MENTAL & EMOTIONAL HEALTH OF 2SGBTQ+ MEN

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GMSH
GAY MEN'S SEXUAL HEALTH ALLIANCE

ABOUT THIS FACTSHEET

This fact sheet is for frontline, outreach staff, public health staff, others providing mental, and emotional health, to the communities of Two-Spirit, gay, bisexual, trans and queer men (2SGBTQ+). Mental and emotional health and wellbeing are integral to the overall health of 2SGBTQ+ men.

MENTAL HEALTH

The World Health Organisation defines mental health as "a state of well-being in which the individual realises [their] own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to [their] community."[1] Mental well-being is composed of a vastly complex mixture of several interconnected elements, including—but not limited to—social, societal, economic, and educational factors which combine to uniquely influence all of us.[1] It is also linked to physical health, affecting factors such as how we age and how long we live.[1,2]

According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), a mental health disorder can be described as psychobiological dysfunction causing "clinically significant distress…or disability."[3] The reactions produced cannot be expected responses to stressors; grieving a loved one soon after their passing or feeling in a trance-like state at a religious event are considered normal responses.[3] Mental disorders are associated with negative physical, social, financial, and sexual health outcomes.[4,5] Examples of mental health conditions include depression, anxiety, bipolar disorder, posttraumatic stress disorder, and obsessive compulsive disorder.[4]

Based on participants aged 15 years or older in the Canadian Community Health Surveys (CCHSs) between 2019 and 2021, 29.7% of 2SLGBTQ+ persons (n=1,289,300)[6] rate their mental health as "fair or poor, compared with fewer than 1 in 10 non-2SLGBTQ+ individuals (9.1% of 27,943,700 people)."[7] The largest percentage of "fair or poor" for both 2SLGBTQ+ and non-2SLGBTQ+ cohorts were seen in those aged 15 to 24 years, compared to those aged 25 to 64 years and 65 and over.[8-10] It is important to note that—of the total group of 2SLGBTQ+ participants—39.2% were cisgender men, 3.9% were transgender men or women, and 4.2% were non-binary persons.[6]

Likewise, as per the Canadian Mental Health Association, 1 in 3 2SLGBTQ+ (which includes lesbians and all other sexual and gender communities in addition to 2SGBTQ men) Canadians suffer from poor mental health, with 2 in 5 diagnosed with an anxiety disorder. 82% of transgender clients have reported thinking about suicide and 40% have attempted it; in contrast, only 4% of the general population have attempted suicide.[11-13]

EMOTIONAL HEALTH

Emotional health—or emotional well-being—groups together "many psychological concepts such as life satisfaction, life purpose, and… emotions." Autonomy (a sense of individuality), personal growth, self-acceptance, empathy, and enjoying relationships with others are also markers of positive emotional health. Although related (and sometimes viewed as a subset of mental health), it is not the same as mental health.[13]

As per the 2019 CCHS, gay and bisexual men had significantly lower average self-reported community belonging results, while bisexual men also had significantly lower happiness, psychological well-being and mean life satisfaction scores versus the gay and heterosexual male groups.[14] Similarly, clients belonging to gender minorities (e.g., transgender men, transgender women, non-binary individuals) reported significantly lower life satisfaction scores, with potentially significantly lower self-rated happiness results when compared to cisgender respondents.[14] Due to the relatively few participants, all people belonging to a gender minority were grouped together for the results of this survey.[14]

TRAUMA AND 2SGBTQ+ MEN

To provide client-centered mental and emotional healthcare tailored to the unique needs of 2SGBTQ+ men, it is crucial to be aware of the history of criminalization, discrimination, stigma, physical and/or sexual violence, laws, and state-sanctioned homophobia that continue to impact cis and trans 2SGBTQ+ men.[15] The AIDS epidemic and the loss of thousands of lives of gay and bi men who have sex with men (MSM) has a cumulative and intergenerational trauma that continues to impact the well-being of 2SGBTQ+ men by affecting various aspects of their general health.[15,16]

AN OVERVIEW OF 2SLGBTQ+ HISTORY IN CANADA

Criminalisation

Until 1861, homosexuality was punishable by death in the British lands which would become Canada; the law was amended to 10 years to life in prison.[16] From 1890 through 1961, "gross indecency," "criminal sexual psychopathy," and "dangerous sexual offender" were charges and terms in the Criminal Code to target 2SLGBTQ+ people (most often MSM).[16] In May 1969, under the government of Pierre Trudeau, gay sex was decriminalized in Canada, albeit with provisions[16]:

"parties [of no more than two] involved had to be 21 years of age or older and conduct their affairs in private."[17] Sexual orientation protections in provincial Human Rights Codes were added years later, from 1977 (Québec) to 1998 (Alberta).[16] Gender identity and gender expression were included much later in the federal Human Rights Act, in 2017.[16] In December 2021, conversion therapies—religion-based practices that tries to make gay people straight[18]—were finally banned across the country by the House of Commons (having come into effect on January 7th, 2022).[16,19]

Table 1. Changes to legal and medical distinctions of 2SLGBTQ+ peoples in Canada[16,19-26]

YEAR	EVENT
1969	Consensual sex between two adults of the same sex in private removed from the Criminal Code of Canada[16]
1973	Homosexuality no longer classified as a mental illness in the DSM; however, this was somewhat replaced by the Sexual Orientation Disturbance (SOD) diagnosis, if people "with same-sex attractions found them distressing and wanted to change"[20]
1977-1998	Territories and provinces prohibited discrimination based on sexual orientation (Ontario in 1986)[16]
1978	Gays and lesbians permitted as immigrants to Canada[21]
1992	The WHO removes homosexuality from its International Classification of Diseases but "gender identity disorders" (e.g., transsexualism, dual-role transvestism, gender identity disorder of childhood) remain[22]
2003	Ontario legalizes same-sex marriage[16,21]
2005	Canada allows same-sex marriage[16]
2012	Ontario recognizes gender identity and gender expression in its human rights legislation[23]
2013	Gender dysphoria replaces gender identity disorder in the DSM-5[24,25]
2017	The Canadian Human Rights Act adds gender identity and gender expression to the list of prohibited grounds of discrimination[26]
2022	Conversion therapy ban comes into effect in Canada[19]

2SLGBTQ+: Two-Spirit, lesbian, gay, bisexual, transgender, queer and additional identities; DSM: Diagnostic and Statistic Manual of Mental Disorders; LGBT: lesbian, gay, bisexual, transgender; WHO: World Health Organisation

LGBT Purge: The Fruit Machine[27-31]

From the late 1950s until the early 1990s, 2SLGBTQ+ people who worked as members of the Canadian Armed Forces or as federal employees were targeted by the Royal Canadian Mounted Police and the military police through active surveillance (e.g., telephone wire tapping, surveillance & stalking), interrogations, and ultimately employment dismissal if suspected of homosexuality.[27] In particular, 'fruit machines'[28] were used in the 1960s with materials such as erotic pictures of men and women to attempt—albeit unsuccessfully—the discernment of gay people from straight people. As a potential blackmail tool by Soviet spies, homosexuality was viewed as a Cold War weakness and a liability to national security, not to mention a moral failure by society as a whole; thus, it was kept secret by individuals.[28]

Thousands of LGBT persons suffered from these initiatives, as outing, homelessness, depression, and suicide were amongst the rotten fruits of the Canadian government's bigoted labour. A 2018 documentary[29] has been made detailing the LGBT purge and is available with French subtitles at **https://www.youtube.com/watch?v=_8csvaoHHl0.30**

On November 28th, 2017, Prime Minister Justin Trudeau offered a national apology to all LGBT civil servants and military staff members affected by these events.[31]

Pride and protest

The first gay rights protests in Canada took place in Ottawa and Vancouver in August 1971.[16] The first Pride celebration took place in Toronto in 1972 but did not get endorsed by the City of Toronto until 1991.[16] On February 5th, 1981, Toronto police raided four bathhouses and arrested almost 300 men[32] on "indecent act" charges since the 1969 decriminalisation did not apply to public gatherings and limited groups to two men only.[16,17] The bathhouse raids were the largest mass arrests in Canada since 1970.[32] While this event was followed by the protests of 3,000 individuals, such arrests persisted for over 20 years in Canada.[16]

As a result of a lawsuit in 2000 brought upon by a raid of a women-only venue (Pussy Palace), training programs for law enforcement in Toronto on interaction with 2SLGBTQ+ communities have been established since 2002.[16,33]

In 2018, the Government of Canada finally allowed for the criminal record expungement of eligible offences involving consensual same-sex sexual activity.[16,34]

The HIV/AIDS crisis, blood donation and current elderly 2SGBTQ men

From the 1980s to the present, MSM in Canada have been disproportionately affected by HIV infection and its health impacts.[35] Feeling ignored by the healthcare system and government, the creation of organisations such as AIDS Vancouver and AIDS Action Now were crucial to increasing medication treatment options for HIV.[16] HIV remains a major issue in Canada, with 65,270 individuals living with HIV at the end of 2022—51% of whom were MSM.[35]

Blood donation bans were also set in place, where no man who had had sex with another man since 1977 was allowed to give blood, due to fear of HIV. The rule now states that donors—who are no longer asked about their sexual orientation[36]—must refrain from anal sex with a new partner or multiple partners for at least three months, and that HIV pre-exposure prophylaxis (HIV PrEP) use must be stopped for at least four months prior to donation.[36-38]

To put it into perspective, someone born when gay sex was provisionally decriminalized in May of 1969 would not even be 55 years old at the time of writing this document.[16,17] There remain many individuals who have dealt with historical anti-2SGBTQ+ discrimination (much of which is not listed here)[16] in Canada who must bear the mental and emotional scars.[39] Indeed, older age, living with HIV, and sexual and/or gender minority status (2SLGBTQ+) have been associated with depressive symptoms (including suicidality),[40] with elderly clients who live alone at even greater risk.[41, 42] Using data from 2019 to 2021, 2SGBTQ+ men above 64 years of age were more likely to live alone than non-2SGBTQ+ individuals in Canada.[43] Maintaining close relationships with friends and family members (chosen and/or biological family) may help counter depression in these clients,[41,44,45] though biological family ties are less likely in 2SLGBTQ+ individuals.[42,45]

MINORITY STRESS AND SYNDEMICS

Minority stress is defined as the psychological strain resulting from stigma, violence, rejection and discrimination, decisions about disclosure of sexual orientation or gender identity (SOGI), and internalization of homo/bi/transphobia that 2SGBTQ+ men face in a heterosexist and cissexist society. First defined by Meyers in 2003,[46] minority stress has become the hallmark of understanding the mental health impact of discrimination in sexual and gender minority populations.[47,48]

Interrelated to minority stress is syndemics, which "examines the health consequences of identifiable disease interactions and the social, environmental, or economic factors that promote such interaction and worsen disease."[49] For gay

and bisexual MSM, syndemic factors include the HIV epidemic, as well as the higher rates of sexually transmitted blood-borne infections, depression, suicidal ideation, substance use, eating disorders, and marginalization.[49-51]

With the historical impact of criminal laws, prejudice, and discrimination in society and institutions, these systems of oppression affect 2SGBTQ+ men consciously and unconsciously, including their sense of self, identity, self-worth and self-esteem, and confidence. The experience of "acute and chronic, low-level stress—from external and internalized events and processes—contributes to the notably high levels of stress-related physical illness, anxiety, depression and even suicidality reported"[52] in sexual and gender minority people. Individuals from sexual and gender minorities feel "they are less important than their peers, which may lead to experiences of shame, isolation, lack of confidence or trauma."[52] Despite the huge gains in human rights in Canada, many "will present with some residual expressions of trauma simply because they have lived with a sense of chronic stress due to their position in society as a member of a minority group."[52] The residual effects of these stresses over the years impact various aspects of their health.[52]

INTERSECTIONALITY

It is important to view clients through the lens of intersectionality—where people are appreciated as a unique collection of traits and experiences.[53] Experiences of homophobia, biphobia, transphobia, racism, sexism, ableism, poverty, and more may factor significantly into one person's overall mental and emotional well-being while not factoring much or at all to another[53,54] Further, the more societal challenges one has to face, the more likely their mental health will suffer as a result.[55,56]

FAMILY ACCEPTANCE AND SOCIAL SUPPORT

Based on certain cultural traditions, religions, and family environments, the coming out experience can wildly vary between clients, particularly young people.[57] Some may think it necessary at the time, and "want explicit support from parents and family members."[41] A positive experience can lead to "acceptance and a feeling of liberation,"[57] where improved self-confidence can lead to seeking out more school and community leadership roles.[57] In contrast, hostile family surroundings can lead to identity hiding, internalized hatred (e.g., homophobia, biphobia, transphobia, heterosexism), and a fear of rejection. Further, poorer social supports with respect to sexuality can lead to higher rates of suicidality, substance use, shame, guilt, absenteeism, and violence.[57,58]

2SGBTQ men more often report experiencing abuse during childhood than cisgender heterosexual people.[59] Across several studies, gay men

reported 1.6 to 4 times more instances of childhood sexual and physical abuse compared to heterosexual respondents.[59-61] Gay and bisexual men also note "parental alcohol abuse, mental illness or poverty" at higher rates than heterosexual people.[59] Per the 2011 Trans PULSE Project, 65.7% of trans men noted experiencing sexual or physical abuse before 16 years of age.[62]

LIVING CONDITIONS

2SGBTQ+ men have, on average, lower household incomes, lower employment rates, and greater housing insecurity compared to their cisgender heterosexual counterparts.[43,63] According to 181 of the Ontario transgender men surveyed in the 2011 Trans PULSE Project, 50.0% had yearly income-to-needs ratios—"dividing the midpoint of the categories for household gross yearly income by the number of individuals supported on that income"[62]—of less than $15,000 and 16.6% were unemployed despite an estimated 51.4% being post-secondary graduates and 75.7% having at least some college or university education.[62] Among 202 of participants who answered corresponding questions on the survey, 63.0% had been diagnosed with a major mental health disorder—namely, "schizophrenia, borderline personality disorder, dissociative identity disorder, or anxiety disorders."[62]

HEALTHCARE ACCESS AND CLIENT ABANDONMENT[13]

Sadly, there is a "growing burden on both clients and providers from within 2SLGBTQ+ communities to maintain continuity of mental health care"[13] in Canada. Healthcare providers (HCPs) are unable or unwilling to maintain 2SLGBTQ+ clients, leading to gaps in care and forcing people to navigate through the system to find a culturally competent and sensitive HCP.

2SGBTQ CULTURE, TRAUMA AND SELF-WORTH

Stressors for 2SGBTQ men are not limited to the heterosexual world.[59,62,64] In the realm of 2SLGBTQ+ culture, self-acceptance and self-worth are prevailing issues affecting mental and emotional health.[45,59,62] These stressors—both internal and external—can lead to worsened states of mental and emotional well-being (e.g., depression, anxiety, social anxiety).[65,66] Self-compassion (trying to relieve your suffering through understanding "in a non-defensive and non-judgmental way"[65,66]) is one way in which we fight back against this.[65]

SHAME AND BODY IMAGE

Shame and body dysmorphia (significant distress resulting from looking at your appearance unfairly)[67] are more often seen in 2SGBTQ men than in their cisgender heterosexual peers.[65,68,69] Ideal body fat, thinness drive, muscular drive (muscle dysmorphia),[65] an unhealthy obsession with healthy nutrition, and not wanting to look at one's body altogether are some ways in which body dysmorphia is measured.[69] For trans men, shame is one of the main factors leading to internalized transphobia "along with pride, passing and alienation."[65] Feeling regularly objectified and judged is something transmasculine clients may have to deal with more often than cisgender people.[69] These traits may be reinforced due to some who place discriminatory "body ideals upon masculine, younger, and white bodies."[70] Conversely, there are subcultures, such as the Bear community, who prefer the look of the "naturally developing/aging male [body]."[71] However, characteristics deemed 'ideal' still divide the community, including those related to age, weight, and ethnicity.[71]

RACE AND RACISM

Sexual racism is a prominent feature of some contemporary 2SGBTQ men.[72,73] Stereotypes and fetishization have left many men of colour feeling a mixture of exclusion, objectification, and/or at a disadvantage to create new platonic, romantic, and/or sexual relationships.[72-74] According to a study conducted between 2010 and 2012 in Toronto, gay and bisexual MSM "face immense cultural pressure to meet body image ideals within the predominantly white gay community in Toronto" where "racism and other types of social oppression have a negative effect on [them] and their well-being."[74] The study, titled 'Colour Matters,' also notes active resistance, where these populations have pushed back against pushed body image standards and eroticized stereotyping.[74]

However, while results of the Colour Matters study are beneficial, there were differences in the levels of anxiety, depression, and internalized homophobia, among other metrics.[74]

More studies in this field should be conducted across all ethnic and racialized communities to further provide an intersectional base for mental and emotional health supports for different community members (e.g., Two-Spirit individuals and African, Caribbean, Black, East Asian, South Asian, Southeast Asian, Latino, Hispanic, and Brazilian MSM).[53,73,74]

SUBSTANCE USE

2SGBTQ men are more likely to engage in many forms of substance use.[75,76] This may be due to many factors, including a partying subculture (e.g., at circuit parties or during sex) and as a coping mechanism for societal marginalization or intimate partner violence.[75,77]

BISEXUAL INVISIBILITY/ERASURE

Bisexual men face 'bi-erasure' as many people do not recognise bisexuality as an authentic identity, even in queer-dominated spaces.[78,79] They may be grouped together with gay clients and not appreciated as their own category of people with their own specific needs.[79] However, bisexuals suffer worse health than heterosexuals, gays, and lesbians, with higher rates of anxiety, depression, other mood disorders, and substance use (e.g., tobacco, marijuana, alcohol, and other drugs).[65,78,79] Further, compared to heterosexuals, they exhibit higher rates of sexually transmitted infection (STI) diagnoses, heart disease, and cancer risk factors while also being screened for cancer less often.[78]

TRANSMASCULINE DATING AND GENDER-AFFIRMING CARE

Socially, transmasculine clients may seek out romantic partners online as opposed to in-person due to concerns including safety, rejection, and fetishisation.[80,81] Transgender individuals may be at two to three times higher risk of physical and sexual IPV than cisgender people.[66] Further, "any [intimate partner violence] victimisation is significantly associated with sexual risk measures…, substance use…and [worse] mental health in transgender populations."[77]

Gender-affirming care—which can include hormone therapy or surgery—can end up decreasing one's feelings of depression and instill a sense of calmness in transmasculine clients.[62] However, people can still experience tension, nervousness, gloominess, depression, and tiredness during the process.[62] The rate of regret after gender-affirming surgery across 27 studies (n=7928)—33% of whom had masculinising procedures—was very low at 1%.[62] In comparison, a survey of post-plastic surgery sentiment in the UK showed that 65% of clients regretted their decision.[82]

PHYSICAL, SEXUAL AND SPIRITUAL LINKS TO MENTAL AND EMOTIONAL HEALTH

Interwoven with mental and emotional well-being are other facets of the human health profile, including their physical, sexual, and spiritual counterparts.[83-95] For example, positive emotional health may translate to better quality of life in people living with HIV.[96-99]

Stress can physically manifest in several ways—high blood sugar levels, inflammation, poor recovery, changes in digestive activity, lower blood flow to the part of the brain which deals with handling emotions (prefrontal cortex), and a shift in the hormonal system that deals with stress (the hypothalamic-pituitary-adrenal axis).[100] The longer these physical effects last, the higher chance that mental and emotional health will be affected.[100] For the purposes and scope of this document, only the general actions of the vagus nerve (VN) and the gastrointestinal (GI) system will be discussed.

The vagus nerve (VN) is a wide-reaching nerve, originating in the lower part of the brain and spreading to places such as the heart and gastrointestinal (GI) system.[83,84] Communication between the VN and other areas of the body is key to expressing and regulating emotion, mood, digestion, heart rate, blood pressure, breathing, speech, and more.[83-85] Using electrical signals, the VN can be stimulated to help improve conditions including depression that does not improve with medication, anxiety, post-traumatic stress disorder, and inflammatory bowel disease.[84,85]

The GI system works with the VN and more of the central nervous system via its microorganisms (the gut microbiome)[86] and the gut's own nervous system (the enteric nervous system).[87] Food choice is a major factor in the make-up of the gut microbiome population—where certain bacterial populations may be over- or under-represented based on dietary habits. Medications, social conditions, and other lifestyle choices may also affect the gut microbiome.[86,88,89] The result of these lifestyle factors may contribute to changes in mental, emotional, physical, and sexual health.[86,88,89] In particular, sexual arousal and response can be affected by imbalances in the gut microbiome through differences in released body chemicals which include dopamine, serotonin, and nitric oxide.[89] For people receiving anal sex (bottoms), research suggests that bottoming may change the microbiome of the gut and mouth, and imbalances can lead to "anal pain, inflammation and pelvic muscle issues."[89]

Sexuality is "a drive and an inherent need for human beings" for several reasons, including sexual pleasure, procreation and love.[5] Functionally, it is "a complex bio-psycho-social process, coordinated by the neurological, vascular and endocrine systems."[101] It can be affected by levels of intimacy, daily perceived stress and even therapeutic interventions for mental health disorders, among other mental and emotional health measures.[5,102,103] Sexual desire and arousal can, in turn, also affect subjective stress levels.[102] For client care, communication between individuals and their HCPs on "aspects of sexual intimacy, life desires, frustrations, and fears undoubtedly constitutes the best mental health care."[5] For example, an honest description of potential medication side-effects—reduced libido or sexual function, in particular—may stop some clients from inappropriately forgoing treatments for other ailments.[5]

Spirituality, in its quest for understanding transcendent questions of the universe, and/or religiosity—belief in a supra-natural world with a God (at least in Western cultures)[90]—have been associated with improved mental, emotional and physical health outcomes.[91] High levels of spirituality or religiosity were associated with lower rates of hospitalization and pain, with greater levels of survival, functional status, and cardiovascular health.[91] Further, lower levels of depression, suicidality, and substance use were observed in these clients, as well as a potential "buffer against post-traumatic stress."[91] However, while religion can be used as a positive force for mental and emotional well-being benefits (e.g., being able to forgive another through religious doctrine), negativity borne out of religion (e.g., acting to punish someone for their sins) or religion without spirituality can have the opposite effect on one's health.[91,92] In a U.S. study of over 1000 gay and bisexual men (GBM), findings showed that "spirituality was significantly positively associated with positive mental health outcomes" and that "religiosity devoid of spirituality was associated with negative mental health outcomes."[92]

While some HCPs may not consider the interconnectedness of these elements,[93] a holistic approach should be used when forming strategies for personalized client care.[13]

DEFENDING YOUR MENTAL AND EMOTIONAL HEALTH

PREVENTIVE MEDICINE AND SELF-CARE

Just as cavities may be prevented with adequate oral hygiene, preventive mental healthcare can help shield clients from worsening mental health and improve outcomes for those already living with mental disorders.[93] At the moment, healthcare strategies tend to be more devoted to identifying and actively treating existing mental health issues rather than preventing the formation of proverbial cavities, particularly in low-resource areas.[93]

Healthy coping strategies, or responding to stressful situations in a constructive manner, can foster positive mental well-being, increase energy, lower chance of illness, and improve the brain's ability to learn and process experiences.[1,104] Confronting issues—alone or with supports (e.g., family, friends, mental health professionals)—can help lower one's own internalized prejudices or improve depression.[1,41,53,84,105,106] Some coping strategies include the following:

- **Eating a healthy diet** (e.g., fruits, vegetables, fish, whole grains, low sodium)[84,104,105]
- **Exercising regularly** ("at least 150 minutes of moderate aerobic activity" or "75 minutes of vigorous aerobic activity" per week)[104,107]; this can include walking, household chores, biking, lifting weights, jogging, washing your car, and more[107]
- **Getting enough sleep** (about seven to nine hours per night)[108] at the same time every night[104]
- **Making time to relax** (e.g., reading, listening to music)[104]
- **Gaining more insight into your mental health and focusing on positive thoughts** (e.g., writing down experiences and repeating the positive parts in your mind, practicing meditation, saying "no" when taking on more than you can handle, discussing your issues with people you trust)[1,4,104,109]

The results of these activities may not be instantly apparent.[1] One must find coping strategies they enjoy which may also help one stay consistent in achieving mental and emotional health goals over time.[107] However, professional help may be required to achieve improvements for more serious conditions.[106]

- **Speaking to a mental health professional** (e.g., family doctor, psychotherapist, social worker, or psychiatrist; asking about mindfulness techniques, cognitive behavioural therapy, medication, and/or other interventions)[67,106,109,110]

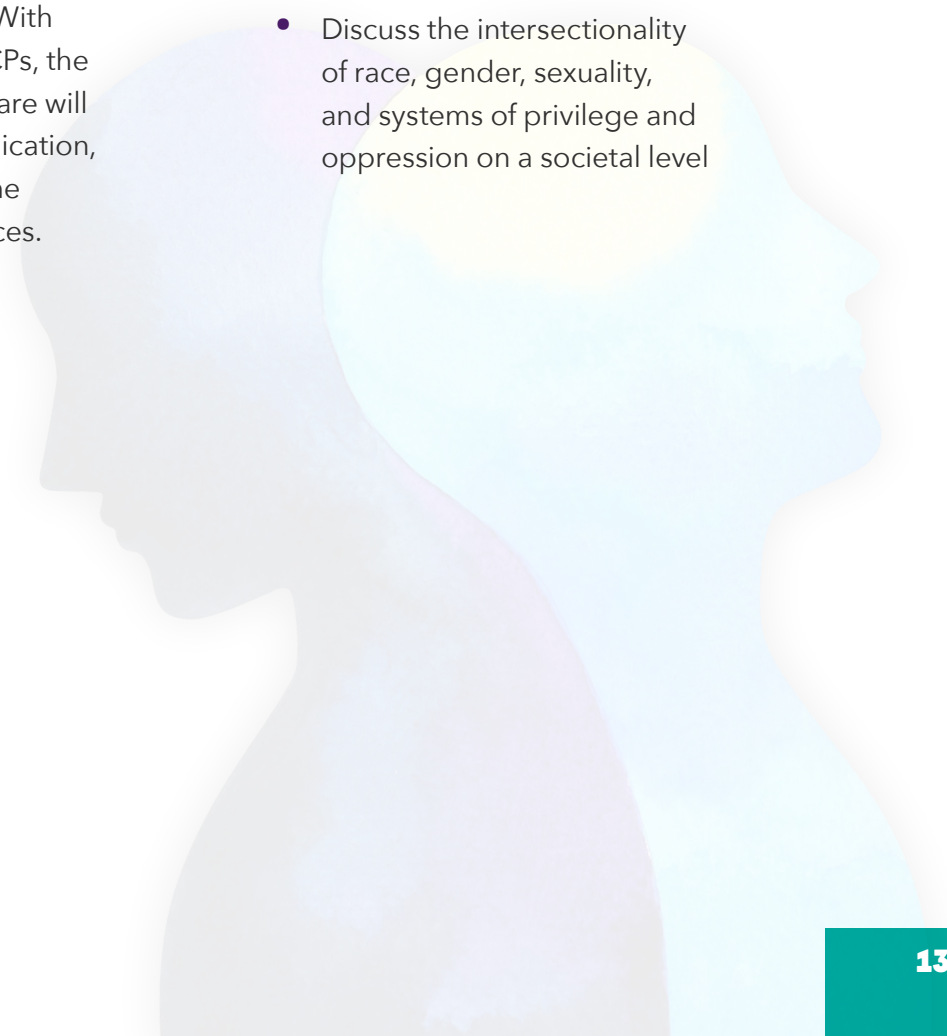
HEALTHCARE SYSTEM IMPROVEMENTS[13]

Collaboration and advocacy for intersectional changes as they relate to local communities should be ongoing with governmental and hospital services to constantly elevate and fine-tune the quality, availability and continuity of mental health services for 2SGBTQ men going forward.

Examples include creating and updating HCP libraries devoted to focused care for 2SGBTQ men, with community members employed to help with resource creation and navigation. HCPs who identify as 2SGBTQ men should also help lead their communities and educate other providers to more independently treat clients. With more acceptance among HCPs, the formation of a web of local care will allow for open HCP communication, a network for referrals and the establishment of best practices.

CLIENT-CENTRED MENTAL AND EMOTIONAL CARE TIPS FOR HEALTHCARE PROVIDERS[56]

- Explore the unique lived experience of the clients
- Discuss the biopsychosocial context of the client's life (the social and historical context of the client's lived experiences) and the impact on their emotional, mental, physical, spiritual, and sexual health in a safe, confidential, and nonjudgemental setting
- Use a trauma-informed lens to examine formative experiences with the client's biological family, chosen family, and communities to explore various internalized experiences
- Discuss the intersectionality of race, gender, sexuality, and systems of privilege and oppression on a societal level



NEXT STEPS: MORE RESOURCES TO MANAGE MENTAL AND EMOTIONAL HEALTH

Clients taking ownership of their own care may help in improving their mental and emotional health.[111] Here are some resources which may help people take that first step to take control of their mental and emotional healthcare[44,112-123]:

- Finding mental health support through the Government of Ontario[112]
- In-person, phone and virtual resources for Ontario 2SLGBTQ+ clients under 30 years old[113]
- Find a 2SLGBTQ-friendly service provider through Rainbow Health Ontario[114]
- A thorough mental health support manual for Indigiqueer, Two-Spirit, LGBTQ+ and gender non-conforming Indigenous youth (includes lots of extra resources near the end)[44]
- Find a doctor or nurse practitioner through the Government of Ontario[115]
- Sexual assault support from the Toronto Rape Crisis Centre[116]
- Science-based exercise tips—including full workouts—by Jeff Nippard[117]
- Healthy eating information by the Government of Canada[118]
- A video on mindfulness meditation guided by a clinical psychologist[119]
- The mental health guide for cis and trans queer guys: Skills to cope and thrive as your authentic self by Rahim Thawer[120]
- A video on insight for HCPs on how to mobilise for the well-being of 2SLGBTQ+ peoples[121]
- Good head: a mental health resources for gay, bisexual, queer and other guys into guys[122]
- Finding support groups for LGBTBQIA+ newcomers in Ontario[123]

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