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**Title** Identifying and addressing sexual health in serious mental illness: views of mental health staff working in two NHS organisations in England

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**Abstract**

People with serious mental illness (service users) have needs related to sexual health and sexuality, yet these have been poorly addressed in mental health services. This article reports the current practice of mental health professionals in relation to sexual health. Focus groups conducted in two mental health trusts explored routine practice in relation to discussing, assessing and planning care in relation to sexual health. A thematic analysis identified seven themes: sexual health provision is a complex issue; mental health staff are aware of sexual health needs; current provision regarding sexual health is “neglected”; barriers to sexual health provision; enabling a discussion around sexual health; sexual health provision is a role for mental health professionals; and training needs. Mental health staff are aware of complex issues related to sexual health for service users but this is mainly seen through the lens of risk management and safeguarding. We need to develop the mental health workforce to be able to incorporate sexual health into routine healthcare.

**Keywords:** sexual health; mental health nursing; qualitative; focus group; serious mental illness

## **Introduction**

Access to sexual health, and the ability to experience a safe and satisfying sex life and expression of one's own sexuality is a fundamental human right (World Health Organization, 2006). This is central to quality of life (Eklund and Östman, 2010; Wilmoth, 2007) and considered to be a significant part of a person's mental health recovery (Tennille and Wright, 2013). However, this topic isn't routinely addressed in mental health care.

Service users aspire to have healthy, safe and supportive intimate relationships, however the reality is often more bleak (McCann, 2010); issues include elevated rates of intimate partner violence and abuse, sexually transmitted infections, and unintended pregnancy. McCann (2010) undertook qualitative interviews with people with psychosis who said that intimate relationships were important, but also reported significant issues around exploitation and abuse within those relationships and that they rarely discussed these issues with their care workers. Khalifeh et al (2015) and González Cases et al (2014) both report that intimate partner violence (IPV) is much higher in service users. Elkington et al (2013) and Wainberg et al (2016) found a relationship between internalised mental health stigma in this group, and their choices in sexual relationships, which leads to increased sexual risk behaviour. A recent meta-analysis also demonstrates that they have elevated rates of HIV (as well as hepatitis B and C) (Hughes et al., 2015). Whilst rates of pregnancy in service users are lower than the general population, unintended pregnancy is higher. (Miller and Finnerty, 1996; Dickerson et al., 2004). In an Australian study of 220 women attending mental health services, they found an average of 3 pregnancies each, and of these 61.2% were classified as unintended (Hauck et al., 2015).

Given the significant needs, there is little evidence to guide mental health staff in working with sexual health issues. Hughes and Gray (2009) conducted a survey of mental health staff in a London mental health NHS service. Whilst staff reported "feeling comfortable discussing sexual issues", they rarely did this in routine practice (Hughes and Gray, 2009). In Australia, Quinn and colleagues (2011) found in a qualitative study that generally mental health nurses avoided the topic of sexual health. The reasons they gave included professional boundary concerns, sexual health of service users not being a priority, and that it was not their responsibility (Quinn et al., 2011). However, this was a single site

study in Australia and therefore difficult to know if these themes would generalise to mental health staff working in other countries and settings.

In order to understand how best to meet the sexual health needs of service users, we need to understand the current practice and development needs of the mental health workforce. Therefore, this study aimed to explore the views of mental health staff working in UK NHS mental health services about the sexual health needs of the users of these services, as well as barriers and facilitators to improving sexual health.

## **Method**

The study design was exploratory and qualitative using focus groups as the method of data collection, and was conducted in two mental health provider organisations (NHS Foundation Trusts) in England, one in the north and one in the south of the country.

Mental health professionals (nurses, health care assistants, occupational therapists, social workers and psychiatrists) from both community and inpatient mental health services were invited to participate. In the London site, the deputy Director of Nursing for the Trust (who is also a nurse researcher) and in the Yorkshire site, a Psychiatry Trainee doctor (on research placement at the University of York) distributed an email through internal Trust communications inviting mental health professionals to attend the focus groups. They were informed that the aim of the group was to discuss the sexual health issues which people with serious mental illness experience and explore their routine clinical practice in relation to this. An information leaflet was sent out to those who volunteered to attend and signed consent was obtained at the start of each focus group. NHS research involving staff only does not require NHS Ethical approval, however NHS Research and Development approvals were obtained.

Four one hour facilitated focus groups were conducted. The London based groups were facilitated by the deputy director of nursing and an external nurse researcher and were conducted in May 2015. The Yorkshire based groups, conducted in July 2015, were facilitated by two psychiatrists on academic placement at the University of York under the supervision of the lead researcher for the study (who was the external facilitator of the London groups). None of the facilitators were part of the line management structures for any of the participants. Although one of the facilitators in London was

Deputy Director of Nursing, this role was specifically for building research capacity rather than clinical management. Two sets of groups at each site were undertaken in order to keep each group small enough to facilitate participation by all the attendees. The lead researcher briefed the facilitators of the Yorkshire group but did not share themes that had emerged from the London focus group transcripts so as not to influence their engagement with the participants.

As this was an exploratory study, there wasn't a detailed and specific topic guide for the focus groups. However in all focus groups two key questions were asked:

- What are the sexual health and sexuality needs of people with serious mental illness?
- What do you do in terms of this in your clinical practice?

As the conversation developed the facilitators used communication skills of elaboration, reflection, summarising and probing in order to further to explore issues that emerged in the discussions with the participants.

#### Analysis

The analytical approach to this study was data driven and inductive using thematic analysis (Braun and Clarke, 2006). Each transcript was scrutinised for themes in an iterative process. Texts were labelled with initial thoughts before creating explanatory codes (a basic unit of meaning). Following this stage the data was managed as one source - a list of codes (nodes in NVivo) which consisted of text from the focus groups combined. Coded data were then reviewed for fittingness. For example, data under each code were assessed to ensure they shared the same meaning. If extracts differed in meaning then codes were expanded (or collapsed where similar). Deleting codes was avoided in case they became pertinent further down the process of analysis. Codes with similar properties were grouped into tentative themes which were refined and their boundaries demarcated by further scrutiny of the text. Finally, each theme was defined and named and a thematic map was generated. Initial coding was undertaken by the lead researcher and further refined through discussion between the other researchers.

## Results

Twenty seven staff participated in the groups in total: mental health nurses (n=18), healthcare assistants (n=2), psychiatrists (n=7). No OT or social work staff responded to the initial invite. An average of 6 healthcare professionals participated in each focus group.

Seven main themes were identified: sexual health provision is a complex issue; mental health staff are aware of sexual health needs; current provision regarding sexual health is “neglected”; barriers to sexual health provision; enabling a discussion around sexual health; sexual health provision is a role for mental health professionals; and training needs.

### 1. Sexual health provision is a complex issue:

Sexual health was perceived as something far more complex than other areas of physical health with “conflicting requirements” such as, confidentiality versus safeguarding. Safeguarding related to sexual health was described as “particularly sticky”. Examples included difficulty intervening appropriately in cases where service users were being exploited by someone who is also identified as providing them with support and supporting a young female who was having unprotected sex with multiple partners who she met on the internet. Participants described difficulties differentiating safeguarding issues from acceptable lifestyle choices. For example;

*“There's something in our training, in our experience, our social expectations.  
(Pause) and I think when people bring dilemmas about relationships and their sex  
lives to team meetings, I think sometimes they're the most difficult discussions,  
cos it's, you know, it, it might, on the face of it, be a very bad relationship, but is it  
really for us to say? It's very awkward. It's, it's a dilemma, I know, on inpatient  
units, but perhaps even more so in the community where, you know, the duty of  
care is less apparent and more distant, but actually still exists.” Participant 6,  
group 1, female*

Procedures around safeguarding were unclear in this area, especially where HIV status was unknown. Further complexities included “what gets shared”; service users receiving a confidential service at a sexual health clinic or GP was paramount yet uncertainty around information sharing between primary care and secondary care staff was evident. Implications of failure to share information between clinical services were highlighted; for example, the risk of prescribing teratogenic medications to pregnant women due to failure to share information about pregnancy:

*“We found out that one of our community patients was pregnant and she'd seen the GP a fortnight beforehand and we only found out cos we'd rung the GP to query something completely unrelated, and he said “[and by] the way, did you realise that this person's pregnant?” And then we're in the dilemma of, you know, in that first trimester we've got a high dose of antipsychotic, and it would have been good to have known from the GP straight off, cos there's all the safeguarding issues and so on to talk about.” Participant 8, group 1, female*

Paradoxically, there was a sense that planning sexual health care for service users and more complex needs was more familiar and comfortable than general prevention and promotion. For example, experience of supporting sexual health needs of people with known sexual offences and learning disabilities were described. The following excerpt, in addition to sexual stigma, captures an ethos of risk management as opposed to prevention and promotion, which might go some way to explaining the paradox:

*“It's a real bad bias, and it's a stereotype, but if you had a, a young gay man you'd probably be more alive to it [sexual health care] than if you had a young person, another young person” participant, 2, group 4, female*

## 2. Mental health staff are aware of sexual health needs

The participants were aware of a range of sexual health needs present in people who used mental health services. These clustered around high risk sexual behaviours such as the use of sex workers; and having condomless sex with multiple partners, as well as other factors that could impinge on satisfaction and expression of sexuality such as sexual dysfunction, loneliness (not being able to obtain a sexual relationship) and impact of childhood sexual abuse. Illness related issues such as sexual disinhibition (including public nudity and masturbation) were also mentioned. Participants recognised that the majority of service users are sexually active, and perceived that their sexual behaviour and sexual expression was risky and / or problematic.

*“Issues of either disinhibition due to mania or impulsivity and maladaptive or self-defeating coping behaviours resulting in unprotected sex, STIs, unplanned pregnancy, particularly significant in people who are given mood stabilisers”*

*Participant 1, group 2, male*

*“I think a lot of the Ladies who are recurrently in and out of hospital, have chaotic sexual partners and there’s often associated drug use.” Participant 2, group 2, female*

## 3. Current provision regarding sexual health is “neglected”

Although the groups acknowledged an increasing awareness of the need for sexual health provision, the current provision was described as “sketchy”, “variable” and “neglected”. Sexual health was rarely addressed in years of clinical practice. Reasons included it being less of a priority compared with other areas of physical and mental health, and less risk due to common complaints of loneliness.

*“I’ve been doing some work around that recently with practice nurses; but within that it’s, yeah, I mean it’s, sexual health is, again, neglected, isn’t it, really? Because we are focusing more on physical health but we’re still not addressing people’s sexual health. So I think it’s an area really that, and I think most nurses*

*are increasingly being aware that it's something that we need to address"*

*participant 1, group 4, female*

One participant felt that they were "neglectful" in terms of attending to sexual health

*"I think we're quite neglectful to be honest" participant 2, group 4, female*

One participant explained why sexual health, compared with other physical health related issues, was less of a priority:

*"it's in the top five, for me, along with like dentistry, smoking, obesity, I don't know, sedentary lifestyles and sexual health, the only thing that keeps it from, I think it's probably at the bottom end of that top five only because people are generally very isolated, a lot of our patients are very isolated and have very poor quality sexual lives. Working within the community, you know, it's, a very common recurring complaint is loneliness, lack of, you know, intimate relationships in general, which, which sexual life is, is a component of .... so from a service side of things, you know, that's, that's not as concerning to us as sort of an unfulfilled thing, so it's only cos it's not dangerous" participant 1, group 3, male*

Similar views, in terms of perception of risk, were expressed by another participant:

*"Because some of the treatments we give people affect sexual wellbeing, I wonder whether it's something we ignore a bit" participant 6, group 1, female*

Other participants also felt compared with mental health issues, addressing sexual health was less of a priority;

*"We don't see them [sexual health issues] as top of the list. We try to sort out other things" participant 7, group 2, male*

*“Where I know I don’t ask the questions is where someone is referred with, you know a straight forward psychiatric illness such as severe depression or OCD and I am aware that I don’t ask the questions about sexual health at that time, and I think I do it because other things seem to be more of a priority at the time”*  
*participant 2, group 2, female*

#### 4. Barriers to sexual health provision

Participants identified multiple issues that act as obstacles to asking and intervening about sexual health. These were mainly around organisational and personal issues, followed by issues related to mis-match of culture, gender, and age between the staff and service users, as well as the quality of the therapeutic alliance. Organisational obstacles included: accessing sexual health services (i.e. genital urinary medicine; GUM). Participants mentioned that a lack of local ‘drop in services’ made them less flexible for service users, who may have difficulties attending specific appointments and/ following up a referral. Sexual health provision within mental health services was reported as limited. They reported difficulties accessing contraception for service users (e.g. condoms were not available to be given out to service users), a lack of staff trained in phlebotomy (to offer blood tests for blood borne viruses), obtaining blood results (often testing took place off site and results posted back), and inconsistent access to pregnancy testing. One area of specific concern was raised in the Yorkshire focus group (which contained staff who prescribed medication) which related to whether they routinely checked if there was a possibility of pregnancy prior to prescribing psychotropic medication. There was conflicting practice on this issue with one prescriber reporting always checking this out and another who said they didn’t (but saw that this was important)

*“I would always routinely ask if I was going to prescribe any psychotropic medication about whether someone’s planning a family”* participant 2, group 2,  
*female*

*“No it certainly isn’t something I ask routinely, It probably is something that I should (pause)...because even the less toxic medications that we prescribe, it’s*

probably worth knowing whether somebody is at risk or planning or thinking about the possibility of falling pregnant.” *Participant 1, group 2, male*

Risk issues seemed to be most likely to trigger staff into action in relation to sexual health is risk issues. The decision to broach the topic largely depended on whether they perceived the person as being “high risk” such as injecting drug use, engaged in sex work or known to have a blood borne virus. With these service users, they did access external services for support and treatment.

Staff -related barriers were centred on feeling they had limited knowledge and varied confidence and skills in sexual health. They reported rarely initiating conversation around sexual health. Such discussions were felt to be unfamiliar and “outside normal practice”:

*“this is outside normal practice, so, for both parties, so from the staff member’s point of view, if this person’s not used to being asked this, or it isn’t something that is routinely asked and I’m, you know, no-one wants to go out on a limb with anything or no-one wants to sort of be doing something that deviates from the norm, so if it’s not routine, if it doesn’t form part of routine questioning to be questioning somebody about an intimate part of their life, you know, out, outside of the framework of what I’m supposed to do during my assessment makes you feel uncomfortable, like, you know, you’re untested waters, you know”*

*Participant 1, group 3, male*

They felt it was “easy to avoid” and one participant described “brushing over” the topic in a consultation and hoping to themselves that the person would not express any needs in that area; in their heads thinking “please don’t say anything that might be complicated”. They felt that sexual issues were outside their scope of usual practice and there was some anxiety expressed about the reaction they might get from the service user if they did ask questions about sexual health. For example:

*“I think I would worry that the patient would think, well why is she asking me this, it’s not got anything to do with my mental health problem.” Participant 4, group 2, female*

*Some patients are gonna react badly to it as well, they’re like, well I’m here for my mental health (...) why are you asking me about that, you know” Participant 2, group 3, female*

Participants felt that asking about sexual health was intrusive and, potentially damaging to therapeutic alliance, and beyond their remit as mental health professionals. There was also some discussion about how the demographics of the staff and the service user matched (or not) and how this may affect the way the questions were asked and received. This included differences in age, gender, sexuality and culture between the staff member and the service user. The following excerpt captures the sensitivity demonstrated by a male worker to the potential impact of such a discussion being initiated by him with a female service user:

*“perhaps, you know, females and, you know, that’s something that perhaps, if, in case they have experienced, you know, trauma and abuse when they was younger or, and it was a male, but I suppose equally men suffers from abuse as well; so maybe it is a gender thing and it’s something that I, I’m just aware of, you know” participant 3, group 3, male*

Similarly, the following excerpt captures how one psychiatrist observed an apparent unease between male staff and female service users when discussing sexual issues:

*“Maybe it is gender specific then, because on the ward where we work with women, I’ve known males ....sort of like brush over the question...., and like the*

*females on the ward feel more comfortable talking to the female members of staff about that “ participant 3, group 1 female*

The general unease expressed by most participants was exemplified by one participant who said she felt like a “fish out of water” and another who described assessing sexual health as being like “opening a can of worms”. Participants were also concerned about the potential for causing distress to a vulnerable person when asking about sexual health.

#### 5. Enabling a discussion around sexual health

In the focus groups, the facilitators asked what could help staff in asking about sexual health. Two inter-related solutions were identified. It has already been identified that sexual health is not seen as a core part of routine enquiry in mental health so a solution that was posed by the participants was to ensure that at an organisational level sexual health promotion was seen as routine and therefore “legitimised” discussions around sexual health. This could include routine health screening, assessing for sexual side effects to psychotropic medication and routine assessments. Staff felt they needed “permission” to assess sexual health:

*“We give health information and promotion advice on a whole load of things don’t we? But we don’t really on sexual health; and in a way we kind of, I don’t know, need permission to do that” Participant 1, group 4, female*

Use of tools such as The Manchester Short Assessment (MANSA) and the Beck Depression Inventory were identified by the participants as legitimate (and perhaps easier) ways of asking about relationships, sex life and interest in sex than a less structured discussion. Participants felt that having some sort of pro-forma would give them the “right to ask the question, or feel enabled, because, you know, the form says”.

*“I think if there was a proforma there and you had to do it then you, I’d be more than happy to do it” Participant 3, group 3, male*

As well as tools to support conversations about sex, other suggestions included advocacy roles such as facilitating and accompanying service users to their GP or sexual health clinic (rather than signposting) were identified as potentially valuable.

They also talked about the need to have a “sexual health champion” at a senior level in the organisation to drive the sexual health agenda. They also suggested that if completion of sexual health assessments was a target and part of the commissioning contract then there would be more compliance with this.

#### 6. Sexual health provision is a role for mental health professionals

Although all participants recognised they had a role in sexual health provision, the role of mental health nurses was specifically highlighted. Nurses felt that sexual health could be a legitimate part of mental health nursing.

*“There’s definitely a role for us as nurses around sexual health with our clients”  
[service users] participant 1, group 4, female*

The role of mental health nurses was compared to the practice nurse; with the former being perceived as multi-faceted e.g. “We [nurses] wear different hats” and less judgemental due to familiarity with “the chaos” of the life of a service user. Aside from the ethos of risk management, delivery of care by mental health nurses was described as holistic therefore could encompass sexual health.

*“We’re mental health nurses, but we look after them as well, holistically, we also, you know, sort of, we help them with the benefits, we also, you know, we’re different people in one aren’t we?” participant 4, group 4, female*

Implications of poor sexual health and the impact on a person’s mental health were acknowledged. Participants in both groups described mental health nurses being skilled at asking about areas of life that are not comfortable such as suicide, self-harm and experiences of sexual abuse.

*“Actually it is something that we need to address, because it does affect a lot of other sort of things about the person’s care. Remember we talked about, initially, safety, the young person’s safety, their physical health and then relationships, and then sort of their future, the children. So yeah, I think you, you know, it’s really important for us to address it, cos it’s not just sexual health, it’s sexual and other things around that person” Participant 4, group 4, female*

However, as reported previously, participants wondered if service users may not feel it appropriate to discuss their sexual health with their mental health professional, especially if it was someone involved in their care long term. Changing perceptions was therefore *seen* as key to opening a dialogue between service users and their mental health workers.

#### 7. Training needs

It was suggested that it would be important that sexual health was included in the pre-registration Nursing Degree curriculum and afterwards should be addressed as part of post-qualification professional development for all staff groups.

*“The stuff we cover now is diabetes, you know, bit of coronary heart disease if we, you know, we don’t, there’s no sexual health content actually in any of the post-qualification stuff that we do” participant 1, group 3, male*

Specific areas for training were suggested and these included physical and psychosocial aspects of sexual health e.g. knowledge of STIs (symptoms, treatment and transmission);

*“Chlamydia we all know a bit about, I suppose, through the public campaigns and teenage girls and the virus and vaccinations, but, to be honest, I wouldn’t have a clue” Participant 3, group 4, female*

high risk behaviours, knowledge of local service provision, and skills to encourage and support service users to improve the quality of their intimate sexual relationships (through the use of social skills training, advocacy and tackling mental health stigma).

*“How do you enter into a sexual relationship with someone, cos a lot of our people wouldn’t have the skills to do that; and is, is it harder for us, as mental health nurses, to engage with that type of need than it is to manage who’s high level risk? Which is more challenging; and do we need training in both?”  
Participant 2, group 4, female*

## **Discussion**

Service users have significant unmet needs in terms of sexual health, and the evidence suggests this is not being addressed (Hughes et al., 2016; Gascoyne et al., 2016; Quinn and Happell, 2015a). Little is known about current practice from the perspective of mental health staff, although research indicates that sexual health is an area that is overlooked and ignored, and that there is genuine concern about raising the topic for fear of causing embarrassment and potential distress (Quinn et al., 2011). In order to understand the perspective of staff working in NHS services in the UK, we undertook the four focus groups described above.

Overall we found that participants were aware of issues related to sexual health and sexual relationships for service users but this is mainly viewed through the lens of risk management and safeguarding. This was also observed in Quinn's study where the behaviour of mental health nurses towards sexual relationships and sexual health were strongly influenced by the need to avoid any possible risks (Quinn and Happell, 2015b). The language used in the focus groups suggests that this is perceived as a difficult and challenging area of care which leads to it being avoided, which also concurs with Quinn's findings (2011).

In our study participants expressed worries about causing distress and embarrassment, concerns about own lack of knowledge and the subsequent lack of confidence in managing this (i.e. not wanting to "open a can of worms"). Avoiding sexual health in the guise of protecting the person from distress or embarrassment or from a seemingly unsolvable sexual health concern is not an uncommon finding (Krebs and Marrs, 2006; French, 2010; Shell, 2007). In addition to these internal issues, there are clear challenges on a practical level within mental health services such as a lack of availability of condoms, limited STI testing, pregnancy testing, and lack of an organisational buy in to sexual health assessment (structural issues). This issue has already been identified by a previous study (Hughes and Gray, 2009). There was also concern expressed that there was a general lack of information about local sexual health service provision and pathways into these for their service users.

Whilst they expressed significant reservations about their current skills and confidence in sexual health, they also recognised that there could be an opportunity to engage more with the sexual health of service users. Certainly as the conversations evolved, there was a sense that as a mental health professional working often for many months or years with some of the service users on their caseloads (in the community) that they have a good rapport and therefore could use that therapeutic relationship to start broaching the topic. Quinn was able to demonstrate that after sexual health "desensitisation" training that mental health nurses were able to comfortably conduct conversations about sexual health (Quinn et al., 2013).

The findings of focus groups in two different sites in England confirm that mental health staff are aware of these needs, but are unsure what their role is and lack confidence and knowledge to proactively address this in routine care. Therefore two areas to explore further would be:

- a) How to improve access to sexual health services - either through in-house or mainstream provision
- b) What organisational and training interventions could be effective in improving staff knowledge, confidence and skills in talking to service users about sexual health and whether these would increase the inclusion of sexual health into routine mental health care

In terms of the latter, Quinn (2013) indicated that training can increase the likelihood of mental health staff engaging in sexual health dialogue. However, this was a small qualitative study. Further evidence of the effectiveness of training in changing behaviour in practice is needed through controlled trials, and using objective measures of sexual health practice.

#### Study limitations

This was a qualitative study involving a group of mental health staff who volunteered to participate. The findings should therefore be interpreted with caution as they may not represent the views of the wider mental health workforce. However, the themes that arose from two geographically distanced mental health NHS Trusts were very similar and certainly data saturation was reached with the four focus groups. In addition, the themes that emerged concurred with Quinn's study in Australia, suggesting common themes have been identified. However, again there needs to be some caution with this as the facilitators based their focus group on Quinn's work and therefore could have influenced the themes that emerged. A further limitation is that this study lacks the perspective of service users especially in terms of talking about sexual health with their mental health workers.

#### **Conclusion**

Service users have significant and unmet needs regarding sexual health. This study adds to the evidence that sexual health is a topic that is not addressed routinely by mental health staff. There are significant interpersonal and organisational barriers that need to be addressed in order to address this health inequality.

**Implications:**

Mental health services are in a key position to promote sexual health as part of the wider initiative to improve physical health for service users.

**Relevance for Clinical Practice**

Mental health staff in focus groups reported significant sexual health needs for service users, however they also reported that they would not broach the subject routinely unless there was an area of significant risk raised. Key barriers to asking about sexual health were lack of knowledge about the topic and concerns about causing distress and embarrassment. However, participants also felt that they were in a prime position to offer support around sexual health as part of the wider initiative to improve physical health for service users, but they would require help to overcome the interpersonal and organisational barriers identified.

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