MIND YOUR "BUSINESS"

How to Make the Connections between Mental Health and Sexual Health

Action Canada for Sexual Health & Rights
Action Canada pour la santé & les droits sexuels
@srhweek

HOW TO MAKE THE CONNECTIONS BETWEEN MENTAL HEALTH AND SEXUAL HEALTH

What does good health care look like? A positive health care experience can look like many things to different people. It's not about perfect scripts, it’s about increasing capacity to provide affirming care for diverse people and communities. Although Canada’s health care system is universal, not everyone has equal access to the care they need and deserve, which results in health disparities. When it comes to mental health and sexual health, individuals may feel hesitant to access health care due to concerns around or previous experiences of stigma and discrimination. This handbook includes scenarios, discussion prompts, and tips for health care professionals to provide comprehensive and affirming care related to mental and sexual health and all the ways they intersect.

This handbook was produced as part of Sexual and Reproductive Health Awareness Week. An annual campaign hosted by Action Canada for Sexual Health and Rights to promote sexual and reproductive health in Canada. For more information visit www.srhweek.ca

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Action Canada for Sexual Health & Rights is a progressive, pro-choice charitable organization committed to advancing and upholding sexual and reproductive health and rights in Canada and globally.

TABLE OF CONTENTS

QUESTIONS TO ASK YOURSELF

In all aspects of our lives, we deserve to be treated as the full and complex individuals we all are. This means recognizing mental and sexual/reproductive health and wellness as integral to our overall well-being.

Everyone is entitled to positive and affirming health care that routinely and proactively meets their mental health and sexual/reproductive health needs **and all the ways in which they connect**. Mental health and sexual/reproductive health do not exist in silos. There is a significant amount of research and experiences supporting the many links between mental and sexual/reproductive health.

How are mental and sexual/reproductive health connected?

There are countless scenarios that point to the need for positive and affirming health care that routinely and proactively assess and meets our mental health and sexual/reproductive health needs and **all the ways they connect**! The following are some of the many examples that illustrate the connections between mental health and sexual/reproductive health. Each example includes questions to help you think through interventions that could enhance the mental and sexual wellbeing of your patients/clients. The examples are intended to illustrate why health care providers must proactively address **the myriad connections between mental and sexual/reproductive health care** and foster a relationship that leads to better care for everyone.

Before, during and after pregnancy

Experiencing depression and/or anxiety during (perinatal) or after (postpartum) pregnancy is common in Canada and across developed countries. 10 to 15% of people who have given birth are affected by postpartum depression and/or anxiety[1] and about the same percentage of people experience symptoms of a major depressive disorder during their pregnancy.[2] Perinatal and postpartum depression has been associated with many poor outcomes, including maternal, child and family unit challenges. In some rare cases, people experience postpartum psychosis, a psychiatric emergency in which symptoms of mania, depression, severe confusion, loss of inhibition, paranoia, hallucinations, or delusions occur beginning suddenly in the first two weeks after childbirth. When supporting people around reproductive health issues, it also important for health care providers to be vigilant when their patients/clients are having difficulty conceiving, have suffered a pregnancy or infant loss or when a patient weans their child from breastfeeding as some people will experience post-weaning depression and anxiety.

How can you provide the best possible care during and/or after pregnancy that addresses sexual and mental health? Ask yourself the following:

1. What is your level of knowledge and capacity as it relates to the mental and sexual health needs of your pregnant and postpartum patients/clients? Those trying to conceive? Experiencing infertility? Being involuntarily childless? Having experienced pregnancy or infant losses? Weaning after breastfeeding? Supporting trans or gender non-conforming patients/clients who are pregnant or trying to conceive?
2. How commonly do you proactively assess the mental wellness of each of your pregnant and postpartum patients/clients to ensure you can detect stress, depression or anxiety? What about people trying to conceive, experiencing infertility, being involuntarily childless? pregnancy or infant losses? Weaning after breastfeeding?
3. What are assumptions to avoid when caring for pregnant or postpartum patients/clients? For those trying to conceive? For LGBTQ2S+ (Lesbian, Gay, Bisexual, Trans, Queer, Two-Spirit, and more) patients/clients? For people of colour?[3]
4. How seriously do you take the concerns of patients/clients and their assessment of how they are doing during times of reproductive transitions?
5. What kind of support and resources are available in your community for your patients/clients as they navigate pregnancy? The postpartum period? Infertility?

[1] For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3118237/
[2] For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3083253/
[3] Did you know? In 2010, a study coined the term “weathering” to speak to the wear on people’s bodies from chronic stress of racism and daily micro-aggressions. This has profound implications for mental health generally but also during pregnancy. It means that for Black women (and other racialized people), the risks for pregnancy start at an earlier age than many clinicians — and patients/clients— realize, and the effects on their bodies may be much greater than for white women. For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2861506/

Being involuntarily childless? Pregnancy or infant loss? Weaning after breastfeeding?

Menstrual cycles

Hormonal fluctuations can have significant impacts on people of reproductive age. Premenstrual Dysphoric Disorder (PMDD) affects 3% to 8% of people who menstruate. PMDD symptoms include severe depression, anxiety and extreme irritability, all of which impact a person's daily life and their relationships with others. Another common hormonal disorder related to menstrual cycles is Polycystic ovary syndrome (PCOS), a set of symptoms due to elevated androgens in people with female reproductive organs. Signs and symptoms of PCOS include irregular or no menstrual periods, heavy periods, excess body and facial hair, weight gain, acne, pelvic pain, difficulty getting pregnant, and patches of thick, darker, velvety skin. PCOS can also lead to severe mental health issues including anxiety, depression, and eating disorders.[4]

Similarly, the end of the reproductive years can also bring mental health challenges, including depression during perimenopause. Perimenopause marks the time when the body begins the transition to menopause (the time that marks the end of someone's menstrual cycles) and includes the years leading up to menopause (anywhere from two to eight years) plus the first year after a person's final period. Because of the intense hormone changes during perimenopause, people are more likely to have menopause related depression before they reach actual menopause.

How can you provide the best possible care related to mental wellness and menstrual cycles? Ask yourself the following:

1. What is your level of knowledge and capacity as it relates to premenstrual syndromes and how they are identified, diagnosed and (when required) treated?
2. Do you proactively assess a patients'/clients' mental wellness related to menstrual cycles and/or reproductive systems? Do you do so throughout their lives?
3. How inclusive are you in your language around menstruation and reproductive health systems?
4. How seriously do you take patients'/clients' reports of pain,[5] fatigue, irregularities, and/or mood swings related to their menstrual cycles or reproductive systems?

[4] For more information visit http://nursing.columbia.edu/psychiatric-complications-women-polycystic-ovary-syndrome-most-often-linked-menstrual-irregularities

[5] Did you know? The study "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain" found that women were less likely to receive aggressive treatment when diagnosed and were more likely to have their pain characterized as "emotional," "psychogenic" and therefore "not real." Many refer to this tendency to not take women's pain seriously as the "Gender Pain Gap." The same is true for people of colour, including Black people and Indigenous people. A recent study examining racial disparities reveals that people feel more empathy towards white people than towards Black people, particularly in the context of medical treatment and the ability to feel pain. This has been coined as the racial empathy gap and it explains how people, including health care providers, assume Black people feel less pain, which impacts pain management, diagnoses, treatment plans, and the general quality of the care people receive. For more information visit http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1144&context=fac_pubs;

5. What kind of resources and/or supports are available in your community for your patients/clients who may struggle with premenstrual syndromes? Polycystic Ovary Syndrome? What kind of resources and/or supports are available to help navigate perimenopause/menopause?

Depression

Depression affects every part of daily life, including sexuality.[6] It can impact a person's sex drive, which can affect their relationships and/or ability to nurture intimacy with partners. Some anti-depressants can also curb libido, cause erectile dysfunction (ED), a decrease in vaginal lubrication, or difficulties achieving orgasm. or an inability to have an orgasm.

How can you provide the best possible care when it comes to the sexual and mental health or people living with depression? Ask yourself the following:

1. What is your level of knowledge and capacity related to sexual health and depression? The side effects of some antidepressants on libido or sexual response? How sexual problems may arise with depression or when using antidepressants?
2. When discussing treatment options for depression, do you proactively assess people's wellbeing related to their sexual lives, sexual responses and relationships?
3. How seriously do you take your patients'/clients' concerns related to sexual side effects from antidepressants?
4. What kind of resources and/or supports are available in your community for your patients/clients who may struggle with sexual dysfunctions related to their depression or use of antidepressants?

HIV, Syphilis and other Sexually Transmitted Infections (STIs)

Mental health issues are closely linked with HIV. Mental health conditions have been shown to increase the likelihood of getting HIV and people living with HIV may also be impacted by mental health issues, especially depression and anxiety. These can result from the diagnosis of HIV and living with a complex and stigmatized illness. HIV can also produce psychological impacts due to its effects on the central nervous system.[7] This is certainly relevant for people living with HIV who are pregnant. With growing numbers of people living with HIV who are of child-bearing age combined with increased access to effective clinical protocols for preventing mother/parent-to-child transmission (MTCT) of HIV, mental health related factors have become increasingly relevant due to their potential to affect a person's quality of life, obstetric outcomes, and risk of MTCT.[8]

And then in the last decade, there has been a significant rise in syphilis, a sexually transmitted

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0048546; and http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf

[6] For more information visit https://www.webmd.com/depression/features/depression-and-sex#1

[7] For more information visit http://www.catie.ca/en/hiv-canada/7/7-4

[8] For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4120872/

infection caused by a bacterium that attacks the body in three stages. In most cities gay and bisexual men have been hit hardest by it, and as many as 1/2 of syphilis cases are among men who are HIV positive. Syphilis can easily be tested and treated if caught early enough. If not treated, syphilis can evolve to neurosyphilis which can lead to serious health complications, including but not limited to blindness, confusion, sudden personality changes, changes in mental stability, dementia, depression, suicidal ideation, etc.

Beyond HIV and Syphilis, it also matters to speak to the potential mental and emotional impact of other sexually transmitted infections. Sometimes, because there are still several social stigmas when it comes to being diagnosed with an STI or living with one that, while manageable, may not be curable like herpes, severe stress and depression many people have a difficult time with their diagnoses, both physically and mentally and can experience severe stress and depression.

How can you provide the best possible mental and sexual health care for people living with HIV, including those who are trying to conceive or are pregnant? Those who are or may be infected with Syphilis? Those who are diagnosed with an Sexually Transmitted Infection?

1. What is your level of knowledge and capacity as it relates to caring for people living with HIV? To the specific mental health needs of people living with HIV? To the specific sexual health needs of people living with HIV? To the specific prenatal care for pregnant or breastfeeding people living with HIV? What about as it relates to caring for people who are or may be infected with Syphilis? Who have just been diagnosed with an sexually transmitted infection?
2. What kind of supports do you offer people living with HIV as they navigate stigma and discrimination? HIV disclosure to potential romantic and sexual partners? STBBI testing? The risk of HIV criminalization? People who have been diagnosed with an STI, including infections that while manageable may not be curable?
3. Do you proactively assess the sexual and mental health and wellbeing of your patients/clients living with HIV? How open and supportive are you when discussing the sexual lives and sexual health needs of your patients/clients living with HIV? Who may be or are infected with syphilis? Who have been diagnosed with an STI?
4. What kind of resources and/or supports are available in your community for your patients/clients living with HIV? Those who are, may be or are at risk of being infected with syphilis? Those who have been diagnosed with an STI?

Hormonal contraception

A recent study[9] indicates an increased risk of depression as a potential adverse side effect of all forms of hormonal contraception. Higher risks are attributed to progesterone-only forms of hormonal contraception, including IUDs. It is important that health care providers discuss this possibility with their patients/clients during contraceptive counselling in the same way they would counsel them about other possible side effects (such as increased risk of blood clots) to

[9] For more information visit https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2552796

ensure patients/clients have the information they need to make an informed choice based on current evidence.

How can you provide the best possible mental and sexual health care for patients/clients using or considering hormonal contraception? Ask yourself the following:

1. What is your level of knowledge as it relates to the impact of different contraceptives on mental health and wellness? What is your knowledge and capacity in offering birth control counselling to individual patients/clients? Managing side-effects of hormonal contraception?
2. Do you proactively assess your patients'/clients' sexual and mental health and wellbeing as it relates to their use of hormonal contraceptives?
3. What kind of resources and/or supports are available in your community in terms of accessing birth control and support around family planning and pregnancy options?

Endometriosis

Endometriosis is a painful reproductive disorder that affects millions of people worldwide. This medical condition occurs when the lining of the uterus, called the endometrium, grows in other places, such as the fallopian tubes, ovaries or along the pelvis. When that lining breaks down, like the regular lining in the uterus that produces the menstruation, it has nowhere to go. This causes cysts, heavy periods, severe cramps, severe pelvic pain, and even infertility[10].

The pain, which can be debilitating, is due to internal bleeding from the lining being shed inside the body and can also lead to scar tissue formation, blocked fallopian tubes, and bowel problems. There is a positive correlation between pain levels in people with pelvic endometriosis and symptoms of depression and anxiety. A 2015 study found that people who experience pelvic pain because of endometriosis have an impaired quality of life and are more susceptible to mental illnesses.[11] Many people experience long delays in getting an endometriosis diagnosis even in the presence of very significant symptoms, which can further exacerbate the mental health impacts of the pain.[12] This is in part explained by the unconscious biases[13] that may impact how people's pain is assessed and treated.

How can you provide the best possible mental and sexual health care for people with pelvic endometriosis? Ask yourself the following:

[10] For more information visit https://www.acog.org/-/media/For-Patients/faq013.pdf?dmc=1&ts=20150224T1558008586
[11] For more information visit https://www.sciencedaily.com/releases/2015/12/151221071636.htm
[12] For more information visit https://www.theguardian.com/society/ng-interactive/2015/sep/27/the-pain-is-paralysing-30-women-describe-living-with-endometriosis
[13] For more information visit http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1144&context=fac_pubs

1. What is your level of knowledge and capacity as it relates to treating patients/clients who experience chronic pelvic pain? To identifying, diagnosing, supporting, and treating patients/clients who may be suffering from endometriosis?
2. Do you proactively assess your patients'/clients' sexual and mental health and wellbeing as it relates to chronic pelvic pain, pain during sexual intercourse, premenstrual and menstrual pain, and/or endometriosis?
3. How seriously do you take patients'/clients' reports of pain related to their reproductive systems and menstrual cycles?
4. What kind of resources and/or supports are available in your community for patients/clients who suffer from chronic pelvic pain and/or endometriosis?

Genital sexual pain

Vulvodynia is a chronic pain syndrome associated with burning, stinging, irritation, or sharp vulvar pain and it affects an estimated 16% of people with vulvas and vaginas in the general population.[14] Pain presentation varies and may be described as spontaneous, provoked by stimulation (i.e., intercourse or tampon use), or both. People with vulvodynia report a poor quality of life and suffer from psychological distress manifested as anxiety and depression. Some studies[15] note the increased prevalence of vulvodynia among those who screen positive for depression or Post Traumatic Stress Disorder (PTSD), which suggest that these disorders may contribute to the likelihood of reporting vulvodynia. Chronic vaginal or vulvar pain like vulvodynia and vaginismus[16] (a painful vaginal spasm occurring during penetration) and dyspareunia[17] (which is genital pain associated with sexual intercourse) can greatly impact people's mental health and wellness.

How can you provide the best possible mental and sexual/reproductive health care for patients/clients experiencing chronic and/or acute vaginal or vulvar pain? Ask yourself the following:

1. What is your level of knowledge and capacity as it relates to treating patients/clients who experience chronic vulvar or vaginal pain? As it relates to identifying, diagnosing, supporting, and treating patients/clients who may be suffering from the symptoms of conditions like vulvodynia, vaginismus, and/or dyspareunia?
2. Do you proactively assess your patients'/clients' sexual and mental health and wellbeing as it relates to chronic vulvar or vaginal pain, or pain during sexual intercourse?
3. How seriously do you take patients'/clients' reports of vulvar or vaginal pain and/or pain during sexual intercourse?

[14] For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4014358/
[15] For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628213/
[16] For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3136020/
[17] For more information visit https://www.ncbi.nlm.nih.gov/pubmed/25369624

4. What kind of resources and/or supports are available in your community for patients/clients who experience chronic vulvar and/or vaginal pain?

IMPORTANT CONSIDERATIONS

Gender, sexuality and mental health

Large Canadian studies indicate that lesbian, gay, bisexual and queer people are more likely than their heterosexual peers to report unmet mental health needs.[18] In the same vein, the Trans Pulse study[19] shows that for Trans people, experiences of discrimination and violence can result in exclusion from social spaces, unemployment, avoidance of health care, and poor mental health.

This must be understood in the context of historical and ongoing pathologization of LGBTQ2S+ identities and the ongoing experience of stigma, prejudice and discrimination[20] society-wide, including in health care settings.[21] This is compounded for individuals and communities also marginalized because of race, ethnicity, disability, etc.

Studies have found high rates of depression, anxiety, obsessive compulsive and phobic disorders, suicidal thoughts and acts, self-harm, and alcohol and drug dependence among LGBTQ+ people. Youth have an increased risk of suicide, substance abuse, isolation and experiencing sexual violence.[22] LGBTQ2S+ elders are also particularly at risk of mental health concerns.[23]

Experiences of homophobia, transphobia and the loss of community and family support that often comes from disclosing sexual orientation and/or gender identity are crucial factors that impact people's health and wellbeing. These experiences are compounded for Black, Indigenous and racialized LGBTQ+ people as they experience the stress of racial discrimination and access to appropriate mental and sexual/reproductive health care is often compromised.

How can you provide the best possible sexual and mental health care for LGBTQ2S+ patients/clients? Ask yourself the following:

1. What is your level of knowledge and capacity as it relates to the specific mental and sexual health needs of LGBTQ2S+ patients/clients?

[18] For more information visit https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2011/06/RHO_FactSheet_LGBTQMENTALHEALTH_E.pdf
[19] For more information visit http://transpulseproject.ca/research/
[20] Did you know? A survey of 132 medical schools in the U.S. and Canada found that schools spend an average of only five hours on LGBTQ2S+ health issues. Nine schools reported no hours of LGBTQ2S+ health taught during preclinical years and 44 reported no hours during clinical years. https://jamanetwork.com/journals/jama/fullarticle/1104294
[21] For more information visit http://www.srhweek.ca/providers/people-and-communities/diverse-sexual-orientations/ and http://www.srhweek.ca/providers/people-and-communities/trans-and-gender-diverse-people/
[22] For more information visit https://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2011/06/RHO_FactSheet_LGBTQMENTALHEALTH_E.pdf
[23] For more information visit http://brainxchange.ca/Public/Files/LGBT-and-Dementia/RHO_Slides.aspx

2. What are steps you can take to increase your personal and/or institutional capacity to care for LGBTQ2s+ people and communities?24 Are there LGBTQ2s+ staff and health care providers in your facility?
3. Have you taken steps to make your practice safe, inclusive, and affirming for LGBTQ2S+ people and communities?25 How about specifically for trans and gender diverse patients/clients? How can your routine questions to assess mental and sexual health as well as your patient history intake be LGBTQ2S+ affirming?
4. How commonly do you proactively assess patients'/clients' mental and sexual wellness as it relates to the specific risks faced by LGBTQ2S+ people and communities in a way that is affirming of everyone's sexuality and gender identity/expression?
5. How do you help optimize the support of parents and guardians of LGBTQ2S+ children and youth who are patients/clients?26 How do you help optimize support LGBTQ2S+ seniors who may be moving into assisted living facilities?
6. What kind of resources and/or supports are available in your community for your LGBTQ2S+ patients/clients of all ages?

Sexual trauma and mental health

Sexual violence[27] and the loss of safety and bodily autonomy that survivors of sexual trauma experience(d) can bring a host of mental health impacts[28] like depression, anxiety, post-traumatic stress disorder, personality disruption, attachment disruption, and addiction. Survivors of sexual violence are more likely than the average person to attempt suicide. In addition to the violence itself, survivors of sexual violence and abuse must also contend with pervasive myths about sexual assault that can further isolate and stigmatize them.

How can you provide the best possible mental and sexual/reproductive health care for survivors of sexual violence? Ask yourself the following:

1. What is your level of knowledge and capacity as it relates to supporting the mental and sexual health of patients/clients who have experienced sexual violence?[29] How familiar are you with the theory and practice of trauma-informed care?[30]

[24] For more information see link to http://www.srhweek.ca/providers/people-and-communities/diverse-sexual-orientations/ and http://www.srhweek.ca/providers/people-and-communities/trans-and-gender-diverse-people/
[25] For more information visit http://www.srhweek.ca/providers/inclusive-practice/
[26] Did you know? Strong family support is one of the strongest protective factor for LGBTQ2s+ youth's overall health and wellbeing!
[27] Any unwanted act of a sexual nature that is imposed on another person.
[28] For more information visit https://www.cdc.gov/violenceprevention/sexualviolence/consequences.html
[29] For more information visit http://www.srhweek.ca/providers/people-and-communities/sexual-violence/
[30] For more information read the section on Trauma Informed Care

2. What kind of supports and accommodations can you offer in the context of sexual health care to ensure patients/clients who have experienced sexual trauma feel most comfortable and supported?[31]
3. Do you proactively assess the mental and sexual health and wellness of your patients/clients who have experienced sexual violence? If they haven't disclosed these experiences to you, how can you make your practice (including your assessment of mental and sexual wellbeing) more inclusive, affirming, and safe for patients/clients who may have experienced sexual violence?
4. What kind of resources and/or supports are available in your community to support your patients/clients who have experienced sexual violence?

Intimate Partner Violence and Reproductive Coercion

The impact of intimate partner violence on the health and wellbeing of people and their families is devastating. Intimate partner violence is the most common form of violence against women globally and is associated with many health problems (including injuries, chronic diseases, substance abuse, reproductive health problems, HIV and AIDS, and low birth weight). The mental health consequences of Intimate partner violence can be severe and include posttraumatic stress disorder (PTSD), depression, anxiety, and eating disorders.[32]

While we often discuss intimate partner violence and reproductive coercion as issues only affecting cis women, intimate partner violence is common in LGBTQ2S+ communities and it may also include behaviors that draw on the experiences of LGBTQ individuals, such as "outing" or restricting a person's access to items that are central to their gender or sexual identity.[33]

Intimate partner violence makes people more at risk of mental health issues and not being able to control their sexual and reproductive lives (including deciding when to be pregnant, when and how to use birth control, if or when to access abortion, how and when to practice safer sex, protect themselves from HIV infection, etc.).

Among other things, studies are showing that people who report a history of intimate partner violence are more likely to report behaviours known to increase the risk for HIV (including injection drug use, treatment for a sexually transmitted infection (STI), giving or receiving money or drugs for sex, and anal sex without a condom in the past year).[34]

Violence and poor reproductive health outcomes are strongly linked. The likelihood of reproductive coercion in cases of intimate partner violence increases the risk of unintended pregnancies. One study found that women with unintended pregnancies were four times more likely to have experienced intimate partner violence than women whose pregnancies were

[31] For more information visit http://www.srhweek.ca/providers/people-and-communities/sexual-violence/
[32] For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4165041
[33] For more information visit https://www.rainbowhealthontario.ca/wp-content/uploads/2016/07/RHO_FactSheet_LGBTQIntimatePartnerViolence_E.pdf
[34] For more information visit https://www.cdc.gov/violenceprevention/pdf/ipv/13_243567_green_aag-a.pdf

intended.[35] In 2007, the prevalence of intimate partner violence was nearly three times greater for women seeking an abortion compared with women who were continuing their pregnancies.[36]

Reproductive coercion[37] is a form of intimate partner violence related to reproductive health, where behaviours are used to maintain power, control, and domination within a relationship and over a partner. Examples include: explicit attempts to impregnate a partner against their will, controlling the outcomes of a pregnancy (e.g., forcing an abortion or preventing a person from accessing an abortion), coercing a partner to have unprotected sex, and interfering with contraceptive methods.[38]

How can you provide the best possible mental and sexual/reproductive health care for patients/clients experiencing intimate partner violence and/or reproductive coercion? Ask yourself the following:

1. What is your level of knowledge and capacity as it relates to victims/survivors of intimate partner violence? As it relates to the mental and sexual health needs of patients/clients who face intimate partner violence and/or reproductive coercion? As it relates to trauma-informed care?[39]
2. How commonly do you proactively assess if your patients/clients may be experiencing intimate partner violence and/or reproductive coercion? How can you create a safe environment for assessment and disclosure?
3. What is your level of knowledge and capacity regarding the direct interventions health providers can make to address reproductive and sexual coercion? Regarding what to be mindful of in terms of language and framing?
4. What is your level of knowledge and capacity in terms of supporting LGBTQ2S+ patients/clients who are experiencing intimate partner violence?[40]
5. What kind of support and resources are available in your community for your patients/clients who are victims of intimate partner violence and/or reproductive coercion?[41]

[35] For more information visit https://journals.lww.com/greenjournal/Abstract/1995/06000/The_Relationship_Between_Pregnancy_Intendedness.24.aspx
[36] For more information visit https://www.ncbi.nlm.nih.gov/pubmed/17493373
[37] For more information visit https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-and-Sexual-Coercion
[38] For more information visit https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-and-Sexual-Coercion
[39] For more information read the section on Trauma Informed Care
[40] For more information visit https://www.rainbowhealthontario.ca/wp-content/uploads/2016/07/RHO_FactSheet_LGBTQIntimatePartnerViolence_E.pdf
[41] Did you know? According to the American College of Gynecologists and Obstetricians, interventions by health care providers that focus on awareness of reproductive and sexual coercion and provide harm-reduction strategies reduce pregnancy coercion by 71% among women who experience intimate partner violence. Integrating assessment and intervention into standard reproductive health care can enhance the overall quality of care and improve reproductive health outcomes. Because of the known link between reproductive health and violence, health care providers should screen their patients for intimate partner violence and reproductive and sexual coercion at periodic intervals, such as annual examinations, new patient visits, and during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup). Here are some examples of screening questions to ask: Has your partner

The stigma of mental health diagnoses

Sexual health is a state of physical, mental, and social wellbeing in relation to sexuality. People living with mental health conditions are sexual beings and are entitled to their sexual health. That said, stigma that exists around both mental health and sexuality has meant that many people who experience mental health conditions are often stereotyped as either hypersexualised, asexual, or undeserving/unfit to engage in sexual or romantic relationships. This type of stigma can have impacts on sexual risk-taking and how patients/clients with mental health conditions are treated in health care settings.[42] The sexual and reproductive health needs of people with mental health conditions are often neglected because of these stereotypes. This results in health disparities from a lack of appropriate information and/or appropriate supports. For example, women with bipolar disorder may be more likely to experience reproductive events such as unplanned pregnancies or contract sexually transmitted infections because of possible bipolar symptoms like risk-taking and disinhibition.[43] This is then compounded by a lack of comprehensive, stigma-free care that takes seriously the connections between mental and sexual/reproductive health, resulting in poorer health outcomes.

How can you provide the best possible sexual/reproductive health care for people living with mental health conditions? Ask yourself the following:

1. What is your level of knowledge and capacity as it relates to supporting the sexual health of your patients/clients with mental health conditions?
2. Do you proactively assess your patients'/clients' sexual health and wellbeing when treating or supporting them for mental conditions?
3. What kind of supports do you offer patients/clients with mental conditions as they navigate stigma and discrimination related to their mental health and their sexuality?
4. What kind of resources and/or supports are available in your community to support the sexual health and wellbeing of your patients/clients with mental health conditions? Those who are considering their pregnancy options?[44]

Health impacts of colonialism and racism

In 2017, the Saskatoon Health Authority published a report highlighting the experiences of Indigenous women being coerced into tubal ligations[45] (a method of permanent birth control). While the report speaks to recent occurrences, it is important for health care providers to be

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ever forced you to do something sexually that you did not want to do or refused your request to use condoms? Has your partner ever tried to get you pregnant when you did not want to be pregnant? Are you worried your partner will hurt you if you do not do what he/she/they wants with the pregnancy? Does your partner support your decision about when or if you want to become pregnant?[41]

[42] For more information visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4251893/
[43] For more information visit https://www.ncbi.nlm.nih.gov/pubmed/12956668
[44] For more information visit http://www.srhweek.ca/providers/people-and-communities/pregnancy-options-and-family-planning/
[45] For more information visit https://www.saskatoonhealthregion.ca/DocumentsInternal/Tubal_Ligation_intheSaskatoonHealthRegion_the_Lived_Experience_of_Aboriginal_Women_BoyerandBartlett_July_22_2017.pdf

aware of the long historical context of the political and health care systems' attempt at controlling the reproductive abilities of Indigenous peoples in Canada. Historically, Canada's sterilization policies have had detrimental effects on Indigenous peoples and communities. Large numbers of Indigenous men and women were sterilized for being "mentally unfit" for not conforming to It is therefore crucial for our health care system to work towards increasing our collective ability to provide appropriate and competent care that considers the impacts and manifestations of systemic discrimination[46] and intergenerational trauma on mental and sexual health as well as the history of how accessing reproductive health care has impacted Black, Indigenous, and racialized people (and other marginalized communities) and how that can impact the trust between patients/clients and providers.[47]

How can you provide the best possible mental and sexual health care for Indigenous and racialized people and communities? Ask yourself the following:

1. What is your level of knowledge and capacity as it relates to offering mental and sexual health care to Black, Indigenous and racialized patients/clients in a culturally competent way?
2. What is your level of knowledge and capacity as it relates to the specific mental and sexual health needs of Black, Indigenous, and racialized communities?[48]
3. What are steps you can take to boost your personal or institutional capacity to provide the best possible care for Black, Indigenous and racialized people and communities? Are there Black, Indigenous and racialized staff and health care providers in your facility? What is your knowledge of the context in which certain populations have historically experienced sexual and reproductive health care (and control)? How could that change how you present options to your patients/clients and the language you use?[49]
4. Do you proactively assess patients'/clients' mental and sexual wellness as it relates to the specific risks faced by Black, Indigenous and racialized people and communities because of discrimination, intergenerational trauma, and racism?
5. How proactive are you in supporting and/or seeking out resources to ensure your patients/clients have the space and resources to incorporate culture, traditional belief systems, and languages into their health care?[50]

[46] Did you know? The health impacts of racism are well documented. Chronic emotional stress is known to have negative physical and mental health effects. Racism and racial discrimination create a unique environment of pervasive, additional stress for people of racial and ethnic minorities. Racism and racial discrimination adversely affect mental health, producing depression, anxiety, and heightened psychological stress in those who experience it.

[47] For more information visit http://www.srhweek.ca/providers/people-and-communities/sexual-violence/
[48] For more information read the 2017 SRH Week Handbook at http://www.srhweek.ca/2017handbook/
[49] Did you know? Doctor James Marion Sims (considered by many as the father of modern gynecology) is known to have performed shocking experiments on enslaved Black women to develop his expertise. His unethical use of enslaved Black people as human test subjects falls into a long, ethically corrupt history of the development of our medical systems that includes the Tuskegee syphilis experiment and Henrietta Lacks. This certainly informs how many Black people and communities of color experience health care systems. For Indigenous people in Canada, sexual sterilization was long considered to be an official public health measure, informing how Indigenous people today are treated as well as how they experience and access health care systems.
[50] For more information visit http://aboriginalmidwives.ca/

6. What kind of resources and/or supports are available in your community for Black, Indigenous and racialized patients/clients?

STEPS YOU CAN TAKE

Positive health care relies on providers creating the space to discuss health issues in a way that affirms the concerns, knowledge, and experiences of the patient/client. Stigma, embarrassment, shame, or fear can often prevent patients/clients from bringing up topics related to sexual and mental health. As a health care provider, it is important to be proactive in creating a safe space for your patients/clients to comfortably talk to you about these essential components of their overall well-being.

Start off right

- Make sure your intake forms and medical history forms/questionnaires use inclusive language.[51] Make space to write out longer names, gender (not limited to male/female, with space to self-identify), chosen names (if different from government-issued ID), pronouns and sexual orientation. Put posters,[52] stickers and pamphlets around your office/clinic to signal your comfort with sexual and mental health topics.
- Make taking a patient's/client's health history a moment for connection by using inclusive language around gender, partners, mental health, sexual health needs, and sexuality. Include questions on sexual and mental health and wellness in your questionnaire. Work with your patients/clients to create a more complete picture of who they are, why they are seeking care and what their needs are.
- Take note of what your patient/client does or does not consider to be important pieces of information in the context of why they came to see you.

Routinely talk about sexual and mental health

It can be difficult for health care providers and patients/clients to begin the discussion about sexuality and sexual health as well as mental health but patients/clients want to talk to you about their concerns and studies confirm that they want YOU to create this space by to raising the subject first.[53]

- Here are some open-ended questions you can ask as a part of a standard visit to reassure your patients/clients that that their concerns and feelings are important and should be heard.
- Are there any mental health or sexual health concerns you wish to discuss today?

[51] For more information visit http://www.srhweek.ca/providers/inclusive-practice/
[52] You can order free SRH Week posters at http://www.srhweek.ca/order-posters
[53] For more information visit http://www.arhp.org/publications-and-resources/clinical-fact-sheets/shf-talking

- Has this issue or problem affected your life and relationship(s)? Your mental health? Your sexual health?
- Do you have a medical condition that affects your quality of life, including your sexual health and well-being? What about your mental health? Are you experiencing any side-effects from medication that affect your mental or sexual health?
- What are your goals for your sexual health? For your mental health?
- Do you have any concerns over how people around you may feel or react to those choices/results, etc. (e.g., birth control, pregnancy, STBBI disclosure, etc.)?[54]

Increase awareness and comfort levels during your interactions with patients/clients

- Questions about sexual health and mental health should be asked in a matter-of-fact yet sensitive manner like you would with any other health related matter.
- If you believe someone may feel uncomfortable discussing their sexual history, giving an explanation or making linkages to the person's medical history may be helpful.
  You might say: "Sexual health is important to overall health and so is mental health so I always ask patients about it. If it's okay with you, I'll ask you a few questions about sexual/mental health now." Or "Many people with depression notice a change in their sexual function. Have you noticed any change?"
- Ask open-ended questions instead of simple questions. Avoid making assumptions about patients'/clients' mental health, gender, or sexuality.
- You might say: "Do you have a partner/are you sexually active right now?" as opposed to: "How long have you and your husband been married?"
- Respect your patients'/clients' knowledge about their bodies and mind. Follow their lead around the language they use about themselves, their bodies, and their partners/families.
- Meet patients/clients where they are at in terms of language and medical terminology and offer different learning styles. For instance, while verbal communication can work well for some patients/clients, brochures, videos, and information packets, or even a written note from you, to be taken home can be useful to create and affirm understanding.
- Communicate clearly and openly and make the conversation interactive. Make sure you are clear and that your patient/client understands you by checking in throughout the conversation (including when you use medical terminology).

[54] For more resources to help screen and intervene in those scenarios read the section on intimate partner violence and reproductive coercion

- Be mindful about inadvertently judgmental language such as “getting over” or “moving past” difficult situations. This implies that there is a certain trajectory or definitive end-point when it comes to processing experiences and can shut down conversations over time. Move away from terms like “normal” or “getting back to normal.” Instead, try “optimal” or “healthy,” acknowledging that what feels and looks healthy will differ for everyone.

Explore and validate concerns

Quality of care is improved when patients/clients can participate more actively in their care and when health care providers explore and validate patient/client concerns.[55]

- Use active listening and open-ended questions to explore your patients'/clients’ concerns and needs to help get an in-depth understanding of their symptoms, feelings, ideas and expectations. This is especially important when you seek information about topics patients/clients may feel shame or shyness about.
- Validate patients'/clients’ concerns by using statements that express empathy, legitimation, or respect. Avoid cutting off the discussion by changing the topic and not offering follow-ups to concerns brought up by patients/clients. Even if your questions follow a thread in your mind, if it seems like you are changing topics, it can shut down the conversation. Make sure you are clear about following up on concerns brought up by your patient/client.
- Pay attention to both the verbal and non-verbal cues from the patient/client and, when noticing any discrepancy between the two, use open-ended questions to explore this according to your patient’s/client’s comfort level. Be alert about your own non-verbal cues like body language, hand gestures, and eye-contact. Show interest in what your patients/clients tell you with your mannerisms, body language and active involvement like leaning towards the person, taking notes, eye contact, etc.
- Always provide information on what the patient/client wants to know and promptly respond to their questions and/or reactions.

WRONG WAY TO EXPLORE AND VALIDATE CONCERNS

Doctor: So, what brings you in today?

Patient: I’m having bad cramps. [Patient expresses a concern]

Doctor: Have you ever been on any kind of medication? [Cut-off: Doctor did not respond to the concern and changed the topic.]

Patient: Um no, well, I used to be on the birth control pill but I’m not anymore, I stopped because it didn’t feel right. [Patient expresses another concern.]

[55] For more information visit http://www.annfammed.org/content/5/1/21.full.pdf

Doctor: So, do you use any kind of birth control? [Doctor missed the opportunity to validate the patient's concerns. Asks related questions but without making the link to the patient.]

Patient: No, I've been trying to conceive.

Doctor: Okay. Okay. And when was your last physical exam, like pelvic exam, breast exam, all that? [Doctor again redirects the conversation and misses an opportunity to explore if the patient has experienced fertility issues and if it could be in any way related to primary concern, severe pelvic pain that ramps up in sync with menstrual cycle.]

RIGHT WAY TO EXPLORE AND VALIDATE CONCERNS

Doctor: So, what brings you in today?

Patient: I'm having bad cramps. [Patient states a concern]

Doctor: Tell me more about those cramps, do you get them all the time? [Doctor explores the patient's concerns.]

Patient: When I'm about to have my periods, I get really terrible pain that puts me on the verge of tears. I can't get out of bed and sometimes the only thing to make the pain go away is to force myself back to sleep. I can barely move, it's so painful. I would say sometimes as bad as a 9 out of 10 and I don't know what to do. I can't leave the house and have been missing work. [Describes in more detail]

Doctor: Intense and chronic pain can really have an impact on quality of life, eh? [Validates the patient's concerns and feelings]

Patient: It's been so difficult, I should say that I've been feeling pretty depressed these days because of it. I can't do anything fun, I'm having trouble at work.

Doctor: This sounds very challenging. I am glad you scheduled a visit so we can get to the bottom of this. Do you remember when it started? [Further explores the patient's concerns]

Patient: Yes, it wasn't too long after I stopped using the birth control pill [Gives more information]

Doctor: Did you stop using the pill for a specific reason? [More exploration]

Patient: Yes, at first it was because it made me feel off but then my partner and I decided it could be a good time to start trying for a baby. We've been trying for over a year now.

Identify and challenge stigma and discrimination in health care settings

Stigma is a broad term that is used to describe **the negative and stereotypical thoughts, attitudes and feelings** people may hold about another group of people based on specific grounds[56] that serve to distinguish them from other members of a society.

[56] For example, race, sexual orientation, gender, HIV status, religion and/or engaging in stigmatized behaviors like drug use, sex work, or non-monogamous or unpartnered sex.

Discrimination refers to the decisions and behaviours that are based, **consciously or not,** on negative stereotypes.

Discrimination can happen on an individual level. For example, a nurse double-gloving to care for a patient living with HIV, a doctor dismissing a woman's account of pelvic pain as "not serious," a triage nurse assuming an Indigenous patient's symptoms are due to alcoholism and/or drug use, or a doctor refusing to use someone's correct pronouns. It can also look like verbal abuse, inappropriate jokes, harassment, bullying, denying care or assumptions informing diagnoses and treatment plans.

Discrimination can happen on an institutional level. When laws and policies are inadequate, inequitable and fail to promote the safety and wellness of patients, and can also take the form of unequally distributing resources in ways that leave the needs of marginalized individuals unmet.

Know the impacts of stigma and discrimination

- Stigma and discrimination have real consequences on access to health care and on health outcomes.[57] Stigma has been identified as a factor in patients'/clients' reluctance to seek care for mental and sexual health concerns. Stigma can also hinder the relationship between health care providers and their patients/clients. This can lead to patients/clients choosing to end their treatment early, impact adherence to treatment, shrink likelihood of seeking out preventative care or following up on concerns early on, etc.
- Stigma and discrimination surrounding mental illness can lead to patients/clients not having their physical care needs met or not having their mental health symptoms taken seriously when it comes to non-mental health concerns.[58] This is attributed to health care providers misattributing physical symptoms to the patient's/client's mental illness, which creates delays in treatment.

Breakdown common mental health stereotypes

STEREOTYPE: People with mental health conditions are dangerous and unpredictable.

REALITY: Most people with mental health conditions never commit acts of violence and are actually more likely than others to be victims of violence.

STEREOTYPE: People with mental health conditions are incompetent, irrational, or childlike.

REALITY: Just as with other patients/clients, patients/clients with mental health conditions will vary in terms of their competence levels, knowledge, ability to care for themselves, etc. Assume competence and meet people where they are at.

STEREOTYPE: People with mental health conditions are weak or have character flaws that lead to their conditions.

[57] For more information visit http://onlinelibrary.wiley.com/doi/10.1111/acps.12612/abstract
[58] For more information visit https://www.mentalhealthcommission.ca/sites/default/files/2017-03/MI%20stigma%20in%20healthcare_barriers%20to%20access%20and%20evidence%20based%20solutions.pdf

REALITY: People who have mental health conditions are no more or less at fault or in control of their symptoms as people who struggle with physical health conditions. Even when behaviors or choices may have exacerbated a mental or physical illness, we cannot understand people's overall health outside of social determinants of health and out of the context of circumstances and life events.

STEREOTYPE: People with mental health conditions are either not sexual at all or hypersexual depending on diagnoses. They do not have romantic lives, they are not good parents or they are not part of families.

REALITY: People with mental health conditions are social and sexual beings. Having a mental health condition does not make you unworthy of your sexuality and sexual life, unworthy of a romantic life or unworthy of being a parent. Of course, there are people with mental health conditions who are asexual, aromantic, single, celibate, child-free, etc. but we cannot and should not make assumptions about people's sexual, romantic or family status because of a diagnosis.

Know the facts

When it comes to sexuality and sexual health, here's what you need to know:

- Stigma and discrimination around sexuality, sexual orientation and identity and certain sexual behaviors stems from sex negativity. Sex negativity is the idea (conscious or not) that sex is harmful, shameful, disgusting or sinful. Only specific types of sexual expression are exempt from moral condemnation (heterosexual married or monogamous sex between cisgender people). Even if we don't believe we hold these views, these ideas have been cultivated for centuries and to this day, shape our culture.
- Sex negativity devalues sex and sexual experiences. It makes us believe that any sexual expression that does not conform to the societal "norm" is not valuable. It erases the honest expression of sexualities and authentic connection between people. It often leads to people feeling shame and fear when it comes to the sex they are having or not having and shame around talking about sex and sexual health. This can look like the complete invisibility of non-heterosexuality in health care settings, including in medical school curricula, feeling afraid, repulsed and/or angered by people living with HIV who are having sex, or by two men having sex, or a man having sex with a trans woman, or people who have multiple casual partners, someone selling sexual services, etc. It can also manifest in palpable discomfort around talking about certain types of sexual behaviors (e.g., anal sex, fisting, etc.), a lack of knowledge around the sexual health needs of certain populations (e.g., the need for trans men to get routine pap tests), or talking about someone with a sexually transmitted infection as "dirty" and so on.

Reduce stigma and discrimination

- Know the facts. Educate yourself about mental health and sexual health. Train yourself on hard skills necessary to support your patients'/clients' sexual and mental health needs. Decipher the facts from the myths and educate others around you.

- Choose your words wisely. Be aware of stigmatizing or blaming language. Understand that you cannot know about someone's history just by looking at them. Always speak as if anyone could be in the room with you. Challenge those around you who use derogatory or hurtful language about others.
- Stigma and discrimination are often unintentionally perpetuated but good intentions do not prevent the negative impacts of stigmatizing language or actions. If someone tells you your behaviour or language has impacted them negatively, believe them and apologize, regardless of your "good intentions." Act on feedback to make your practice more inclusive.
- Reflect on your own values and assumptions when it comes to stigmatized communities, behaviours and health issues.[59]
- Focus on people's strengths and contributions. Everyone makes valuable contributions to society. Their health concerns are just one part of who they are.
- Make time for professional development. Skills-based training can help improve understanding, confidence and comfort in offering non-judgmental and affirming health care (including mental and sexual health care) to diverse populations.
- Make sure all staff receive ongoing support and the appropriate tools needed to provide inclusive care, such as intake forms that ask the right questions, supportive policies and procedures, and necessary training (e.g., cultural safety training, youth sensitivity training, de-escalation techniques, non-violent communication, training in working with clients with disabilities, etc.).
- Consider attending or holding myth-busting sessions to allow yourself and/or staff to identify and challenge unconscious biases, misinformation, and stereotypes, and ask any questions they may have about mental health and sexual health.[60]
- While training and skills building is crucial, more importantly, rights must be enforced. Research has shown that education on mental health and discrimination alone is not likely to be effective in changing people's behaviour over the long term, and should be complemented with other approaches that are institutional in nature and include accountability mechanisms to ensure that all patients/clients can safely access care.

Provide Trauma-Informed Care

Trauma, defined generally, is an experience that overwhelms an individual's capacity to cope and typically falls under five categories:[61]

1. Single-incident trauma: related to a specific event like a car accident, the death of a loved one, a sexual assault, etc.

[59] Visit http://www.srhweek.ca/providers for more resources
[60] For more information visit http://onlinelibrary.wiley.com/doi/10.1111/acps.12612/abstract
[61] For more information see the Trauma Informed Practice Guide, 2013 at http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

2. Complex or repetitive trauma: stemming from repeated or ongoing incidents such as abuse, intimate partner violence, reproductive coercion, war, experiencing discrimination and micro-aggressions on a regular basis on the basis of race, sex, gender, disability, etc.

3. Developmental trauma: resulting from early exposure to trauma as an infant, child or youth.[62]

4. Intergenerational trauma: resulting from living with or having familial or close ties to trauma survivors.

5. Historical trauma: the cumulative trauma that can occur across generations from massive group trauma, such as genocide and colonialism.

Know the impacts of trauma

- Trauma has impacts on physical, mental, sexual and emotional health. To cope with the impacts of trauma, individuals might display behaviours perceived by health care providers as unhealthy and/or risky, (e.g., substance use or cutting).[63] People then need to contend with the stigma that surrounds their coping mechanisms on top of their trauma.
- Trauma can result in hesitancy to access health care, particularly sexual health care when the trauma experienced is sexual in nature. Certain components of health care, such as gynecological examinations, rectal examinations, and childbirth, can trigger a trauma response depending on an individual's past experiences. Stigma around coping behaviours can also delay seeking care.

Follow the guiding principles of Trauma-Informed Care

Considering what we know about the health consequences of trauma and how these may impact access to health care, it is important for health care providers to seek training on how to provide trauma-informed care. It does not require you to be a specialist in trauma-specific care, but rather to build skills and awareness of what trauma is and how it manifests and impacts people. This knowledge is the foundation of an organizational culture of trauma-informed care.

Here are key guiding principles of a trauma-informed approach as articulated by agencies and partners in health care who have adopted this lens:

- Safety
- Trustworthiness
- Compassion
- Collaboration
- Choice and Control

[62] Did you know? There is more and more evidence supporting the importance of health care providers universally screening for ACE (Adverse Childhood Events). https://centerforyouthwellness.org/the-science/
[63] Did you know? An individual with four or more ACEs (Adverse Childhood Event) is 10 times more likely to be an IV drug user as someone with no ACEs. And when you look at the proportions of people who are incarcerated, we're talking about greater than 90 percent. https://centerforyouthwellness.org/health-impacts/

- Cultural Competence
- Empowerment/Strength-Based
- Interconnectedness of Mind, Body and Spirit
- Staff Wellness

To equip ourselves to be able to offer Trauma-informed care is not the same thing as offering Trauma-specific services though both can happen in the same facilities.[64] In their 2013 Trauma-Informed Practice Guide,[65], the Center for Excellence in Women's Health helps us understand the important distinctions between these two different types of care.[66]

In short, Trauma-Informed Care:

- Works at the patient/client, staff, and system levels from the core principles of trauma awareness; safety; trustworthiness, choice and collaboration; and building of strengths and skills.

- Addresses the connections between trauma, mental health, and substance; identifies trauma symptoms or adaptations; and offers supports and strategies that increase safety and support connection to services.

These are principles to work from and adapt to any workplace, services offered and/or types of care.

Working in parallel, Trauma-Specific Services:

- Are offered in a trauma-informed environment and are focused on treating trauma through therapeutic interventions involving practitioners with specialist skills.

- Are based on detailed assessments to patients/clients with trauma, mental health, and substance use concerns that seek and consent to integrated treatment.

Trauma-specific services more directly address the health care needs that come from traumatic life experiences and facilitate trauma recovery through specialized counselling and other clinical interventions.

While we may not all offer trauma-specific services, all health care providers and all health and social services can create an environment where patients/clients do not experience further traumatization or re-traumatization and can make decisions about their health care at a pace that feels safe to them.

- Trauma-informed care recognizes the omnipresence of trauma and its impact on health and access to health care.

- Trauma-informed care does not require that patients disclose trauma. It refers to an overall approach or philosophy that works to prioritize physical and emotional safety and choice in decisions relating to treatment and care. This means you can employ

[64] For more information visit http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
[65] For more information visit http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
[66] For a detailed strategy on how to implement trauma-informed healthcare, please consult: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

trauma-informed strategies in every patient/client interaction, not just when a patient/client discloses trauma to you.

- Trauma-informed care prioritizes the creation an atmosphere of safety and empowerment where patients/clients do not experience further traumatization or re-traumatization through feelings of powerlessness or loss of control, microaggressions and cultural insensitivity, not being believed, or being denied care.

Establish safety and trust

There are tangible ways to foster a sense of safety and trustworthiness with your patients/clients.

- Ensure that your intake forms and procedures are inclusive. Do not erase anyone's identities, ensure patient/client privacy, and clearly and plainly state confidentiality protocols and when the duty to disclose exists.
- Provide clear information on programming, appointments and what will happen during the duration of an appointment, treatment options, and follow-ups.
- Ensure you have your patients/clients informed consent.
- Make your space more welcoming of diverse communities, less threatening, and more accessible.
- Ensure staff education and professional development as well as policies and practices that support staff wellness. Staff need to be taken care of and equipped with the resources necessary to offer the best care to a diversity of people; staff retention also means patients/clients have the opportunity to build trust with familiar individuals.

Offer control, safety and choice

Since powerlessness and a loss of control are central to experiences of trauma, it is important that your practice creates opportunities for patients/clients to experience and exhibit control, safety and choice. As a health care provider, this means:

- Communicating openly, working to identify and address power imbalances inherent in patient-provider relationships by, among other things, actively including patients/clients in their own care and allowing patients/clients to express their feelings without fearing judgment. It focuses on "doing with" as opposed to "doing to.
- Offering your patients/clients choices in their mental or sexual health care plan and, where possible, adapting to meet their needs. For example, if a patient/client who wishes to have an abortion is concerned about a surgical abortion triggering a trauma-response, their care team should offer the option for a medication-based abortion. Or, if a gynecological exam is anxiety inducing for a patient/client, they may prefer to be sitting upright rather than lying flat, which may evoke feelings of powerlessness and loss of control.

- Offering choice in everything you can: treatment options, how a patient/client will be contacted, how often a patient/client wishes to see you, where and how they are seated in the examination room or office, whether they wish to speak or be spoken to during physical examinations, whether they are permitted a support person in the room, and the gender of the specialists you are referring them to.

Adopt a strengths-based approach and offer skills building

Health care providers can assist their patients/clients in identifying their strengths and to help further develop resiliency and coping skills by:

- Teaching and modeling skills on how to identify triggers[67] and skills to help patients/clients calm and re-center themselves after being triggered.
- When patients/clients discuss the strategies they use to cope with trauma, do not judge. Work from a harm reduction approach.[68] If you see a problem with a behaviour that your patient/client is engaging in, ask yourself: Do I just disagree with this on a moral level or are there specific harms associated with the behaviour that need to be addressed? How can I support them as they engage in this behaviour? How can I support them if they express they wish to change the behaviour during that process?

Address the needs of diverse people and communities

A key aspect of a trauma-informed practice is understanding how trauma can be experienced differently by people depending on their identities and/or social locations. It is important to remember that health care is never "one-size-fits-all."[69]

[67] Triggers are experiences like smells, sounds, certain words or feelings, that cause someone to recall a previous traumatic memory.
[68] Harm reduction is a public health philosophy that acknowledges the importance of non-judgement and the reduction of harms associated with certain behaviours rather than attempting to stop or prevent certain behaviours.
[69] For more information on providing affirming and non-stigmatizing health care for patients/clients from different, diverse communities, see www.srhweek.ca/providers.