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QUALITATIVE RESEARCH

From silos to buckets: a qualitative study of how sexual health clinics address their clients' mental health needs

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Abstract

Objectives To describe the current constraints, facilitators, and future prospects for addressing mental health and substance use (MHSU) concerns within sexual health clinics in two cities in British Columbia, Canada.

Methods We conducted in-depth interviews with 22 providers (14 nurses, 3 physicians, 3 administrators, 2 other health professionals) from six sexual health clinics.

Results Providers consistently affirmed that MHSU-related concerns co-occur with sexual health concerns among clients presenting to sexual health clinics. Three factors constrained the providers' abilities to effectively address MHSU service needs: (1) clinic mandates or funding models (specific to sexually transmitted infections (STI)/HIV or reproductive health); (2) "siloing" (i.e., physical and administrative separation) of services; and (3) limited familiarity with MHSU service referral pathways. Mental health stigma was an additional provider-perceived barrier for sexual health clinic clients. The low barrier, "safe" nature of sexual health clinics, however, facilitated the ability of clients to open up about MHSU concerns, while the acquired experiences of sexual health nurses in counselling enabled clinicians to address clients' MHSU needs. In response to this context, participants described actionable solutions, specifically co-location of sexual health and MHSU services.

Conclusion Sexual health clinicians in British Columbia generally affirm the results of previous quantitative and client-focused research showing high rates of MHSU-related needs among sexual health clinic clients. Providers prioritized specific short-term (referral-focused) and long-term (healthcare re-organization, co-location of sexual and MHSU services) solutions for improving access to MHSU services for those using sexual health services.

Résumé

Objectifs Décrire les contraintes, opportunités et les idées novatrices pour adresser les problèmes de santé mentale et de toxicomanie dans des cliniques de santé sexuelle dans deux villes de la Colombie-Britannique au Canada.

Méthodes Nous avons effectué des entrevues en profondeur avec 22 professionnels de la santé (14 infirmières, 3 médecins, 3 administrateurs et 2 autres professionnels en santé) provenant de six cliniques de santé sexuelle.

Résultats Les professionnels confirmaient que les problèmes de santé mentale et de toxicomanie surviennent de façon concurrente avec les problèmes de santé sexuelle parmi les usagers des cliniques de santé sexuelle. Trois facteurs contraignaient la capacité des professionnels à adresser efficacement les besoins en santé mentale et en toxicomanie des usagers : 1) le mandat ou le modèle de financement (mandat de clinique précis, traitant les ITS/VIH et la santé sexuelle); 2) le fait de travailler en isolation (la séparation physique et administrative des services); et, 3) le manque de connaissance pour l'aiguillage vers les services en santé mentale et de toxicomanie. Les professionnels ont aussi souligné que la stigmatisation des problèmes de santé mentale est un obstacle important pour les usagers des cliniques de santé sexuelle. Par contre, l'accessibilité et la nature « sécuritaire » des

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cliniques de santé sexuelle et l'expérience des infirmiers en counseling permettaient aux usagers de partager leurs préoccupations en matière de santé mentale et toxicomanie. Les professionnels ont suggéré des solutions réalisables, notamment, la cohabitation des services de santé sexuelle, de santé mentale et de toxicomanie.

Conclusion Les professionnels en santé sexuelle de la Colombie-Britannique sont généralement en accord avec les résultats des études quantitatives antérieures et des études sur les usagers qui indiquent des taux élevés de besoins non comblés de santé mentale et toxicomanie parmi les usagers de cliniques de santé sexuelles. Les professionnels ont privilégié des solutions à court terme (l'aiguillage des usagers vers d'autres services) et à long terme (la réorganisation des services de santé, et la cohabitation des services de santé sexuelle, de santé mentale et de toxicomanie) pour améliorer l'accessibilité aux services de santé mentale et toxicomanie pour les usagers des services de santé sexuelle.

Keywords Sexual health · Counselling · Mental health services · Mental health · Public health · Sexually transmitted diseases

Mots-clés Santé sexuelle · Counseling · Services de santé mentale · Santé mentale · Santé publique · Infections transmises sexuellement

Introduction

Sexual health clinics are specialized settings for the prevention, diagnosis, and treatment of sexually transmitted infections (STI) and reproductive health concerns (Masaro et al. 2012; Tanton et al. 2017). While these clinics are mandated to focus on STI and reproductive health, interactions with sexual health clinicians often lead to much more than a STI diagnosis or pregnancy test (Carey and Senn 2013). Several studies have suggested a high burden of mental health needs (depression, anxiety, history of sexual abuse, relationship challenges, other mental health conditions) and substance use reported by clients in sexual health clinics (Achterbergh et al. 2018; Bauer et al. 2002; Cook et al. 2006; Erbelding et al. 2001; Seivewright et al. 2004; Senn et al. 2010). For example, across six STI clinics in Greater Vancouver, Canada, 39% of clients reported a recent need for mental health or substance use (MHSU)-related care (Salway et al. 2019). It is therefore unsurprising that when exploring what has brought someone in, clinicians will sometimes discover that the client's presenting sexual health concern is connected to several psychosocial issues.

In light of the significant burden of MHSU disorders in the general population (Ratnasingham et al. 2012), advocates have suggested new strategies for identifying and supporting individuals struggling with MHSU in a range of health service settings (Kates et al. 2011; Lindert et al. 2017). For instance, Szymanski et al. (2013) found that co-location of mental health services in primary care was beneficial for patients who had a diagnosis of depression. Individuals who received integrated mental healthcare in primary care experienced a greater likelihood of initiation of psychotherapy and use of antidepressant medication, compared with those who only received primary care (Szymanski et al. 2013, 346).

While research has addressed mental health service integration in primary care settings, little is known about how integration would work in public health clinics, particularly sexual health clinics. Carey and Senn (2013) found that clients of sexual health clinics in Upstate New York felt comfortable seeking support for a wide range of health and psychosocial issues, highlighting the importance of these sites in reaching populations with healthcare needs that are not met elsewhere. Similarly, Golden and Kerndt (2015) queried whether sexual health clinics in the United States are "playing a safety net function" by supporting individuals who lack access to other primary care providers (Golden and Kerndt 2015). In Canada, sexual health clinics are accessible to clients who may be deterred from accessing care due to issues of privacy, embarrassment, or stigma related to sexual health (Hottes et al. 2012; Karamouzian et al. 2018; Shoveller et al. 2009). In many cases, clients who are unable to navigate the complexities of the mental healthcare system will seek support from low-barrier and accessible providers like these clinics (van Os et al. 2019; Young et al. 2001).

None of the aforementioned studies examined clinicians' perspective, nor queried how they did this work, or which kinds of supports would enable them to be more effective. In-depth interviews are warranted to better characterize the role that sexual health clinics play in responding to clients' MHSU-related needs. Our objective is to describe the current constraints and facilitators and future prospects for addressing MHSU concerns within sexual health clinics in two major cities in British Columbia, Canada.

Methods

In this qualitative thematic analysis study, we interviewed providers from six low-barrier sexual and reproductive health clinics in Greater Vancouver and Victoria, BC, Canada. We included two types of sexual health clinics: public and non-profit. Public health clinics are staffed by clinicians (predominantly nurses, with some physician or nurse practitioner

involvement), who are salaried employees of public health authorities. Non-profit sexual health clinics primarily rely on physician fee-for-service billings and are staffed by a mix of physicians and nurses. For this study, low-barrier meant that the clinics were characterized by one or more of the following traits.

(1) Cost: Free to user, often without showing health insurance card.
(2) Privacy/anonymity: Clients can be tested using a pseudonym.
(3) Open and inclusive spaces for sexual minorities: Judgement-free and sexual minority-affirming interactions (Salway et al. 2019).
(4) Self-referral: Clients can receive care without getting a referral from a primary care physician.

Two of the clinics in this study primarily serve sexual minorities, with explicit focus/branding to sexual minority communities, though providers from all six clinics described their clinical environments as striving to be safe and inclusive spaces for sexual and gender minority clients.

Eligible participants included sexual health nurses and physicians, administrators, and other support staff (e.g., counselors, educators). We visited sexual health clinics within three government agencies and three non-profit organizations. A purposive sample was recruited using snowball sampling (i.e., asking participants for recommendations of other potential participants) and word of mouth, in order to reach the target population (i.e., sexual health clinicians) (Robinson et al. 2017). Recruitment proceeded iteratively throughout the study (March–July 2018) in order to target settings, clinic roles, and perspectives that were absent among participants sampled earlier during the data collection period. All participants provided written informed consent before the interview. Each interview was held in a private office or board room, lasted between 30 and 60 minutes, was audio recorded, and transcribed verbatim.

The interview guide included interviewee's role and experience in the STI clinic; current approach to addressing clients' mental health needs; and potential future models for integrating mental healthcare at the STI clinic. Semi-structured interviews were employed, allowing for dialogue between interviewer and participant, as well as for the participant to answer questions in an open manner (Dicicco-Bloom and Crabtree 2006). All interviews were completed by the first or second author. Both interviewers were present for the first four interviews in order to harmonize approaches to future interviews, which were conducted separately. The same interview guide was used throughout the study, and questions were dropped only if preempted by the participant's earlier remarks.

We used inductive thematic analysis to identify common themes (Braun and Clarke 2006), which were subsequently amended as new data were collected and analyzed. We chose thematic analysis because of its flexibility with regard to theory, given the novelty of our research topic. The first two authors achieved this by first immersing themselves in the data by listening to audio-recordings of interviews, accuracy checking transcripts, and re-reading transcripts. Coding was facilitated using NVivo software version 12.2 for Mac. Transcripts were double-coded by both analysts to increase coverage of codes and verify the meanings of codes in relation to transcripts. Codes were descriptive and remained "close" to the data (i.e., in vivo or paraphrased). Codes were then grouped thematically, and those themes that were best supported by the data (based on both depth—level of insight and emotion within data—and breadth—i.e., consistency across transcripts) were defined and refined, following recommendations of Braun and Clarke (2006), seeking internal consistency within themes as well as relation between themes and the overarching "story" of our analysis. We additionally used our positions as health researchers (i.e., reflexivity/positionality) to move from descriptive to interpretative analysis. For example, the first author had no experience working in sexual health clinics prior to this study, while the second author had 16 years of experience working in such settings, allowing the two authors to exploit an insider/outsider dynamic when interpreting concepts related to professional practice (Kanuha 2000). This study protocol was approved by the Behavioural Research Ethics Board at the University of British Columbia and institutional review boards of participating health authorities.

Results

A total of 22 interviews were conducted with staff from 6 sexual health clinics between March and July 2018, including 12 sexual health clinic nurses, 2 sexual health clinic coordinators, 2 physicians, 2 outreach nurses, 1 counselor, 1 mental health program manager, 1 administrator, and 1 educator.

Participants universally expressed agreement that MHSU concerns were prevalent and prominent in their sexual health clinical work and with few exceptions supported the notion of addressing—if not integrating—MHSU services within sexual health clinical settings. One nurse noted the interconnection between sexual and mental health, and described how a clinic visit can be a tipping point for a client due to the volume of issues they might be facing:

> 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 [Medical Services Plan], so they can't get medication or care.

Where participants expressed doubt about whether MHSU service integration was appropriate, they cited concerns about what this would mean in terms of added workload for clinicians. For example, one nurse reflected their desire to better understand psychosocial factors that may be driving the presenting sexual health issues but the challenge of doing this given an already burdensome workload:

> I'd love to spend more time with some of our clients… to get into you know, why—without judging or anything of course—they have this many partners, or [why they are] taking such risks. Cause some of them, you know… they're continually sexually assaulted, or drugs are involved… It seems we try to fit in as much as we can during testing and treatment… we'll do what we can and then after that, we hope they get the care they need.

Below, we further delineate the factors described by providers to support or inhibit sexual/mental health service integration, specifically outlining the following three thematic categories, which were identified based on the structure of the interview and the themes with the greatest amount of supporting data: (1) constraints and barriers; (2) enablers and facilitators; and (3) proposed solutions.

Barriers and constraints

Participants described constraints relating to the kinds of care they wanted to provide or were able to provide (i.e., clinic mandate or funding, siloing of services, and lack of knowledge of trusted mental health resources and referral options), but also barriers experienced by clients with regard to access to mental healthcare (i.e., stigma).

Funding/clinic mandate Funding determines the amount of time a clinician spends with a client. For instance, physicians in the non-profit clinics typically operate under a fee-for-service model (i.e., fees are paid based on a standardized appointment time), whereas most clinicians are salaried in the public health clinics; thus, appointment structures vary across these settings. This can sometimes allow more time flexibility for public health clinicians, compared with those working in non-profit clinics. This was illustrated by the explanation of one physician working in a public health clinic:

> I think that with our funding model here, we don't waste our time, but we can deal with issues that arise around mental health and substance use, whereas I feel like other models you can't really. Or, you can, but then you have to sort of look at what you're doing for work in a different way, right? It'd be very difficult to work full-time in that model – in a system where you can't take the time out.

Similarly, a nurse working at a non-profit clinic serving youth and adults explained the restrictive nature of having a fee-for-service funding model. Clients frequenting this clinic occasionally have mental health and emotional issues that are uncovered during their appointments. Yet, the time allotted for appointments often inhibits a more fulsome exploration of these issues. Relatedly, clinic mandate constrains how providers allocate the limited amount of time they do have with clients. One nurse reflected on this dilemma, noting the tension between acute psychosocial needs of their clients and the funding mandate that relates to HIV testing and treatment: "I sometimes… go through a real dry spell of testing people, I think, what am I doing?... if they [administrators] look at that and say 'well, what's the point of this program if they're not fulfilling all their mandates?'"

Siloing of services "Siloing" of services makes it difficult to tend to clients' MHSU needs. For instance, clinicians described how mental health treatments are often administered in completely separate buildings, or separate wards in a hospital. A clinic coordinator described this bifurcation in terms of the history of mental health services. They said:

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

The separation of services is a constraint, not only because it is deeply entrenched in the daily functioning of the healthcare system in general but also because it inhibits timely access to mental health professionals. A physician working in a public health clinic expressed how siloing affects the length of time a client has to wait before accessing help: "I mean it's quite a long process, but I think even now, in this day and age, it's nice to be able to pick people up where they're at. Because every time you have to send someone to some other place, they don't often end up there, right?"

Lack of knowledge of trusted mental health resources and referral options Timely access to MHSU providers was also constrained by sexual health clinicians' own knowledge of trusted mental health resources and referral options. An outreach nurse (i.e., working in multiple settings beyond the clinic) explained how they manage clients' expectations in this context of sparse and unreliable MHSU referrals:

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

Many clinicians felt that the resources to which they could refer people for mental healthcare were disjointed, and they could not verify the utility and/or quality of these referrals. Several nurses mentioned not knowing where to refer clients for MHSU help at all, or having difficulties identifying fit-for-purpose services within their clinic's referrals list—in the few cases where such a list was available. One nurse expressed concern that the MHSU referral list in their clinic was out-of-date, or missing some referrals. While this nurse described having a "good counselling resources handout" in their clinic, they felt like there was a disconnect in terms of a realistic expectation of how accessible and useful the resources are. They said: "I think once I got a follow up phone call from someone after I gave them some counselling resources, and they said, 'I just wanted to let you know that this resource is only for women, or people who've experienced trauma, and this resource doesn't actually exist anymore.'"

Stigma Finally, mental health stigma constituted a prominent barrier that providers identified for their clients. One nurse explained the apparent parallels between mental health stigma and sexual health stigma: "I always felt those two areas [mental health and sexual health] are areas where adults probably need some more advocacy… I worked at a nurse [phone] line for a while, and it became really clear working on the phones that there's a lot of stigma around those two areas, and there's a lot of difficulty for adults to access the care they need." This nurse went a step further to explain that in some cases the two forms of stigma may be related, noting: "I feel like all of our connotations around sex that are so negative just overwhelm some people… there might be some things that all contribute… [to] mental health and sexual health, I think they totally have a lot of linkages on each other." Through exchanges like these, we observed that providers perceive low-barrier sexual health clinics to in fact be uniquely poised to address mental health-related stigma as a barrier, due to the fact that these clinics are spaces where "taboo" subject matters are already being discussed—e.g., related to sexuality and sexual health.

Facilitators and enablers

Despite these multiple challenges in addressing MHSU concerns, we identified one factor that, according to service providers, facilitates the ability of clients to discuss MHSU concerns (i.e., the low barrier and "safe" nature of sexual health clinics), and one factor that enables clinicians to do the work of addressing their clients' mental health needs (i.e., the acquired experiences of nurses in counselling).

Low barrier nature of clinics Providers reflected that showing identification before a sexual health appointment can feel stigmatizing, dangerous, or uncomfortable if clients do not normally share details of their private life with strangers, or if they are uncomfortable speaking about sex and their sexuality. Some low barrier clinics seem to eliminate this discomfort. For example, one participant described how anonymity affects willingness to ask not only about sexual and reproductive health services but also about MHSU, particularly in rural communities where people working in healthcare might be personal acquaintances or family members:

> Because everyone knows everyone in a rural community. So you have a young person coming into a non-profit clinic, because 'Auntie' works at the pharmacy, so they can get their contraception at the non-profit clinic. Or it's hard enough to talk about sex, and then to do it with your family doctor, and the family doctor is your mother's doctor as well, even if you know about confidentiality, et cetera. So the clinics are really important in rural communities. Really, really important in rural communities, because you're talking about stigmatized issues. And all of these are stigmatized issues. Sex, mental health, drugs.

Not having to show an insurance card is helpful not only for those with privacy-related concerns, but also for people without medical insurance. A nurse working in a public health clinic explained that some people are just visiting Canada, or do not have permanent resident status, and use the sexual health clinic like a free clinic. This ancillary use of low-barrier clinics demonstrates how these sexual health clinics fill a primary healthcare gap in the larger healthcare system.

Acquired knowledge and counselling experience The other enabling factor identified by clinicians is the particular knowledge and experience they gain over the course of their career in sexual healthcare. Many nurses reported that over time, they developed competencies in counselling, despite receiving little-to-no formal training in MHSU counselling. This speaks to the frequency with which they encounter MHSU-related needs, but also to the particular nature of the clinicians who work in sexual health. The sexual health clinicians we interviewed represented a workforce with particular passions and motivations. Most sought out work in community-based sexual health because they care about meaningfully improving the lives of clients who may otherwise face marginalization on the basis of their sexuality. This is significant because it helps explain how and why so many providers found ways to meet their clients' MHSU-related needs, despite having relatively little formal training to support this work.

One participant described gaining this experience over time, and how at the beginning of their career, they were very "perfunctory and focused on the function," but that over time, they "focus[ed] less on being encumbered by getting through the steps, and more on the experience for the client." Another nurse described it as "learning along the way," from "years of practice and sometimes failing." A nurse working in a public health clinic echoed this notion of acquired experience over time, saying:

> As you get more competent and comfortable with [the medical side], then you start to pick up on other parts, 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.

Another clinician, working in a clinic predominantly serving sexual minorities, explained how they begin each appointment by asking the client "how's your heart," in an effort to understand which life events or interpersonal issues lead each person to come in.

> [I ask] "How's your heart?" because, was it a hard breakup? How's it going with that? Because actually, that's way more important than the testing. We can take care of all of that stuff very well with all of the resources that we have. But, the critical point is the person who needs to feel that they're okay, that they're a good person. […] So, I just always think that the heart and the mind are connected like an integral part of us, and we can't help but address that.

Recommendations

When the interviewees offered ideas about possible new ways to address the MHSU-related needs of clients, MHSU/sexual health service co-location (i.e., physically situating MHSU services in the same building as sexual health services) was repeatedly asserted as the way forward for addressing sexual health clients' MHSU concerns. Most clinicians suggested having specially trained MHSU workers working within the clinic, because it would lead to easier, more accurate referrals, and immediate help for the client. A nurse expressed this in terms of simplifying the process for clients: "I would like to be able to just get somebody that support in that moment. Instead of all these steps and processes and referrals that are needed." Another participant, a sexual health educator, expressed the need for co-location in order to relieve the financial burden on those seeking mental health help, by making low-cost counselling available within the clinic. They suggested having a counselor on staff, specialized in understanding the intersection of mental health and sexuality:

> I know there are a few counselors here in [BC city] that focus on sexuality and gender in terms of their practice, but people have to pay out of pocket for those services. So, ideally if that could be covered within the scope of what people are accessing here, and recognizing the really extreme financial barriers to being able to access services, especially with such personal and sensitive topics. People that are experts in that area, I just think there would be such great value in that.

The co-location of services was seen by clinicians as a step forward in providing more complete care to their clients, with one participant stating it would be the "way of the future." They explained that at the very least, more communication and cooperation between the different kinds of care providers currently operating in silos would be beneficial, but that co-location would be even more forward-thinking. One participant who worked in a site that had undertaken some co-location suggested that their approach was to "put a bunch of buckets [related to MHSU services] around that bucket [of sexual health services]."

Some clinicians went further to suggest the creation of centres dedicated to integrated sexual and mental health services. For example, one nurse described: "I think if we had wellness centres that included sexual health, included addictions, included mental health, what else can we have? If we just had this whole centre." A different nurse in a clinic serving a community made up mostly of sexual minorities described a similar kind of building, explaining that it could be a mental health walk-in clinic where people could get counselling or a psychiatric referral. This demonstrates the immediacy

and breadth of the clients' MHSU-related needs, which are often poorly addressed elsewhere in the current healthcare system.

While discussing the co-location of services in various forms, clinicians also detailed the kinds of providers they felt would best respond to the currently unaddressed needs. Counsellors, psychologists, social workers, and more nurses were the most common responses. While opinions differed about the particular professional training of MHSU provider to be co-located, it was clear that sensitivity to gender and sexual minority-affirming approaches was required. A nurse working in a public health clinic explained why a counsellor might be a good option:

> I don't even think it needs to be psychiatry. In fact, many people find that quite [off-putting] as a first step. 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[.]

Discussion

This study explored barriers and solutions to addressing the MHSU-related needs of clients attending sexual health clinics, according to sexual health providers. Our findings indicate that sexual health providers desire co-location of MHSU services within sexual health clinics in Vancouver and Victoria, BC, Canada. We found that sexual health clinicians are a self-selected and motivated group of professionals, with backgrounds making them uniquely situated to uncover underlying MHSU needs, while simultaneously meeting their clients' sexual health needs. Yet, despite clinicians' willingness to address MHSU needs within sexual health appointments, it is clear that not all MHSU-related concerns can be addressed by nurses or physicians, thus creating a need for immediate referral to a preferably co-located mental health professional to provide counselling. The current provider-identified barriers to ensuring access to MHSU services include time constraints, funding models and clinic mandate, the siloing of services, and limited provider knowledge of existing MHSU resources and referral options. The siloed funding model also limits sexual health clinic administrators' ability to integrate MHSU and sexual health services, a constraint that is further confounded by increasing demands on sexual health services, given wait-times and increasing STI rates (British Columbia Centre for Disease Control and Prevention 2018; Mohammed et al. 2018). Despite these pervasive barriers, we discovered ways in which sexual health clinicians nonetheless address at least some of their clients' MHSU-related concerns, i.e., maintaining the low-barrier nature of the clinics, and supporting counselling knowledge and competencies acquired by sexual health clinicians. The "on-the-job" learning we identified suggests that one way of increasing the capacity of clinics to respond to unmet MHSU needs is to introduce mentorship models to allow less-experienced staff to learn from senior staff how to manage and respond to clients' complex MHSU concerns, which may fall outside the domains of formal training they received.

Our findings add to the body of literature that has established that sexual health clinic clients have high rates of MHSU concerns, and are interested in discussing these concerns at the sexual health clinic, by offering the perspective of providers and offering practicable ways forward for doing the work of sexual/MHSU service integration (Bauer et al. 2002; Carey and Senn 2013; Cook et al. 2006; Erbelding et al. 2001; Salway et al. 2019; Seivewright et al. 2004; Senn et al. 2010; Senn et al. 2006; Senn et al. 2016). Participants offered a vision of low-barrier sexual health clinics as a "safety net" for marginalized and stigmatized populations, notably including sexual minorities, who may otherwise be deterred from seeking care.

This study was limited to predominantly urban clinics in Vancouver and Victoria. It would be worthwhile to replicate the study in rural and remote settings to assess whether rural clinics face similar challenges. We found remarkable consistency across interviews in the core themes presented, and very few participants articulated counter-arguments to sexual/MHSU service integration. This is likely a function of our sample—individuals who may have been especially motivated to think about their clients' mental health concerns. Future studies should explore how sexual/MHSU integration may cause unintended consequences, particularly for clinic staff who are managing an increasingly complex area of healthcare. While we included one administrator and two coordinators, further research is needed to understand systems-level or administrative constraints. Finally, this study does not include experiences or perceptions of sexual health or MHSU service users themselves. Future studies should elicit ideas and expectations for sexual/MHSU service integration from clients, which can then be compared and contrasted to the provider opinions shared in this report.

We foresee several next directions related to research and practice. Given that co-location of MHSU providers was resoundingly recommended by the participants of this study, a logical next step is the addition of mental health staff, on a pilot basis and across a number of clinics. Such staff will be best poised for success if they are knowledgeable about sexual health concerns and are readily available to the current sexual health clinic workforce (i.e., fully integrated with the team). In

the meantime, the finding that clinicians may be reluctant to refer clients due to lack of familiarity with siloed mental health services suggests an opportunity to strengthen and improve referral patterns. Clinics may create in-service trainings service mapping tools and communication channels that allow sexual health clinicians to readily identify trustworthy MHSU referrals.

We are heartened by the advice of the participant who offered a bucket metaphor as a welcomed contrast to the silo metaphor. Silos, which epitomize the current arrangement of sexual, mental, and substance use-related health services, are characterized by being closed (even air-tight) and isolated. Thus, participants in this study commented that MHSU services were often "segregated," full of gaps, and plagued by long wait times; this led several clinicians to develop a cynical attitude about the availability of services for their clients. By contrast, buckets are open, transferrable, and even flexible. By putting mental health and substance use "buckets" around the sexual health "bucket," clients may find that if they "fall into" the sexual health bucket, there is a similar low-barrier mental health bucket, adjacent and open.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

References

Achterbergh, R. C. A., van Rooijen, M. S., & de Vries, H. J. C. (2018). *High prevalence of psychosocial problems in a syndemic based intervention to facilitate psychosocial care for high risk MSM in Amsterdam: the SYN.BAS.IN randomized controlled trial – preliminary results*. *IUSTI 2018 World Congress*.

Bauer, H. M., Gibson, P., Hernandez, M., Kent, C., Klausner, J., & Bolan, G. (2002). Intimate partner violence and high risk sexual behaviors among female patients with sexually transmitted diseases. *Sexually Transmitted Diseases, 29*(7), 411–416.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

British Columbia Centre for Disease Control and Prevention. (2018). *STI in British Columbia: Annual Surveillance Report 2016*. https://doi.org/http://www.bccdc.ca/resource-gallery/Documents/Statistics%20and%20Research/Statistics%20and%20Reports/STI/HIV_Annual_Report_2011_20111011.pdf

Carey, M. P., & Senn, T. E. (2013). Health and life concerns among patients attending a publicly funded sexually transmitted infection clinic. *Journal of Public Health Management and Practice, 19*(1), E30–E34. https://doi.org/10.1097/PHH.0b013e31822d4bd5.

Cook, R. L., Comer, D. M., Wiesenfeld, H. C., Chang, C.-C. H., Tarter, R., Lave, J. R., & Clark, D. B. (2006). Alcohol and drug use and related disorders: an underrecognized health issue among adolescents and young adults attending sexually transmitted disease clinics. *Sexually Transmitted Diseases, 33*(9), 565–570. https://doi.org/10.1097/01.olq.0000206422.40319.54.

Dicicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*, 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x.

Erbelding, E. J., Hummel, B., Hogan, T., & Zenilman, J. (2001). High rates of depressive symptoms in STD clinic patients. *Sexually Transmitted Diseases, 28*(5), 281–284. https://doi.org/10.1097/00007435-200105000-00008.

Golden, M. R., & Kerndt, P. R. (2015). What is the role of sexually transmitted disease clinics? *Sexually Transmitted Diseases, 42*(5), 294–296. https://doi.org/10.1097/OLQ.0000000000000271.

Hottes, T. S., Farrell, J., Bondyra, M., Haag, D., Shoveller, J., & Gilbert, M. (2012). Internet-based HIV and sexually transmitted infection testing in British Columbia, Canada: opinions and expectations of prospective clients. *Journal of Medical Internet Research, 14*(2), e41. https://doi.org/10.2196/jmir.1948.

Kanuha, V. K. (2000). "Being" Native versus "Going Native": conducting social work research as an insider. *Social Work, 45*(5), 439–447. https://doi.org/10.1093/sw/45.5.439.

Karamouzian, M., Knight, R., Davis, W. M., Gilbert, M., & Shoveller, J. (2018). Stigma associated with sexually transmissible infection testing in an online testing environment: examining the perspectives of youth in Vancouver, Canada. *Sexual Health, 15*, 46–53. https://doi.org/10.1071/SH17089.

Kates, N., Mazowita, G., Lemire, F., Jayabarathan, A., Bland, R., Selby, P., et al. (2011). The evolution of collaborative mental health care in Canada: a shared vision for the future. *Canadian Journal of Psychiatry, 56*(5), 1–10.

Lindert, J., Bilsen, J., & Jakubauskiene, M. (2017). Public mental health. *European Journal of Public Health, 27*(4), 32–35. https://doi.org/10.1093/eurpub/ckx163.

Masaro, C. L., Johnson, J., Chabot, C., & Shoveller, J. (2012). STI service delivery in British Columbia, Canada; providers' views of their services to youth. *BMC Health Serv Res, 12*, 240–250 Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3469370/?tool=pubmed%0Ahttp://dx.doi.org/10.1186/1472-6963-12-240.

Mohammed, H., Blomquist, P., Ogaz, D., Duffell, S., Furegato, M., Checchi, M., et al. (2018). 100 years of STIs in the UK: a review of national surveillance data. *Sexually Transmitted Infections, 94*, 553–558. https://doi.org/10.1136/sextrans-2017-053273.

Ratnasingham, S., Cairney, J., Rehm, J., Manson, H., & Kurdyak, P. A. (2012). *Opening eyes, opening minds: the Ontario burden of mental illness and addictions report*. *Ontario*: *Institute for Clinical Evaluative Sciences/Public Health Ontario* Retrieved from www.ices.on.ca%5Cnwww.oahpp.ca.

Robinson, K. H., Smith, E., & Davies, C. (2017). Responsibilities, tensions and ways forward: parents' perspectives on children's sexuality education. *Sex Education, 17*(3), 333–347. https://doi.org/10.1080/14681811.2017.1301904.

Salway, T., Ferlatte, O., Shoveller, J., Purdie, A., Grennan, T., Tan, D. H. S., et al. (2019). The need and desire for mental health and substance use – related services among clients of publicly funded sexually transmitted infection clinics in Vancouver, Canada. *Journal of Public Health Management and Practice, 25*(3), E1–E10. https://doi.org/10.1097/PHH.0000000000000904.

Seivewright, H., Salkovskis, P. M., Green, J., Mullan, N., Behr, G., Carlin, E., et al. (2004). Prevalence and service implications of health anxiety in genitourinary medicine clinics. *International Journal of STD & AIDS, 15*, 519–522. https://doi.org/10.1258/0956462041558122.

Senn, T. E., Carey, M. P., Vanable, P. A., Coury-Doniger, P., & Urban, M. A. (2006). Childhood sexual abuse and sexual risk behavior among men and women attending a sexually transmitted disease clinic. *Journal of Consulting and Clinical Psychology, 74*(4), 720–731. https://doi.org/10.1037/0022-006X.74.4.720.

Senn, T. E., Carey, M. P., & Vanable, P. A. (2010). The intersection of violence, substance use, depression, and STDs: testing of a syndemic pattern among patients attending an urban STD clinic. *Journal of the National Medical Association, 102*(7), 614–620. https://doi.org/10.1016/S0027-9684(15)30639-8.

Senn, T. E., Walsh, J. L., & Carey, M. P. (2016). Mediators of the relation between community violence and sexual risk behavior among adults attending a public sexually transmitted infection clinic. *Archives of Sexual Behavior, 45*, 1069–1082. https://doi.org/10.1007/s10508-016-0714-6.

Shoveller, J., Johnson, J., Rosenberg, M., Greaves, L., Patrick, D. M., Oliffe, J. L., & Knight, R. (2009). Youth's experiences with STI testing in four communities in British Columbia, Canada. *Sexually Transmitted Infections, 85*(5), 397–401. https://doi.org/10.1136/sti.2008.035568.

Szymanski, B. R., Bohnert, K. M., Zivin, K., & McCarthy, J. F. (2013). Integrated care: treatment initiation following positive depression screens. *Journal of General Internal Medicine, 28*(3), 346–352. https://doi.org/10.1007/s11606-012-2218-y.

Tanton, C., Geary, R. S., Clifton, S., Field, N., Heap, K. L., Mapp, F., et al. (2017). Sexual health clinic attendance and non-attendance in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Sexually Transmitted Infections, 94*, 267–275. https://doi.org/10.1136/sextrans-2017-053193.

van Os, J., Guloksuz, S., Vijn, T. W., Hafkenscheid, A., & Delespaul, P. (2019). The evidence-based group-level symptom-reduction model as the organizing principle for mental health care: time for change? *World Psychiatry, 18*(1), 88–96. https://doi.org/10.1002/wps.20609.

Young, A., Klap, R., Sherbourne, C., & Wells, K. (2001). The quality of care for depressive and anxiety disorders in the united states. *Archives of General Psychiatry, 58*(1), 55–61. https://doi.org/10.1001/archpsyc.58.1.55.