Title page

Title

Understanding the current sexual health service provision for mental health consumers by nurses in mental health settings: Findings from A Survey in Australia and England

Running head

Sexual health service provision for mental health consumers by nurses in mental health settings

Author information

Chris Quinn

RN, DAS (Nurs), Cert PN, Grad Dip (MHN), PhD,

Clinical Nurse Consultant, Nursing and Practice Development Unit, Forensicare

Adjunct Associate Professor, Synergy, University of Canberra

Chris Platania-Phung

Christopher Bale

Brenda Happell

Elizabeth Hughes

Author correspondence

Chris Quinn

Thomas Embling Hospital

Yarra Bend Road Fairfield, Victoria, Australia, 3078

T +61 3 94959100 | F +61 3 94959199

M +61 0423820487

Chris.quinn@forensicare.vic.gov.au

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/INM.12452](https://doi.org/10.1111/INM.12452)

This article is protected by copyright. All rights reserved

This study was part funded in the UK by National Institute for Health Research Collaboration for Leadership in Applied Health Research- Yorkshire and Humber

Author Manuscript

Article type : Original Article

Title

Understanding the current sexual health service provision for mental health consumers by nurses in mental health settings: Findings from Australia and England

Abstract

Background: Nurses in mental health settings avoid talking to consumers about sexual health concerns. It is unclear whether this avoidance prevents the provision of sexual health care. **Objectives:** To gather information about how mental health nurses respond to sexual health issues within their routine practice, what issues they address, and their view on their role in promoting sexual health for consumers. **Design:** A cross sectional study using an electronic survey questionnaire. **Settings:** The study occurred in four National Health Service Trusts in England and a national call for participants in Australia. **Participants:** Participants were nurse clinicians (n=303) who self-selected by completing surveys available via email and newsletters containing links to the survey. **Methods:** This is a cross sectional study consisting of an electronic survey questionnaire originally generated from a previous study in the United Kingdom. **Results:** Mental health nurses do not routinely include sexual health in their practice, are poorly prepared in knowing what to do with a sexual health issue, and what services to assist consumers to use. **Conclusions:** In conclusion, it has been well established in the literature that mental health consumers experience high sexual health needs that potentially impact on health and recovery. Mental health nurses are ideally placed to promote sexual health and refer consumers to sexual health and family planning services. Training to improve the confidence and responsiveness of mental health nurses to sexual health is an urgent need.

Key words

Background

There is a growing body of evidence that nurses (Kolbe et al., 2016, Nakopoulou et al., 2009), and in particular, nurses working in mental health settings, avoid talking to mental health consumers about sexual health concerns (McCann, 2010, Östman, 2008, Quinn et al., 2011)(plus reference where Authors names suppressed for anonymity, 2017). It is unclear whether this avoidance extends to the provision of sexual health care. However, it appears logical that if nurses are not providing consumers with opportunities to discuss their concerns, that nurses are also avoiding the sexual health care needs of consumers such as the provision of sexual health education and sexual health screening. This has been observed by Matevosyan (2010) who report that the difficulties around engaging with female consumers have a direct bearing on the poor sexual health outcomes for these women. Avoidance of the provision of sexual health care for mental health consumers may reflect the insignificant inclusion of sexual health in undergraduate and postgraduate nursing curricula (Tsai et al., 2014). The approach to undergraduate training being one where sexual health is presented inconsistently and the time devoted to sexual health in undergraduate nurse training is significantly less than that devoted to other areas of health (Astbury-Ward, 2011). Moreover within Sexual Health National strategy plans in the UK and Australia where priority populations are identified (Australian Government, 2014), there is no inclusion of the sexual health disparities and risks faced by people with pre-existing mental health conditions. However, a recent NHS England publication aiming to promote physical health for people with mental health problems (a resource aimed specifically at mental health nurses) does include a section on sexual health (Nursing Midwifery and Allied Health Professions Policy Unit Quality Division, 2016)

While there is growing evidence supporting the difficulties nurses experience in discussing sexual health with consumers, there is little evidence about the sexual health knowledge of nurses in mental health or their practice in promoting strategies to reduce sexually transmitted infections (STIs) (Walsh

et al., 2014). A UK study reported that most nurses (70%) did not discuss sexual health concerns and a greater percentage (80%) did not assess for sexual side effects resulting from prescribed medications (Hughes and Gray, 2009). This reflects views that sexual health is not a priority for nurses working in mental health settings, not part of their role, and that this practice is also poorly addressed by other health professionals (Quinn et al., 2011). In two qualitative studies, one in Australia and one in the UK, consistent themes emerged regarding nursing (and other mental health) staff's concerns about discussing sexual health. These mainly centred on concerns that asking about sex, which could be misinterpreted by others as a boundary transgression, and that broaching the topic, might distress the consumer (Quinn et al., 2011). (plus Reference not cited for anonymising manuscript 2017) However, the concerns expressed by nurses don't reflect how consumers feel about the topic. This was explored in a study by Phillips and McCann (2007) who reported that consumers want nurses to initiate conversations and assist them with their sexual health concerns (Phillips and McCann, 2007). On the positive side, one study of fourteen nurses providing mental health care (Quinn et al., 2013) reported significant transformation in practice following a brief intervention around important sexual health issues for consumers. The nurses changed from a standpoint of avoidance to one of applying new knowledge and acknowledging the importance of being inclusive of sexual health for consumers.

When compared to the general population, mental health consumers experience higher rates of comorbid physical health problems (Happell et al., 2013, SMI, 2016). Happell (2013) urges for increased commitment by nurses in mental health to the physical health care of consumers, including sexual health care, to reduce health disparities between consumers and that of the general population. Sexual side effects arising from psychiatric medications have also been identified as an obstacle to optimal sexual health for consumers (Blalock and Wood, 2015). This obstacle is well recognised (Üçok et al., 2007) and has been described as a crisis for mental health services (Gray et al., 2010) and particularly the consumers. Blalock (2015) also describes psychological obstacles to achieving sexual health such as sexual vulnerability, sexual abuse and sexual risk behaviours including high risk of acquiring STIs including HIV/AIDS (Agar et al., 2002, Walsh et al., 2014). There have been recommendations for routine screening and assessment of sexual risk behaviour as part of comprehensive mental health care (Gascoyne et al., 2016, Walsh et al., 2014). However, research findings suggest nurses do not address this as part of routine assessment and treatment plans (Hughes and Gray, 2009, Quinn et al., 2012, Quinn et al., 2011). Furthermore, a once-off approach to sexual

health education for consumers is ineffective in improving the sexual health of consumers and in reducing sexual risks for them (Walsh et al., 2014).

To overcome the barriers to the provision of helpful sexual health care by nurses there is a need to better understand how mental health nurses include sexual health care and how they provide sexual health promotion. This article reports the findings from a survey conducted in Australia and England to gather information about how nurses working in mental health settings respond to sexual health issues within their routine practice: what sexual health issues nurses address during their consultations with mental health consumers; and their view on their role on promoting sexual health for mental health consumers.

Methods

Design

This is a cross sectional study consisting of an electronic survey questionnaire.

Settings

The research was undertaken as a national study in Australia and in four National Health Service Trusts in England.

Participants

There were two sets of Registered Nurse participants for this survey: Australian nurses working in mental health settings and nurses from four NHS Trusts within the Yorkshire and Humber region in the UK. As all nurses in the UK sample were within public health services, in order to provide as a direct as possible comparator group, the Australian sample was constrained to those exclusively in the public sector.

Survey development

The survey was developed based on items from a previous workforce survey (Hughes and Gray, 2009) which asked questions about HIV knowledge, awareness and sexual health care; and themes that emerged from qualitative studies undertaken in Australia and England (Hughes, 2017, Quinn et al., 2011). The survey aimed to explore whether specific sexual health issues were addressed during

consultations with consumers, along with exploring the views of nurses on their role in promoting sexual health for mental health consumers. We also included a list of areas of sexual health needs as well as behaviours that can put people at higher risk of sexually transmitted infections and unintended pregnancy and these items were informed by previous literature (Gascoyne et al., 2016, Hughes et al., 2016). Table 2 presents the main sections of the survey, key questions, scope and response formats and tables 3-9 detail the specific items within the survey.

(Table 2 here)

The present survey was originally generated in the UK, . and modifications were made to the language and descriptors of the survey to ensure clarity of meaning for nurses in both Australia and the UK working in mental health care settings. A draft version of the survey was piloted with a sample of volunteers who were nurses working in the UK and Australia. The pilot asked for specific feedback such as whether all words were understood, whether questions were interpreted in the same way, whether response choices were adequate, and about the flow and appeal of the survey. In addition, accessibility, time taken to complete and acceptability were established by the pilot. Based on feedback from the pilot, we made some further minor changes. The survey was designed and administered using commercial computer software (QualtricsTM survey software) that complies with data security requirements in the European Union and Australia. The UK survey was aimed at all clinical staff working in mental health settings, whereas the Australian version only targeted MHNs, so the professional background section was modified to only reflect nursing. In addition, changes to the ethnicity question were adapted in the Australian version to include “Aboriginal/Torres strait and White Australian”. The other minor change was to change “service users” (UK terminology) to “consumers” (Australian terminology). However, the main questions remained the same between the UK and the Australian survey to allow for pooling of data.

Procedure

In Australia, information about the study and a link to the survey was distributed to nurses via the Australian College of Mental Health Nursing (ACMHN) email lists and online newsletter, In the UK, the survey was distributed within four specific NHS organisations in one region of the country. In each service, the information and link to the survey was distributed through internal electronic communications such as weekly organisational e-newsletters and email lists. The survey opened to an

information sheet and participants were asked to indicate that they understood the nature of the study and agreed to participate before they could access the survey. If anyone didn't give consent, they could not complete the survey and would be re-directed away from the survey. Data was collected separately for each organisation, and the Australian data set was collected separately. Some demographic information was collected, however no identifiable information was requested in the surveys. The nurse specific data were extracted from the UK samples and merged with the Australian data set for analysis.

Ethical issues

Ethical approval to conduct the study was provided by the relevant University human research ethics committees in Australia and England. Ethics approval to conduct the study was provided by the HREC of the University of Canberra (16-43). In England Health Research Authority (HRA; the national body for governance of research conducted in the NHS) approval was obtained on 16th March 2016 (IRAS reference: 178845).

Data analysis

Data were analysed using SPSS 24 statistical software (IBM, 2016, Chicago, IL). For each group of questions, the overall distribution of responses (England and Australia combined) were analysed in terms of percentages, means and standard deviations. For some responses where there were ratings on frequencies and level of (disagreement), within-subject patterns were analysed, such as the number of subjects who responded "often" or "always" across different areas. When comparing England and Australia on scale ratings, independent samples t-tests were conducted. In cases of categorical data, chi-square tests were applied. The cut off point for statistical significance was set at .05. For the set of questions on initiating discussions on sexual health, an overall score was developed in order to analyse group differences and the reliability level was assessed. Cronbach's alphas for the female ($\alpha = .94$) and male ($\alpha = .89$) items were high, as was the case for the combined scale ($\alpha = .94$), indicating a high degree of internal consistency for these measures.

Results

Sample

The total sample of completed surveys for the current analysis was 303 nurses working in public mental health settings across Australia (n = 219) and mental health nurses in England (n = 84). Nurses responded from all States and Territories within Australia, with greatest representation from Victoria (58.9%) followed by Queensland (17.8%).

(Table 1 here)

All nurses in the English sample were registered mental health nurses (with an entry level qualification specifically for working in mental health), and all were working in the public sector National Health Service. The participants came from a wide range of mental health nursing roles in various health care settings. For this analysis, the Australian nurses working in the private sector were removed. Most of the Australian nurses had obtained a specialist qualification in mental health nursing (82.6%). Of those with a specialist qualification, the qualifications were Graduate Diploma (36.5%) or Masters (21.9%); Graduate Certificate (11.4%); hospital based certificates (34, 15.5%); and no response/not applicable (14.6%).

Question 1. "Routine sexual health assessments in last three months"

We asked whether a list of sexual health issues were included in routine assessments. Table 3 presents the means and standard deviations (for overall, England, and Australia) and t-test findings in comparing Australia and England on frequency of routine assessments for the list of sexual health issues. There were some significant differences between the Australian and English nurses in relation to topics that they reported they included in assessment. English nurses reported more frequent routine assessments on sexual identity and sexuality, and Australian nurses had a higher rate of discussion of sexually transmitted infections (Table 3).

Twenty-one percent of participants responded "sometimes" or "more frequent" to all the areas of sexual health, however, conversely 20% of the nurses reported "never" for all of the 10 areas of sex and sexuality in routine assessments. So, a fifth of nurses reported some inclusion of sexual health but this also demonstrates that this is the exception not the norm for routine practice in this sample.

For the combined sample “never” was the most common response for sexual identity, gender identity, condoms, satisfaction with sex life and sex work or sex trading. When considering subject patterns, it was found that 26 nurses (8.6%) responded “never” to all ten assessment areas.

(Table 3 here)

Question 2: Initiating discussions on issues in sexual health

This question was concerned with whether nurses initiated discussions on a range of sexual health issues and responses were organised by gender. Table 4 reports descriptive statistics (means, standard deviations) for the overall pooled sample, by country and the sexual health areas by women and men, as well as the percentage of “never” responses. There was some variation in responses to specific items. For example, initiation of discussion around likelihood of pregnancy was more likely to be reported than fertility issues. The response of “never” initiating discussions with female consumers ranged from 25.3% never initiated likelihood of pregnancy to 47.5% never initiated on fertility issues.

Male nurses were more likely to report they initiated discussion about intimate partner violence than male fertility. Percentages ranged from 23.1% (relationship violence and abuse) to 58% (fertility issues).

(Table 4 here)

As 98.3% of participants indicated being either male or female, the subset of analyses of the relationship between gender of nurse and initiating conversations about sexual health did not include those who nominated other categories (‘intersex’ or ‘prefer not to say’). There was a gender effect on the likelihood of nurses to initiate conversations about sexual health with same versus opposite sex consumers. This pattern was found in both the Australian and UK samples (Figure 1). There was an overall significant effect of gender of staff on initiating conversations with consumers, for female consumers ($t(289) = -2.45, p < .05$), and for male consumers ($t(292)=3.72, p < .01$). Figure 1 shows that in both countries, female nurses delivered more care to female consumers than male consumers, while for male nurses there appeared to be no significant differences in care delivery frequency based on sex of consumer.

(Figure 1 here)

3. Settings for sexual health services

We asked respondents where they thought that people could receive help around six sexual health issues (in house, primary care or local sexual health or genitourinary medicine (GUM) clinic). Table 5 presents the percentage of responses for overall (combined), Australia and England.

Primary care was indicated by over 25% of respondents for all of the sexual health issues; pregnancy, HIV and Hepatitis C testing were most likely to be indicated as being provided “in-house” cervical screening, contraceptive choices and termination of pregnancy were perceived to be provided by primary care, and access to condoms and HIV testing by GUM clinics. The highest percentage for the “don’t know” response, was for termination of pregnancy and access to condoms.

Of concern was that overall 10% of the participants responded “don’t know” to where all the sexual health issues would get treated or dealt with. There were England-Australia differences in relation to location of STI testing and contraception: specifically, condoms $\chi^2(3)=25.91$, $p < .001$, HIV testing, $\chi^2(3)=56.69$, $p < .001$, Hep C, $\chi^2(3)=34.72$, $p < .001$, contraceptive choices $\chi^2(3)=33.87$, $p < .001$ and Hep B, $\chi^2(3)=38.19$. with English respondents more likely to say these are provided at GUM clinics and Australian responses were more likely to be “in house”.

(Table 5 here)

Frequency of encountering sexual health issues

We asked how frequently nurses encountered a range of issues in their work.

Table 6 shows that for the overall pooled sample, the response of “never” encountering sexual health issues ranged from 8.3% (for sexual risk-taking) to 23.2% (for sex trading). Table 6 also indicates that the Australian sample tended to have higher mean frequencies than England for all areas. There were four areas where Australia-England differences were statistically significant: Sex work, violence within intimate relationships, sexual assault (as an adult), and sexual risk taking as a result of hypersexuality.

(Table 6 here)

Sexual health needs

This section asked participants to rate specific groups on whether they perceived them to be lower, same or higher risk than the general population (The list contained all high-risk groups as established in the literature). Generally, all groups were correctly perceived as having higher sexual health needs than the general population. Australian nurses were more likely than English nurses to indicate men who have sex with men as having higher sexual health needs than the general population, $\chi^2(1)=8.55$, $p < .01$.

(Table 7 here)

Responses to sexual health issues

We asked what further action would be taken after disclosure or identification of a sexual health need (Table 8). For the pooled sample, over 65% indicated they would discuss with the person in further detail for each of the seven sexual health issues, while just over half (55%) would discuss within one's team and/or supervisor. Less than 5% indicated they "would not discuss as its not part of my role" or had "no idea what I would do".

There were several statistically significant differences between the two samples in self-reported responses to sexual health issues. English nurses were more likely to respond, "discuss with your team and/or supervisor" for each of all the seven sexual health issues. English nurses were more likely to respond, "discuss with the person in further detail" for sex work, sex trading, sexual risk taking resulting from hypersexuality, and sexual risk taking than Australian nurses. The nurses in England were also more likely to discuss sex trading with consumers in further detail, and undertake a safeguarding process by either referral to an external agency or discuss issues in further detail with their team and/or supervisor. They were more likely to undertake safe guarding steps regarding violence within intimate relationships and sexual assault than their Australian counterparts. On the issue of sexual risk taking as a consequence of hypersexuality, nurses from England were more likely to indicate that they had "no idea" what to do apart from discussing this with their team or supervisor. For sexual risk taking as a result of intoxication and sexual risk taking (in general), the nurses in England were more likely to discuss in further detail with the consumer and their team, while the Australian nurses were more likely to initiate safeguarding processes such as referral to specialist services..

(Table 8 here)

Promoting sexual health and comfort in discussing sexual behavior

For the statement “Promoting sexual health for people of mental health services is part of my role”, for the overall sample 54.8% agreed and 20.8% strongly agreed (. However, only 8.3% strongly agreed that sexual health was a high priority in their service.

Table 9 presents aggregate, and Australia and England comparisons of self-reported level of promoting sexual health and confidence in engaging on specific topics or with populations in relation to sex. Table 9 suggests that compared to English nurses, Australian nurses were more likely to report feeling uncomfortable discussing sex and sexuality issues, in particular discussing sexual issues connected with bisexuality, gender identity and reassignment.

(Table 9 here)

Barriers to discussing sexual health issues

Participants were asked to rank four potential barriers to discussing sex and sexuality with consumers. Figure 2 compares English and Australian nurses on the significance of reported barriers. Results indicate that “fear of embarrassing the person” and “fear of destabilising their mental state” tended to be ranked as the primary barrier. In addition, nurses in England seemed to place “fear of embarrassing the person” as the primary barrier more frequently than nurses in Australia.

(Figure 2 here)

Discussion

There is emerging evidence that people who use mental health services have significant and unmet sexual health needs (Gascoyne et al., 2016). Qualitative studies have indicated that sexual health is an area of care that is often avoided by mental health nurses and other clinical staff. A survey was devised and distributed in order to assess mental health staff’s current practice regarding sexual health.

Overall, the survey findings indicated an inadequate response to sexual health from nurses in both countries. One fifth of the participants admitted they *never* explore important issues relating to sexual health in their routine assessments; and 10% responded that they “don’t know” where a range of sexual health services are provided. There was a significant gender effect on the discussion of sexual health topics with a greater likelihood of discussions occurring with same gender consumers. Fear of embarrassment and destabilizing the consumer were ranked as the top reasons to avoid the topic which is unsurprising given the identified avoidance in previous studies (Hughes, 2017, McCann, 2010, Quinn et al., 2011). However, three quarters agreed or agreed strongly that sexual health was part of mental health nursing role, however less than 10% agreed that their service supported addressing sexual health.

As in previous qualitative studies, mental health care staff appeared focused on viewing sexual issues through the lens of risk and safeguarding. For instance, one area that seemed to be addressed is that of intimate partner violence and abuse. This may reflect an increasing focus and awareness of these issues in mental health. (Department of Health Services, 2009, Khalifeh et al., 2015).

Clearly there is a need for change at both the managerial and clinical levels towards promoting sexual health and this will only be possible if it is recognized in national health strategies, as well as being included in pre- and post-registration nurse education. Even if sexual health were included in routine assessments, there is a need for a concerted workforce development strategy that can provide mental health nurses with the tools and confidence to address sexual health in routine care. In the UK, a recent publication on physical health in mental health includes a section in sexual health which is encouraging, and more needs to be done to translate this into routine care (Nursing Midwifery and Allied Health Professions Policy Unit Quality Division, 2016). There is also a need for more specification about what the role of the mental health nurse is in relation to sexual health. For example, as in physical health, it may be that the mental health nurse has a role in identifying needs through comprehensive assessment and then acts as an advocate or can signpost to the right service provider rather than being expected to provide specific sexual health interventions in-house.

Developing a better response to sexual health needs will be challenging without policy drivers that clearly articulate the standards required for best practice. In the UK the Department of Health published guidance for mental health nurses on improving physical health (2016) including a section on sexual health yet there are no mandatory drivers for integrating sexual health into routine

assessment, unlike other aspects of physical health which have payments associated with meeting these targets such as assessment of cardiovascular health and smoking (called CQUINs -The Commissioning for Quality and Innovation (CQUINs) payments framework in England). An NHS England toolkit for improving physical health for people with serious mental illness makes no reference to sexual health (England, 2016)

Within Australia, various State health departments provide guidelines to promoting sexual safety and guidance to how to respond to sexual activity in hospital settings and provide a broader care framework encouraging clinicians to consider the sexual and reproductive health needs of consumers (Queensland Government, 2016).

Given the importance and impact of unaddressed sexual health needs in terms of long term health and wider mental health recovery, it is vital that mental health nurses start to address these issues and are provided with support, training and information resources to be able to do this. It is also important that there needs to be clearer pathways to local sexual health and family planning services from mental health services. Avoiding talking about sex is putting people at risk of harm in terms of untreated STIs, suffering sexual exploitation in silence, and possible long-term health consequences. It's time that mental health nurses took on the challenge of sexual health and incorporate it into areas of work including physical health assessment and comprehensive care planning for recovery (Gascoyne et al., 2016, Quinn et al., 2013).

Relevance to practice or Implications and recommendations

Given the high sexual health needs and potential impact on health and recovery, mental health nurses are in a prime position to deliver sexual health promotion and assess needs, as well as signpost people to the required sexual health and family planning resources. Training with regard to sexual health issues, and interpersonal skills in engaging people in conversations about their sex lives is required. In addition, mental health nurses (and consumers) require specific information resources and clear pathways into sexual health and family planning services.

Limitations

The results are based on a convenience sample comprised of those who self-selected to participate and therefore may not represent the views and practice of all mental health nurses. However, the

sample was comprised of participants from two countries and a range of clinical settings. The findings concur with previous work undertaken by Hughes et al (2009) and Quinn et al (2011, 2013). As it was an anonymous survey, it is unlikely that any of the responses could have been affected by social desirability. .

Conclusion

A survey which included mental health nurses from Australia and the UK indicates that sexual health is not a part of routine mental health care practice; nurses are unclear about what to do if a sexual health problem arose, and also that there are concerns about upsetting or destabilising a consumer if such questions are asked. Clearly, there is a failing to adequately prepare the future mental health nurses at undergraduate and postgraduate level to include sexual health in the care they provide to consumers and a failing at the policy, commissioning and provider level to acknowledge the importance of sexual health promotion for mental health consumers within the physical well-being and recovery agenda.

Acknowledgements

The authors would like to thank all nurses who completed surveys, along with the kind assistance of the Australian College of Mental Health Nursing and the four NHS Trusts in providing survey access to the nurses responding for this study.

References

- Agar, K., Read, J., Bush, J., 2002. Identification of abuse histories in a community mental health centre: the need for policies and training. *Journal of Mental Health* 11 (5), 533-543.
- Astbury-Ward, E., 2011. A questionnaire survey of the provision of training in human sexuality in schools of nursing in the UK. *Sexual & Relationship Therapy* 26 (3), 254-270.
- Australian Government, 2014. Third National Sexually Transmissible Infections Strategy 2014-2017.
- Blalock, K.M., Wood, S.K., 2015. Women Living with Serious Mental Illness: The Impact of Sexual Stigma and Sexual Wellness on Quality of Life. *Women & Therapy* 38 (1/2), 77-88.
- Department of Health Services, 2009. Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units. Victorian Government.

- England, N., 2016. Improving the health of people with serious mental illness. Department of Health, London.
- Gascoyne, S., Hughes, E., McCann, E., Quinn, C., 2016. The sexual health and relationship needs of people with severe mental illness. *Journal of Psychiatric and Mental Health Nursing* 23 (5), 338-343.
- Gascoyne, S., Hughes, E., McCann, E., Quinn, C., 2016. The sexual health and relationship needs of people with severe mental illness. *Journal of Psychiatric & Mental Health Nursing* 23 (5), 338-343.
- Gray, R., White, J., Schulz, M., Abderhalden, C., 2010. Enhancing medication adherence in people with schizophrenia: an international programme of research. *International Journal of Mental Health Nursing* 19 (1), 36 - 44.
- Happell, B., Platania-Phung, C., Scott, D., 2013. Are Nurses in Mental Health Services Providing Physical Health Care for People with Serious Mental Illness? An Australian Perspective. *Issues in Mental Health Nursing* 34 (3), 198-207.
- Hughes, E., 2017. Identifying and addressing sexual health in serious mental illness: views of mental health staff working in two NHS organisations in England.
- Hughes, E., Bassi, S., Gilbody, S., Bland, M., Martin, F., 2016. Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness: A systematic review and meta-analysis. *The Lancet Psychiatry* 3 (1), 40-48.
- Hughes, E., Gray, R., 2009. HIV prevention for people with serious mental illness: a survey of mental health workers' attitudes, knowledge and practice. *Journal of Clinical Nursing* 18 (4), 591-600.
- Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Osborn, D., Johnson, S., Howard, L.M., 2015. Domestic and sexual violence against patients with severe mental illness. *Psychol Med* 45 (4), 875-886.
- Kolbe, N., Kugler, C., Schnepf, W., Jaarsma, T., 2016. Sexual Counseling in Patients With Heart Failure: A Silent Phenomenon: Results From a Convergent Parallel Mixed Method Study. *The Journal Of Cardiovascular Nursing* 31 (1), 53-61.
- Matevosyan, N.R., 2010. Evaluation of perceived sexual functioning in women with serious mental illness. *Sexuality and Disability* 28, 233-243.
- McCann, E., 2010. Investigating mental health service user views regarding sexual and relationship issues. *Journal of Psychiatric and Mental Health Nursing* 17 (3), 251-259.
- McCann, E., 2010. The sexual and relationship needs of people who experience psychosis: quantitative findings of a UK study. *Journal of Psychiatric & Mental Health Nursing* 17 (4), 295-303.
- Nakopoulou, E., Papaharitou, S., Hatzichristou, D., 2009. Patients' Sexual Health: A Qualitative Research Approach on Greek Nurses' Perceptions. *Journal of Sexual Medicine* 6 (8), 2124-2132.
- Nursing, M.a.A.H.P.P.U., 2016. Improving the health of people with mental health problems: actions for mental health nurses. NHS England, London UK.

- Nursing Midwifery and Allied Health Professions Policy Unit Quality Division, 2016. Improving the physical health of people with mental health problems: Actions for mental health nurses.
- Östman, M., 2008. Severe depression and relationships: the effect of mental illness on sexuality. *Sexual & Relationship Therapy* 23 (4), 355-363.
- Phillips, L., McCann, E., 2007. The subjective experiences of people who regularly receive depot neuroleptic medication in the community. *Journal of Psychiatric & Mental Health Nursing* 14 (6), 578 - 586.
- Queensland Government, 2016. Sexual health and safety guidelines: mental health, alcohol and other drug services.
- Quinn, C., Happell, B., Browne, G., 2012. Opportunity lost? Psychiatric medications and problems with sexual function: a role for nurses in mental health. *Journal of Clinical Nursing* 21 (3-4), 415 - 423.
- Quinn, C., Happell, B., Browne, G., 2011. Talking or avoiding? Mental health nurses' views about discussing sexual health with consumers. *International Journal of Mental Health Nursing* 20 (1), 21-28.
- Quinn, C., Happell, B., Welch, A., 2013. The 5-As Framework for Including Sexual Concerns in Mental Health Nursing Practice. *Issues in Mental Health Nursing* 34 (1), 17-24.
- Quinn, C., Happell, B., Welch, A., 2013. Talking about sex as part of our role: Making and sustaining practice change. *International Journal of Mental Health Nursing* 22 (3), 231-240.
- SMI, W.G.f.I.t.P.H.o.P.w., 2016. Improving the physical health of adults with severe mental illness: essential actions
- Royal College of Psychiatrists, London.
- Tsai, L.-Y., Huang, C.-Y., Shih, F.-F., Li, C.-R., Lai, T.-J., 2014. Undergraduate nursing education to address patients' concerns about sexual health: the perceived learning needs of senior traditional four-year and two-year recurrent education (rn-bsn) undergraduate nursing students in taiwan. *Nagoya Journal Of Medical Science* 76 (3-4), 273-284.
- Üçok, A., İncesu, C., Aker, T., Erkoç, Ş., 2007. Sexual dysfunction in patients with schizophrenia on antipsychotic medication. *European Psychiatry* 22 (5), 328-333.
- Walsh, C., McCann, E., Gilbody, S., Hughes, E., 2014. Promoting HIV and sexual safety behaviour in people with severe mental illness: A systematic review of behavioural interventions. *International Journal of Mental Health Nursing* 23 (4), 344-354.

Tables and Figures

Table 1. The participants

	Australia N=219		England N=84		Overall N=303	
Background	N	%	N	%	N	%
Gender						
Male	65	29.7	20	23.8	85	28.1
Female	148	67.6	64	76.2	212	70.0
Intersex	1	0.5	0	0	1	0.3
Prefer not to say	4	1.8	0	0	4	1.3
No response	1	0.5	0	0	1	0.3
Age						
18-30	24	11.0	15	17.9	39	12.9
31-40	45	20.5	20	23.8	65	21.5
41-50	64	29.2	23	27.4	87	28.8
Over 51	85	38.8	26	31.0	111	36.8
No response	1	0.5	0	0	1	0.3
Mental health setting						
Inpatient	141	64.4	34	40.5	175	57.8
Community	57	26.0	49	58.3	106	35.0
Other	21	9.6	1	1.2	22	7.3
Years in mental health						
0-10 years	79	35.0	28	33.3	107	35.3
11-20 years	59	26.7	25	29.8	84	27.7
21-30 years	42	19.2	16	19.0	58	19.1
31 or more years	37	16.9	14	16.7	51	16.8
No response	2	0.9	1	1.2	3	1.0

Table 2. Outline of key sections and questions in survey

Topic	Question	Domains/Areas	Response format
Routine assessments	Thinking about your routine assessments over the past three months, how often did you ask questions about	10 areas	Never, Rarely, Sometimes, Often, Always

	the following?		
Initiative discussions: women	Thinking about routine conversations with women consumers that you work with, how often do you INITIATE discussions on the following?	8 areas	Never, Rarely, Sometimes, Often, Always
Initiating discussions: men	Thinking about routine conversations with male consumers that you work with, how often do you INITIATE discussions on the following?	6 areas	Never, Rarely, Sometimes, Often, Always
Settings for sexual health issues	In which setting (in your own service, at GP or sexual health clinic) would the following sexual health issues be MOST LIKELY managed for people using your mental health service?	8 sexual health issues	Three sites and “I don’t know” option
Encountering sexual health issues	How often do you encounter these matters with the people that you work with on caseload or in hospital?	7 matters	Never, Rarely, Sometimes, Often, Always
Sexual health needs	Thinking about the following groups of people, in your opinion, are the levels of their sexual health needs different to the general population, and if so, lower or higher?	7 groups	Lower need, Same need, Higher need
Responses to sexual health issues	What would be your likely responses to the issues should they arise in working with your caseload: please tick as many as apply.	7 issues	5 response types and “I have no idea what I would do” as an option
Promoting sexual health and comfort in discussing	Considering your role and your service, please answer the following as honestly as you can	8 items	Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree
Barriers to discussing	Please rank the following barriers to discussing sex and sexuality with consumers (1 being most significant barrier and 4 being least significant).	4 barriers	1, 2, 3, 4 (ranking)

Author Manuscript

Table 3: Frequency of questioning about sexual health issues

Sex of service user	Issue	Overall				England		Australia		
	Issue	Overall		England		Australia				
		<i>M(SD)</i>	% “Never”	<i>M (SD)</i>	% “Never”	<i>M (SD)</i>	% “Never”	<i>95%CI</i>	<i>t statistic</i>	<i>p-value</i>
	Condoms	2.19 (1.12)	34.9	1.88 (1.14)	51.2	1.89 (1.04)	31.0	0.07, 0.63	2.46	.626
	Sex work or sex trading	2.05 (1.04)	38.3	1.89 (0.93)	42.9	2.08 (1.08)	38.2	-0.08, 0.45	1.38	.168
	Satisfaction with sex life	1.87 (1.01)	47.5	1.76 (0.99)	53.6	2.32 (1.12)	49.1	-0.18, 0.32	0.51	.608
	Sexually transmitted infections	2.37 (1.11)	27.5	2.02 (1.05)	40.5	2.44 (1.11)	24.5	0.13, 0.69	2.92	.004**
	Gender identity	2.21 (1.18)	35.2	2.33 (1.28)	33.3	2.10 (1.11)	38.9	-0.53, .06	-1.58	.058
	Contraception	2.43 (1.16)	28.4	2.36 (1.19)	32.1	2.39 (1.13)	28.8	-0.26, 0.32	2.00	.85
	Sexual dysfunction	2.49 (1.15)	25.0	2.44 (1.19)	28.6	2.43 (1.12)	25.3	-0.30, 0.28	-0.08	.275
	Sexual identity	2.31 (1.25)	34.6	2.48 (1.28)	32.1	2.16 (1.21)	38.8	0.63, -0.01	-2.00	.046*
	Sexuality	2.55 (1.23)	26.2	2.77 (1.32)	23.8	2.38 (1.16)	29.2	-0.70, -.09	-2.57	.011*
	Intimate partner violence	2.72 (1.21)	21.9	2.65 (1.19)	21.4	2.68 (1.21)	23.0	-0.28, 0.33	-0.18	.861

Note. % "Never" = Percentage of participants who responded 1 "Never" to item. * $p < .05$, ** $p < .01$, *** $p < .001$

Table 4: Frequency of introducing discussions on issues in sexual health for female and male service users

		<i>M(SD)</i>	% "Never"	<i>M (SD)</i>	% "Never"	<i>M (SD)</i>	% "Never"
Female	Contraceptive choices	2.36 (1.19)	32.1	2.21 (1.20)	40.5	2.23 (1.14)	30.8
	Likelihood of pregnancy	2.64 (1.23)	25.3	2.54 (1.25)	32.1	2.64 (1.22)	23.8
	Fertility issues	1.85 (0.97)	47.5	1.85 (1.04)	51.2	1.77 (0.91)	50.2
	Family planning	2.09 (1.07)	38.9	2.05 (1.14)	45.2	2.06 (1.03)	38.3
	History of miscarriage	2.05 (1.07)	40.7	1.96 (1.02)	41.7	2.01 (1.13)	43.0
	History of termination	2.05 (1.09)	39.5	2.01 (1.02)	39.8	2.00 (1.08)	42.1
	Pregnancy tests	2.37 (1.16)	30.9	2.26 (1.22)	28.2	2.38 (1.13)	40.5
	Cervical screening	2.19 (1.20)	39.8	2.00 (1.19)	51.2	2.19 (1.16)	37.9
Male	Self-checking testicular cancer	1.75 (0.94)	51.2	1.82 (1.09)	52.4	1.69 (0.88)	53.5

Male (continued)	Fertility issues	1.60 (0.81)	58.0	1.55 (0.80)	59.8	1.54 (0.77)	54.1
	Family planning	1.88 (0.98)	46.6	1.79 (0.97)	52.4	1.87 (0.98)	47.0
	Contraceptive choices	2.01 (1.07)	41.4	1.99 (1.11)	43.1	1.97 (1.06)	44.0
	Relationship violence and abuse	2.61 (1.16)	23.1	2.73 (1.20)	22.6	2.54 (1.15)	24.9
	Erectile dysfunction	2.24 (1.11)	32.7	2.13 (1.11)	39.3	2.24 (1.11)	32.3
	Problems ejaculating	2.00 (1.10)	43.5	1.86 (1.04)	51.2	2.01 (1.11)	43.3

Note. % “Never” =
Percentage of participants
who responded 1 “Never”
to item. All *ps* > .05.

Table 5: Settings, percentage of response overall and within each country

Issue:	Setting											
	In house			Primary care			Local GUM clinic			Don't know		
	Overall	England	Australia	Overall	England	Australia	Overall	England	Australia	Overall	England	Australia
Termination of pregnancy	17.9	16.7	18.6	54.3	56.0	54.4	9.3	3.6	11.6	17.5	23.8	15.3
Cervical screening	11.6	8.3	13.1	69.9	75.0	69.2	10.6	7.1	12.1	6.6	9.5	5.6
Access to condoms	32.5	14.3	40.6	26.5	34.5	24.1	26.5	41.7	21.2	12.6	9.5	14.2
Pregnancy testing	41.7	34.5	45.1	48.3	52.4	47.4	3.6	7.1	2.3	5.3	6.0	5.1
HIV testing	42.1	27.4	48.1	29.5	15.5	35.2	25.2	54.8	13.9	2.6	2.4	2.8
Hepatitis C testing	45.0	29.8	51.4	34.4	29.8	36.6	17.5	38.1	9.7	2.3	2.4	2.3
Contraceptive choices	23.2	14.3	27.1	54.6	46.4	58.9	13.6	31.0	7.0	7.3	8.3	7.0
Testing and vaccination for Hepatitis B	33.4	22.6	38.0	48.7	40.5	52.3	11.6	28.6	5.1	5.6	8.3	4.6

Note: Percentages do not include missing cases. Missing cases were small (up to n=6)

Table 6: Frequency of encountering sexual health issues

Issue:	Overall		England		Australia		t-statistics		
	%						95%CI	t-value	p-value
	M (SD)	"Never"	M (SD)	% "Never"	M (SD)	% "Never"			
Sex work	2.54 (0.96)	15.2	2.34 (0.98)	19.0	2.62 (0.95)	13.8	0.02, 0.50	2.12	.035*
Sex trading	2.34 (1.02)	23.2	2.24 (0.99)	23.8	2.38 (1.04)	23.1	-0.12, 0.40	1.08	.283
Violence within intimate relationships	3.14 (0.95)	8.3	2.92 (0.87)	9.5	3.23 (0.96)	7.9	0.09, 0.54	2.74	.007**
Sexual assault (as an adult)	2.96 (0.96)	9.3	2.74 (1.00)	14.3	3.05 (0.93)	7.4	0.07, 0.55	2.53	.015*
Sexual risk taking as a result of hypersexuality	2.86 (0.95)	10.3	2.57 (0.99)	16.7	2.97 (0.91)	7.9	0.16, 0.65	3.23	.002**
Sexual risk taking resulting from intoxication with drugs or alcohol	3.13 (1.00)	10.3	3.05 (3.07)	1.00	3.15 (1.00)	9.7	-.17, 0.33	0.24	.530
Sexual risk-taking	3.15 (0.93)	8.3	3.01 (1.01)	11.9	3.20 (0.90)	6.9	-0.05, 0.42	1.56	.121

Note. % "Never" = Percentage of participants who responded 1 "Never" to item. *p < .05, ** p < .01, *** p < .001

Table 7: Perceptions of sexual health needs

Background	n	%	N	%
		% Lower	% Same	% Higher

		need	need	need
People who inject drugs	England	1.2	17.9	81.0
	Australia	2.3	20.7	77.0
	Overall	2.0	19.9	78.1
People who engage in sex work or sex trading	England	0.0	11.9	88.1
	Australia	1.4	11.5	87.1
	Overall	1.0	11.6	87.4
Men who have sex with men	England	1.2	61.9	36.9
	Australia	0.5	44.4	55.1
	Overall	0.7	49.3	50.0
Women who have sex with women	England	8.3	76.2	15.5
	Australia	2.8	73.7	23.5
	Overall	4.3	74.4	21.3
People with comorbid drug and/or alcohol problems	England	0.0	19.0	81.0
	Australia	2.3	23.4	74.3
	Overall	1.7	22.1	76.2
People with a history of sexual abuse	England	1.2	36.9	61.9
	Australia	5.1	25.8	69.1
	Overall	4.0	28.9	67.1
People in abusive relationships	England	1.2	31.0	67.9
	Australia	3.7	28.1	68.2

Overall 3.0 28.9 **68.1**

Note: Modal response indicated in bold font.

Author Manuscript

Table 8: Frequency of responses (as percentages) to sexual health issues

	Discuss with the person in further detail			Undertake a safeguarding process			Referral to external agency			Discuss within your team and/or supervisor			I don't discuss this as its not part of my role			I have no idea what I would do		
	ALL	ENG	AUS	ALL	ENG	AUS	ALL	ENG	AUS	ALL	ENG	AUS	ALL	ENG	AUS	ALL	ENG	AUS
Sex work	75.2	86.9*	70.6*	41.1	48.8	38.1	33.8	36.9	32.6	55.6	66.7*	51.4*	4.6	6.0	4.1	0.7	0.5	0.5
Sex trading	67.9	83.3*	61.9*	40.4	58.3*	33.5*	29.5	41.7*	24.8*	59.9	75.0*	54.1*	4.3	4.8	4.1	3.6	2.4	4.1
Violence within intimate relationships	77.2	84.5	74.3	57.9	79.8*	49.5*	49.0	52.4	47.7	64.9	75.0*	61.0*	1.7	2.4	1.4	0.7	1.2	0.5
Sexual assault (as an adult)	69.9	77.4	67.0	52.3	70.2*	45.4*	55.3	52.4	56.4	62.9	73.8*	58.7*	2.3	4.8	1.4	0.3	1.2	0.0
Sexual risk taking as a result of hypersexuality	75.2	83.3*	72.0*	49.0	41.7	51.8	25.5	23.8	26.1	65.6	78.6*	60.6*	3.0	4.8	2.3	1.0	3.6	0.0
Sexual risk taking as a result of intoxication with drugs/alcohol	79.5	88.1	76.1	46.7	36.9*	50.5*	40.7	42.9	39.9	62.3	77.4*	56.4*	3.0	4.8	2.3	0.7	1.2	0.5
Sexual risk taking	78.5	86.9*	75.2*	47.7	38.1*	51.4*	27.5	29.8	26.6	60.9	71.4*	56.9*	2.6	4.8	1.8	0.7	4.8	1.8

Note. % = Percentage of total participants who selected response. *p < .05 on chi-square test.

Table 9: Feelings about discussing sexual behaviour

	Overall %			Overall M (SD)	England M (SD)	Australia M (SD)	Comparing England & Australia	
	Disagree	Neither	Agree				95% CI	t-statistic
Promoting sexual health for people of mental health services is a part of my role	6.6	16.8	75.6	3.87 (0.90)	3.85 (1.00)	3.88 (0.85)	-0.19, 0.27	0.33 .739
Promoting sexual health is high priority within my service	43.6	30.0	26.1	2.79 (1.09)	2.77 (1.16)	2.79 (1.07)	-0.26, 0.30	0.13 .894
I am generally uncomfortable discussing any issues related to sex and sexuality and would avoid this topic if I can	69.0	18.2	11.9	2.20 (1.00)	1.96 (0.96)	2.30 (1.01)	0.09, 0.58	2.66 .009*
I am uncomfortable discussing sexual behaviour with people who are bisexual	74.3	13.5	11.2	2.09 (1.01)	1.82 (0.97)	2.20 (1.01)	0.06, 0.56	2.96 .004*
I am comfortable discussing sexual behaviour between women and men	13.2	13.2	72.9	3.75 (1.00)	3.74 (1.11)	3.75 (0.09)	-0.24, 0.26	0.09 .931
I am comfortable discussing sexual behaviour of men who have sex with men	13.5	19.1	66.3	3.67 (0.99)	3.73 (1.07)	3.64 (0.96)	-0.34, 0.17	-0.66 .511
I am comfortable discussing sexual behaviour of women who have sex with women	14.5	20.5	64.0	3.64 (0.98)	3.67 (1.09)	3.62 (0.94)	-0.29, 0.21	-0.34 .732
I am uncomfortable discussing issues related to gender identity and reassignment	55.8	20.1	22.8	2.48 (1.17)	2.15 (1.11)	2.61 (0.19)	0.17, 0.75	2.97 .002*

* p < .05, ** p < .01, *** p < .001

Figure 1

Author Manuscript

Figure 2

Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:

Quinn, C;Platania-Phung, C;Bale, C;Happell, B;Hughes, E

Title:

Understanding the current sexual health service provision for mental health consumers by nurses in mental health settings: Findings from a Survey in Australia and England.

Date:

2018-10

Citation:

Quinn, C., Platania-Phung, C., Bale, C., Happell, B. & Hughes, E. (2018). Understanding the current sexual health service provision for mental health consumers by nurses in mental health settings: Findings from a Survey in Australia and England.. *Int J Ment Health Nurs*, 27 (5), pp.1522-1534. <https://doi.org/10.1111/inm.12452>.

Persistent Link:

<http://hdl.handle.net/11343/284633>