasn't out of the window period, so he was returning and I think for someone like that there's just a generalized anxiety going on."

Several participants commented on a common sexual health clinic client profile: someone who presented with a lot of anxiety—sometimes repeatedly—but who had low risk of STI.

Constraints:

We identified 3 constraints that made it difficult for the providers we interviewed to meet their clients' mental health needs:

1. Clinic mandate or funding model
2. Silo-ing of services
3. Limited familiarity with referral resources

Several interviewees explained to us a tension they experienced between recognizing the interconnectedness between sexual and mental health for their clients and their clinic's scope or mandate with regard to sexual health.

> "There is only so much we can really take on. Like I have 20, maybe 25 minutes to see them and really our mandate is sexual health, but it's tricky right because we can say, 'only sexual health.' but there's a lot more to it. … I think in some ways us being distinct is cool, because we are able to do things that we might not be able to do otherwise, but I think it would be nice to have the Ministry [of Health] acknowledge the scope of what we are doing and support us better in terms of funding."

What did we learn (continued)?

"I think we carry the baggage of history, and the history is mental health people got locked up, and segregated, and ostracized, and I think we are dealing with that, and I still see it in acute care, right? It's like you've got mental health wards, and mental health teams, and like, mental health and substance use is over there, and other health care is over here. I've been really trying to kind of, let's get them together, but when we keep segregating it all out, it's hard to do that."

Constraints:

Beyond the sexual health clinic, providers felt limited by the ways in which healthcare services—in this case related to mental health and addictions—have historically been siloed. While these silos are starting to come down, in many cases mental health services remain separated, or at least have intake processes or inclusion criteria that make it difficult for referral from a sexual health clinic.

Finally, we heard how important it is for providers to have some familiarity with mental health resources before they refer clients. This referral process was constrained, sometimes by the silos referenced above, other times by lack of knowledge of the breadth of options available to clients.

"I've had unfortunately some bad experiences with trying to refer people to mental health services, so I'm a little bit cynical about our system … the gaps that exist in our system, and how people fall through them. I've seen it happen many times. So you know I still try, but I try to not set people up for disappointment. So I'll be really clear about, you know, this is the process… ideally this service will be here to help you, but you may need to be persistent in trying to access it. Or, you know, it may take a week, two weeks, a month for someone to get back to you, just so that people have some realistic expectations."

"So, thankfully we're in a really supportive environment, this is a very —this clinic is unlike any other clinical environment in that we're not limited, time limited, with clients. We take as long as we need. Which I would be hard pressed to name another environment where we do that."

Facilitators:

Despite these barriers, we found that sexual health providers in all the clinics we visited were finding ways to make sure their clients mental health-related needs were met. Specifically, interviewees highlighted three facilitators to this work:

1. Flexibility in the time they spent with their clients
2. Low-barrier nature of the clinics
3. Acquired counseling experience

Providers working in the public health clinics we visited noted that most of their shifts allowed for flexibility in how much time they spent with clients. This was an important enabler of effectively meeting clients' mental health-related concerns.

What did we learn (continued)?

Facilitators:

Interviewees also noted that the low-barrier nature of sexual health clinics meant that they were well situated to address other health and social concerns that extend beyond sexual health.

A final facilitator of sexual health providers' ability to address clients' mental health-related concerns is the on-the-job counseling experience acquired over the years of sexual health practice. These acquired skills were especially noteworthy given that few of the providers we spoke with had received formal training in mental health counseling or assessments.

"I see this clinic being accessed more from people who don't have MSP coverage…who are either visiting, or don't have [permanent resident] status or whatever else. They're using it kind of like a free clinic.… So, they come here and try to like access services because otherwise they would have to pay for things outside of a clinic like this, and often those populations have really vulnerable stories…they don't have…you know, trust sometimes, and they don't have the finances to access another way through the system, so often like the counselling that takes place is not related to STIs, it's sort of just the…the kind of…gateway to get into see a health care provider and then the story becomes much more layered around that."

"I've noticed… a progression of my own sort of skills and competencies as a nurse in the area [of mental health]. So as a novice or beginning nurse you're very focused on just the very specifics like STI testing, treatment, diagnosis. As you get more competent and comfortable with that then you start to pick up on other parts of, other things that might be going on with the client. So things like mental health, relationship issues or concerns, or other things like that. So you become a little bit more cognizant of other social aspects of their life that are intertwined or related."

Solutions:

The most commonly suggested solution to better supporting sexual health clinic clients' mental health-related needs was integration, or at least co-location, of providers who are trained and designated to address mental health. Such providers were variously described or identified as counselors, social workers, mental health workers, or peer navigators. The specific discipline of these support personnel was less important than their characteristics, specifically that they be knowledgeable about low-barrier referrals and resources available to clients, and that they be well-versed in issues related to sexual health.

"I don't even think it [the training/discipline of a co-located mental health provider] needs to be psychiatry. In fact, many people find that quite off-putting. So a counsellor would go a long way. Even a registered clinical counsellor or psychologist who has training in cognitive behavioural therapy, but also has knowledge of stigma around maybe sexual practices, or sexual fetishes, or a good understanding of addiction, and a good understanding of mental health concerns with regards to anxiety and depression for sure."

Summary:

We found that sexual health providers are a distinct, self-selected group who are motivated to look beyond STI and reproductive health needs of their clients. The providers we interviewed noted that mental health issues (in particular, anxiety) frequently arise in sexual health visits. Based on our interviews, we can see the several ways to support the work of addressing sexual health clients' mental healthcare needs:

- **Reducing silos**, i.e., by improving or at least clarifying referral pathways from sexual health clinics to mental health providers
- **Co-locating** and integrating sexual health and mental health services
- **Identifying high-anxiety and low-STI risk clients** who frequently access sexual health services and assessing their broader mental health needs

What are we doing next?

Based on the results of this study, we are working toward the following actions:

1. **MindMap**!: MindMap is a mental health service finder tool with the option of selecting services that are queer- and/or gender-affirming. It uses a database of low-barrier (self-referral, low-cost) services to help clinicians identify the best referral for their clients.

2. **Anxiety**: We are preparing to conduct a follow-up study with clients of sexual health clinics to better understand the forms of anxiety they experience before, during, and after sexual health visits. The goal of this study is to identify additional care and support options for clients experiencing chronic anxiety.

3. Finally, we will be taking the results of this study to administrators in the province to recommend co-location and integration of mental health providers within sexual health service settings.

We would love to hear from you about other ways in which these results can be used.

Contact and acknowledgments

For more information contact Travis Salway at travis.salway@bccdc.ca

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