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HCA's' views on sexual health in people with severe mental illness



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Key points

The sexual health of people with severe mental illness is neglected and under-researched

Sexual health should be part of holistic patient assessment in mental health

Healthcare assistants (HCAs) are often the staff members who spend the most time with patients on mental health wards

Training would improve HCAs' confidence to broach sexual health issues with patients

Involving HCAs in assessments and decision making could enhance holistic care

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Abstract Existing research on the sexual health needs of people with severe mental illness is limited and focuses on the views of mental health nurses. The views of healthcare assistants, who are often the staff members who spend the most time with patients, are rarely sought. A small-scale qualitative study has investigated their views on the sexual health needs of people with severe mental illness on mental health wards at Leeds and York Partnership Foundation Trust. Participants reported feelings of embarrassment and a lack of knowledge. Sexual health was not assessed or addressed in a systematic way. Improving healthcare assistants' training and integrating them into decision making could help to meet the sexual health needs of service users and provide truly holistic care.

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People with severe mental illness (SMI) have been shown to be at higher risk of developing physical health problems than the general population (Davies, 2014); they also die, on average, 20 years earlier – mostly from preventable physical health problems (Chang et al, 2011). While the assessment of their physical health is improving, their sexual health is often neglected (Hughes et al, 2016). Much less is known about the sexual health of people with SMI than about the sexual health of the general population. Box 1 features a definition of sexual health.

On mental health wards, healthcare assistants (HCAs) are often the staff members who spend the most time with patients, delivering a range of therapeutic activities and carrying out tasks relating to care plans. They are, therefore, well placed to make observations about patient care and patients' needs (Torjesen, 2009). However, this group within the NHS workforce

is generally not listened to and tends to be under-represented in research.

To help address these problems, I conducted a study investigating the views of HCAs on the sexual health needs of people with SMI on mental health inpatient wards.

Background

In 2017, there were more than 420,000 diagnoses of STIs made in England (Public Health England, 2018). Evidence suggests the prevalence of sexually transmitted blood-borne viruses (BBVs), such as HIV and the hepatitis B virus, is higher in people with SMI (Hughes et al, 2016) and that people with SMI are at increased risk of contracting sexually transmitted infections (STIs) (Hughes and Gray, 2009).

Evidence also suggests the prevalence of domestic abuse and sexual violence against people with SMI is higher than in the general population (Khalifeh et al, 2015). Furthermore, psychiatric medication has been

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Box 1. What is sexual health?

Sexual health is a broad term. The World Health Organization (2006) defines it holistically as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”, adding that it “requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence”.

In that sense, sexual health revolves around the enhancement of people's lives and relationships, rather than simply being an absence of disease. It therefore concerns itself with a wide range of issues, including relationships, sexual dysfunction, sexual violence, unintended pregnancy and sexually transmitted infections.

found to have sexual side-effects (Montejo et al, 2010), potentially leading to sexual dysfunction (Chernomas et al, 2000).

The Five Year Forward View for Mental Health (Mental Health Taskforce, 2016) called for an integrated mental and physical health approach, whereby people with SMI are offered screening and prevention regarding all aspects of their health and wellbeing. *A Framework for Sexual Health Improvement for England* (Department of Health, 2013) recommended that sexual health should be linked to other determinants of health, such as mental health.

Literature review

As part of the study, I searched the literature for papers on the attitudes, experiences and views of health professionals in relation to the sexual health needs of people with SMI. A search on Medline, PsycInfo, EMBASE and CINAHL produced 41 papers, of which five were included in the review. Another 11 papers, identified via Google searches or general reading of the literature, were also included so the literature review was based on 16 sources.

The review showed that the sexual health of people with SMI has received limited attention so far. Existing research focuses on the views of mental health nurses, as opposed to those of the wider mental health workforce. Many mental health nurses feel that, while it is their responsibility to discuss sexual concerns with service users, it is not part of the current holistic assessment. A number of

barriers, such as embarrassment and anxiety, hinder nurses' ability to address sexual health issues. Some nurses also question whether enquiring about sexual health is part of their role (Quinn et al, 2011; Cort et al, 2001).

Qualitative study

The research took the form of a non-experimental qualitative study involving face-to-face interviews with HCAs working at Leeds and York Partnership Foundation Trust. The trust provides specialist mental health and learning disability services in Leeds and across York, the Yorkshire and Humber region.

A convenience sample of five HCAs was recruited from 59 potential participants on mental health inpatient wards at two sites. Participants were recruited via posters displayed in staff rooms, ward staff meetings, and emails circulated to HCAs by ward administrators.

Ethical approval was obtained from the School of Health and Related Research at the University of Sheffield and the study was registered locally via the Integrated Research Application System. As the study involved NHS employees, approval from the Health Research Authority was also obtained.

The interviews were structured through use of a topic guide and took place on trust premises between April and May 2017. Participants were asked about their understanding of the term 'sexual health' and their experiences regarding the sexual health of patients with SMI. The interviews were transcribed verbatim and analysed using the framework approach (Box 2).

Nine themes emerged and were grouped into four core themes:

- Acute inpatient environment;
- Barriers;
- HCAs' roles, standards and competencies;
- Improving the situation.

Outcomes

Acute inpatient environment

Four participants could not give a clear definition of sexual health, instead citing examples of sexual health issues they had encountered in service users:

“Sexual health is like, er, if they have got diseases like STIs and, urm, STIs and chlamydia and all that.”
(Participant B)

Sexual health was often viewed either as the absence of disease or as risky behaviour. Risky behaviour was often attributed to

service users being either unwell or under the influence of substances; 'risky relationships' were also referred to:

“I suppose it's, it's not saying that mental health patients aren't having sex and loving relationships and things like that, but there is, as in the general population, there is promiscuity, you know. There are people having quite risky relationships.” (Participant E)

Participants reported a general resistance from service users to discuss sexual health issues; this appeared to stem from embarrassment. Participant E also talked about sexual health being a private matter and said that, by talking about it:

“We might be sort of being busy bodies, sort of interfering”.

Reluctance of this sort was something mentioned as a worrying factor by participant D, who was concerned that sexual health issues may:

“Go completely under the radar”.

Participants talked about the nature of SMI and the effects it can have on people's ability to make informed and reasoned decisions, especially those who have bipolar disorder or psychosis:

“When you [are in a manic phase], you are a movie star, and you might think they [the other patients] want to have sex with everyone.” (Participant C)

Participants spoke about having to deal daily with a range of sexual health issues. A common experience was service users' lack of sexual inhibition, which meant inappropriate sexual language and behaviour were commonplace on the wards:

*“Well, today for instance, I've been called a f***** slag and [told] go f**** yourself and go f**** a dog.”*
(Participant A)

Box 2. Framework approach

The framework approach, outlined by Braun and Clarke (2006) is a systematic approach that strengthens the rigour of research by adding a level of transparency and allowing people to 'see' the researcher's thought process. A coding matrix is formed through a continuous process of reflection on the collected data. Revisiting participants' accounts ensures there is a connection between the data and the coding matrix.

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Barriers

Participants generally felt comfortable talking with service users about sexual health, but were more comfortable if the discussion was initiated by the service user. They were anxious about initiating discussions for fear of causing embarrassment:

"There's always [pause] potential for awkwardness, feeling of discomfort, feelings of inadequacy, you know, that sort of thing." (Participant E)

HCA's were also anxious about raising the issue of sexual health if there seemed to be more pressing issues that needed to be addressed.

There also appeared to be a sense that, in the wider society, there is a stigma around sexual health similar to the stigma around mental health:

"I think sometimes, with staff [pause], it's more of a personal conversation, like when you talk a lot about their mental health issues, and in that environment, especially in the acute environment, that's not a taboo conversation. Whereas if you talked to someone in the street and talk to them about their mental health, they'd probably walk away from you." (Participant E)

Two of the participants were student mental health nurses who worked as HCAs on the bank and a third was a bank HCA. These participants brought a unique perspective. Bank staff said they never really got involved in patients' long-term care because they were constantly moving between wards, which meant they did not get to know patients enough to discuss their sexual health:

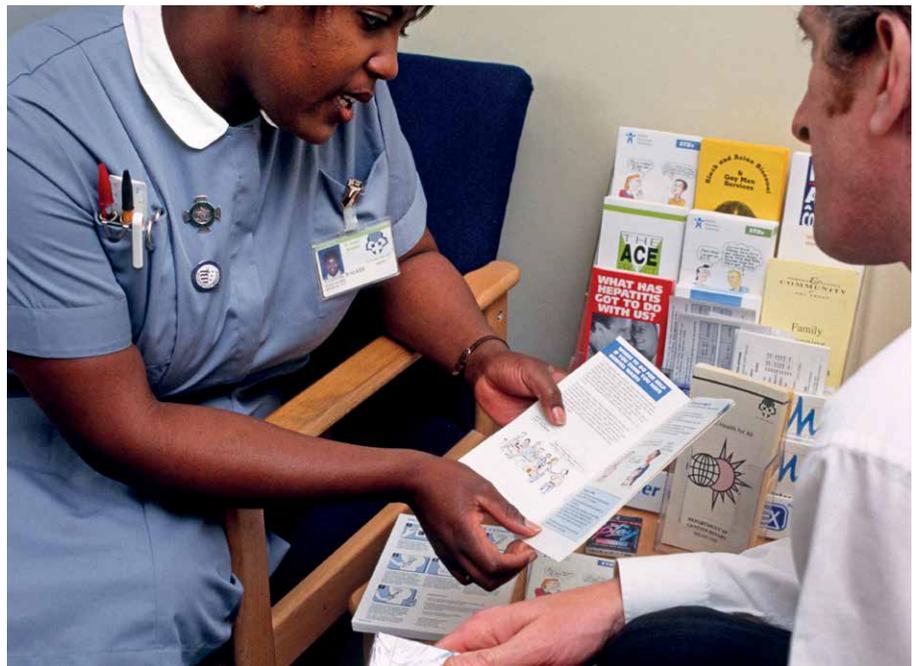
"I guess for me, because I work for the bank, [...] I don't really ever really get involved in someone's long-term care so [pause], er, it can be difficult." (Participant D)

HCAs' roles, standards and competencies

Participants talked about their position within a hierarchical staff structure. Many assumed the sexual health needs of service users were being dealt with by qualified nurses or medical staff:

"I don't go in [patient] reviews. I don't have much to do with doctors' side of it." (Participant C)

Participants mentioned their responsibility to report any medical or risk-related issues to a nurse or doctor, and document



HCAs are well placed to discuss sexual health with people who have severe mental illness

conversations and incidents on electronic recording systems. They appeared to work in isolation from, rather than as part of, the multidisciplinary team (MDT), especially when it came to sexual health:

"I am not in the doctor's review all the time so maybe I miss it, but I don't know. I still feel it is not fully addressed, 'cos there have been a lot of MDT [meetings] where the patients are started on new medications and [...] the side-effects and stuff are not really talked about in a lot detail." (Participant D)

Participants reported not wanting to expose service users to situations that might involve sex and sexuality, and feeling protective towards them. Participant A recounted escorting a service user to a sexual health clinic and explained:

"Sometimes you have to be wary of what [the] context your conversation is when you're out. It's a free country, but we're there to look after and to protect [patients] and make sure that [they're] alright."

Participants valued the therapeutic relationship between themselves and service users, and the importance of listening and talking to patients about their mental and physical health. However, sexual health was not always recognised as an integral part of patients' wellbeing and was seen as a potentially embarrassing subject [insert 'for the patient' as previously you've

said HCAs felt comfortable talking about sexual health and it was patients who were embarrassed] and, therefore, avoided. Sexualised language or behaviour were often considered to be due to a patient's illness.

Improving the situation

Participants felt they needed training to improve their understanding of sexual health topics:

"The main thing is getting staff's confidence in their knowledge about it up to a level where they feel comfortable discussing it." (Participant D)

They spoke about incorporating a basic level of sexual health training into mandatory education. Several participants talked about having support from someone with specialist knowledge about sexual health and one mentioned the possibility of receiving support from a specialist sexual health nurse:

"Maybe just one that floats around, do you know what I mean, er, that you could just refer to." (Participant D)

Participants suggested sexual health assessments should be part of the admission process. They questioned why sexual health histories were not taken on admission, especially as many service users were vulnerable to problems such as sexual exploitation and abuse:

"I feel like maybe we could be doing urine samples when people, patients,

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get admitted, just to test for things like chlamydia” (Participant E)

Discussion

To the best of my knowledge, this study exploring HCAs’ views on the sexual health of people with SMI was the first of its kind. There is a limited body of research on sexual health in mental health settings, with most of the literature focusing on the experiences and views of mental health nurses.

Acute inpatient environment

Participants explained that the sexual health of patients was not routinely assessed, whether by themselves or others. This mirrors the findings of Cole (2000) and Quinn et al (2011). Although professionals are now required to complete physical health checks of people with SMI, there is no such requirement regarding sexual health specifically. The Nursing and Midwifery Council’s code of practice recommends that nurses ensure people’s physical, social and psychological needs are assessed and addressed (NMC, 2018); however, assessing people’s sexual health needs is not yet standard practice.

Staff working on mental health inpatient wards are primarily mental health staff who have limited training in physical health. This lack of training and knowledge, along with working in a busy and often challenging environment, may help explain why study participants viewed sexual health as the absence of either disease or risky behaviour. Higgins et al (2008) described a metaphorical ‘veil of silence’ around sexual health issues. Such a phenomenon may also partly explain why HCAs could consider sexual health to be someone else’s responsibility, something out of their scope of practice.

Participants routinely had to deal with sexualised behaviour and language. Their response tended to be reactive and the issue was not addressed in a systematic way. They often waited for service users to raise sexual health issues themselves – this is concerning, as it suggests there is a lack of leadership or ownership in the assessment of sexual health in people with SMI, and that their sexual health needs are, therefore, left unmet.

People with SMI are at increased risk of contracting STIs and of being exposed to sexual abuse and violence (Hughes et al, 2016; Hughes and Gray, 2009), it could be argued that integrating sexual health into their assessment and care is even more important than in general hospital

settings. Regular screening of those engaged in high-risk sexual behaviours would also be good practice.

HCAs have a role to play in gathering this type of information. They often have built a good rapport with service users so are able to ask them difficult questions and broach difficult subjects. Including HCAs in the assessment process would ensure a collective approach, rather than it being the sole domain of one professional group.

“Service users’ sexual and relationship histories are important but there are many barriers that prevent them from being discussed”

Issues relating to the sexual health of people with SMI are regularly raised on acute mental health inpatient wards, and HCAs are often the people who have to react and deal with these issues. Study participants commonly experienced inappropriate sexualised behaviours and language from service users, which they thought stemmed from people being mentally unwell or from side-effects of psychiatric medication. These sexualised behaviours and language can cause embarrassment and discomfort to HCAs.

Adult patients in mental health settings are often stereotyped and either ‘over-sexed’ or ‘under-sexed’ (Gascoyne et al, 2016). Sometimes sexual desire or sexual behaviour are misinterpreted as symptoms of mental illness and dismissed as such. HCAs may need the support of a clinical supervisor who would, in a safe and confidential environment, identify their training needs and share with them knowledge and good practice on how to deal with sexual health issues.

Barriers

The study found a number of barriers in addressing the sexual health needs of people with SMI. This is perhaps unsurprising, as previous research (Quinn et al, 2011; Hughes and Gray, 2009; Higgins et al 2008; Cort et al, 2001) found similar barriers among mental health nurses. While participants generally appeared to feel comfortable talking about sexual health, there was also often a reluctance to broach the subject with patients. This reluctance appeared to be due to participants’ limited knowledge of sexual health issues, limited

experience in dealing with them, and subsequent lack of confidence in talking about sex and sexuality.

Studies have shown that training can improve the practice and attitudes of staff towards addressing the sexual health needs of service users (Saunamäki et al, 2010). Training staff and encouraging them to explore their own attitudes and values regarding sex and sexuality could help to address the reported lack of confidence and embarrassment.

Participants’ views and experiences reported in this study may raise questions as to whether patients with SMI are receiving truly holistic and person-centred care. According to Quinn and Browne (2009), service users’ sexual and relationship histories are important aspects of their history. However, this study shows there are many barriers that prevent these aspects of patients’ histories from being discussed. Mental health nurses and HCAs are in an excellent position to discuss and respond to sexual health concerns; however, if registered professionals are not taking the lead, HCAs are unlikely to follow.

Bank staff’s work patterns meant they were unable to provide continuity of care or build therapeutic relationships with service users. This shows that a reliance on bank staff to supplement teams has negative implications for the quality and consistency of care. Managers need to ensure not only that there are adequate staffing levels, but also that there are staff who are familiar with service users; this may be particularly challenging given the current financial restraints and workforce issues.

HCA role, standards and competencies

Participants often appeared to work in isolation from the MDT, which mainly consisted of nurses, doctors and consultants. They reported not attending patient review meetings and simply passing on information to nurses or updating electronic records. Participants gave examples of forwarding issues relating to sexual health but were not informed about whether these issues were being addressed. This has worrying implications, because it seems to indicate that there is a lack of communication and leadership around addressing the sexual health needs of service users. It also raises questions about how HCAs are integrated into ward teams and whether the value they offer is recognised.

Kessler et al (2010) found that trusts often use HCAs in relief or substitution roles (that is, relieving nurses of much of the direct and indirect patient care), often

with ambiguous role boundaries. HCAs need to be fully included in the running of a ward, as they are its 'eyes and ears'. They often have distinct qualities, and may also have very rich experiences that can enhance patient care and patient experience. One study participant had worked with survivors of domestic abuse and sexual violence, but that experience was often not used.

Improving the situation

All participants agreed that additional training in sexual health was needed to increase the knowledge base of all staff members and raise the profile of sexual health in the trust. Apart from mandatory training, HCAs are often offered fewer training opportunities than registered staff (Kessler et al, 2010). At present, non-registered staff who do not have formal health and social care qualifications are required to complete the care certificate, which covers a range of healthcare topics but not sexual health.

Participants expressed an interest in improving their knowledge on topics such as STIs and contraception. Training and e-learning on these elements of care should be available to HCAs and other staff groups, while issues such as sexual abuse, sexual exploitation and sexualised behaviours should be expanded in the current mandatory safeguarding training.

Quinn et al (2013) recommended that sexual health be included in clinical skills training. Studies have shown that training and enhancing knowledge can improve staff's practice and attitudes towards the sexual health of service users (Saunamäki et al, 2010).

Limitations

The findings need to be considered in the context of the study's methodological limitations. This study was small and the findings are specific to the study sites. Some diversity in the sample was achieved by including participants from male and female inpatient wards and participants with different levels of experience but future research would benefit from recruiting more participants to ensure that views fully represent the diversity of the wider workforce.

The opt-in recruitment process would have been likely to attract HCAs who had an interest in, or experience of participating in, research or an interest in the topic area. The presence of bank staff and student nurses among participants means the study may not be fully representative of the views and experiences of permanent HCAs on mental health inpatient wards.

"Healthcare assistants need to be fully included in the running of a ward, as they are its 'eyes and ears'"

Conclusion

Increasing attention is being paid to the physical health of people with SMI, but their sexual health appears to be neglected. This study shows that tackling the sexual health needs of people with SMI on inpatient wards is complex and challenging. It found a number of barriers preventing HCAs from addressing the sexual health needs of patients and that sexual health needs were not addressed in a coordinated or systematic way. This could threaten to undermine holistic, person-centred care.

Sexual health should be routinely assessed as part of holistic assessments in mental health. HCAs can play a role in this, as it tends to be they who deliver most therapeutic interventions and so have a thorough understanding of service users' needs. Improved sexual health training and integration of HCAs in reviews and decision making on the ward could enhance the holistic assessment of service users. **NT**

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