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When holistic care is not holistic enough: the role of sexual health in mental health settings

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ABSTRACT

Aim: to explore the preparation that mental health nurses receive to address sexual health in practice.

Background: People who use the mental health services often have complex sexual health needs. Mental health nurses (MHNs) are well placed to offer support. However, this rarely happens in practice and therefore people's sexual health needs are not being routinely addressed. It is not known why this is the case.

Design: Systematic review and meta-ethnography.

Methods: EBSCO, PsychINFO, MEDLINE and ASSIA databases were searched using Booleans with Mesh and key terms including 'mental health nurse' and 'sexual health'. Date range was June 2006 to June 2016. Discursive papers were excluded. Included papers (n=7) were synthesized using a meta-ethnographic approach.

Results: The search yielded 7 studies. Five key themes were identified: the (not so) therapeutic relationship; personal values dictating professional ones; institutionalised fear; being human; education: the answer but where is it?

Conclusions: The findings illustrate the complexity of supporting people with mental health and sexual health needs. They show the discomfort many nurses have about broaching sexual health. Arguably more than with most issues, personal values impacted strongly on professional practice. Understanding the depth and multifaceted nature of these themes is important, because strategies can then be developed to mitigate the barriers to best practice. For example, the findings presented here offer a framework from which structured education and support can be built.

Relevance for Clinical Practice

There is a need for MHNs to be more responsive to concerns around sexual health and it should be routinely included in their practice. This paper illuminates why this is not currently the case. By understanding this, remedial action can be taken by nurse educators. Implications are also discussed in relation to policy, research and practice.

- This paper suggests that there is a current gap in service provision which directly impacts on the delivery of truly holistic care in mental health settings.
- It provides evidence of correlation between mental health and sexual health

issues in practice.

- This paper details the educational and support needs of practitioners in order to address these issues in practice.

Keywords: Mental Health; Sexual Health; Nursing; Education; Review, Attitudes; Service Provision; Barriers;

INTRODUCTION

In 2014 there were approximately 440,000 new diagnoses of sexually transmitted infections (STIs) made in England alone (Public Health England, 2015a). The number of new diagnoses of Human Immunodeficiency Virus (HIV) continue to increase, with 6,151 new HIV diagnoses in 2014 across the UK (Public Health England, 2015b). Elkington *et al* (2012) found that 45% of adolescents with mental illness involved in their study engaged in unsafe sexual behaviour which put them at risk of contracting an STI or HIV. Similarly, the work of Hughes & Gray (2009) showed that people with serious mental illness are at a considerably higher risk of contracting an STI or HIV. They concluded that sexual health promotion needs to be included in mental health settings. This theme is mirrored in the work of King *et al* (2008) who states that adults with serious mental illness should be routinely screened and counselled about their sexual behaviours.

The incidence of sexual side-effects associated with psychiatric medication is around 90% (Montejo *et al*, 2010; Balon, 2006). Unsurprisingly, Apantaku-Olajide;

Gibbons & Higgins (2011) found that the distress of experiencing sexual difficulties exacerbated psychotic symptoms. Furthermore, individuals who are mentally unwell are much more susceptible to exploitation and sexual assault (Khalifeh *et al*, 2015). Having an open dialogue around sexual health is therefore not just good practice but essential (Brown, Lubman & Paxton, 2011; Higgins, Barker & Begley, 2006a; Davison & Huntington, 2010). It is disconcerting therefore that Mental Health Nurses (MHNs) often seem to overlook the importance of sexual health and appear to avoid discussing it with their clients (Quinn, Happell & Welch, 2013; Wong & Mak, 2008; McCann, 2010).

Mental health and sexual health have both been considered taboo at various points in history. In the Victorian era, Allen (2000) describes the mass persecution of anyone who openly expressed their sexuality or were viewed by society to be sexually sinful. The worst individuals were those who engaged in sexual activity out with marriage. Exclusion also awaited anyone who was deemed to be mentally ill (Scull, 1993). Arnold (2009) describes how those that were thought to be 'mad' were quickly removed from mainstream society, so as not to pollute it, and sent to asylums. Interestingly this was often the same fate for those individuals who were thought to have issues of a sexual nature. The work of Gibson, Alexander & Meem (2014) discusses at length how sexual orientation was treated as a mental illness, in particular homosexuality, with often fatal consequences.

In Western countries sexuality and mental health issues attract less overt stigma. This reduction is a product of numerous campaigns, rights organisations, supportive changes to legislation and reporting in the mainstream media (Richards & Barker, 2013; Corrigan *et al*, 2012; Macintyre, Montero Vega & Sagbakken, 2015). Nevertheless, Buehler (2014) states that although sexual issues frequently

arise in practice, most mental health professionals are uncomfortable and poorly equipped to address them.

Although not exclusively focusing on MHNs, a small study by Saunamaki, Andersson & Engstrom (2010) found that 80% of nurses (n=88) did not take the time to discuss sexual health with their patients. This is mirrored in the work of Howard & Gamble (2011) who found that sexual health promotion was not considered a priority by practicing MHNs and was rarely discussed. Dyer & Nair (2012) explain these omissions using the analogy of nurses wanting to avoid 'opening up a can of worms'. Others suggest nurses do not address sexual health with their patients because of their own thoughts and values on the topic (Hoekstra *et al*, 2012; Arikan *et al*, 2014; Saunamaki, Andersson & Engstrom, 2010). If this is the case, it may be that stigma has not been as successfully eradicated as some would like to believe.

All professional guidance for nurses on sexual health points in the same direction. In Scotland, the 10 Essential Shared Capabilities (ESCS) for Mental Health Practice (NHS Education for Scotland, 2011a) were introduced to clarify and improve service provision. They refer to the importance of individuals being able to express their sexuality as well as the respect which must be shown for sexual orientation. In England, *A Framework for Sexual Health Improvement in England* (Department of Health, 2013) makes numerous references to the importance of its inclusion in mental health services. It is highlighted as one of the six key principles of best practice - 'Wider Determinants of Sexual Health'. The Nursing and Midwifery Council (NMC) regulate all UK nurses with the Code of Conduct (NMC, 2008). The code states that nurses are required to act as an advocate for individuals in their care. This involves providing information and support as well as

access to services where required. Advocacy for an individual incorporates sexual health, and so nurses omitting sexual health from their care may not be adhering to the Code.

In summary, the code is clear, yet when it comes to support around sexual health issues, it is apparent that nurses may not be adhering to their professional obligations. The issue is compounded in mental health services where sexual health may be further compromised by many variables including iatrogenesis (Elkington *et al*, 2012; Hughes & Gray, 2009; Brown, Lubman & Paxton, 2011, Higgins, Barker & Begley, 2006a; Quinn, Happell & Welch, 2013; McCann, 2010). Mental health nurses do not routinely review patient's sexual health needs. Explanations range from pressure of time (Saunamaki, Andersson & Engstrom (2010), through to personal discomfort (Hoekstra *et al*, 2012), although there doesn't appear to be very much research on the topic. In order support MHNs to deliver better sexual health care in future it is important to understand their current deficit in more detail. The purpose of this review is to gain this understanding.

METHOD

Aim

The aim of this review was to establish the preparation registered and practicing MHNs received to discuss sexual health issues with their clients.

1. What preparatory education have MHNs received regarding sexual health concerns and behaviours?
2. What are the views and experiences of MHNs in relation to providing sexual health information in practice settings?

3. What are the best practice examples, and barriers that inhibit, the discussion of sexual health issues by MHNs?

Design

Systematic review and meta-ethnography. The systematic review followed PRISMA guidelines. Meta-ethnography was used as analytic process. Originally developed by Noblit and Hare (1988), the purpose of meta-ethnography was to construct overarching theory from a group of relevant qualitative studies. The method remains controversial. Any attempt to synthesise qualitative findings is arguably anathema to the epistemology of qualitative research (Snowden & Atkinson, 2012). Despite this, the pragmatic drive to generalize where possible from qualitative research has been stronger, and so a range of methods has arisen over the last 25 years designed to integrate findings from disparate sources (Toye. *et al*., 2014).

Meta-ethnography is seen to be the most well developed, and also one of the clearest methods to follow (Britten *et al*, 2002; Booth, Sutton & Papaioannou, 2016; Boland, Cherry & Dickson, 2014). It provides an alternative to the more traditional cumulative methods of synthesis and involves a degree of interpretation, with preservation of meaning, which is in keeping with the qualitative studies to be synthesised (Britten *et al*, 2002). Noblit & Hare (1988) outlined a seven-step process for conducting a meta-ethnography which was adopted for this review:

1. Getting started;
2. Deciding what is relevant to the initial interest;
3. Reading the studies;

4. Determining how the studies are related;

5. Translating the studies into one another;

6. Synthesising translations and

7. Expressing the synthesis.

Search and Selection Strategy

A systematic search of available studies was carried out using the following four databases: CINAHL; MEDLINE; ASSIA and PsycINFO. A search strategy was developed using the following terms and Boolean Operators AND/OR/NOT:

> *Mental Health Nurs* OR Psychiat Nurs* AND Sex* Health OR Sex* Wellbeing OR Sex* Advice OR Sex* Information OR Sex* Issue*; Sex OR Welfare AND Mental Health Service User* OR Patient* OR Client* OR Inpatient* OR Consumer* OR Suffer* AND Nurs* Education OR Nurs* CPD OR Nurs* Profession*Development NOT Offen* NOT Abus* NOT Violen* NOT Learning Disabil* NOT Intellectual Disab*.*

Key terms, Booleans and truncations were modified slightly in order to optimize them for all databases. Hand searching was done to obtain poorly indexed citations by scanning reference lists. Snowballing was used iteratively. For example, authors of relevant papers were searched separately. Papers that subsequently cited selected papers were also searched. Some data bases also generate lists of similar articles, so these were also searched. For example,

Mendeley has a 'related article' section. This helped identify articles not found in traditional searching. Grey literature was searched. In total, 1623 papers were identified. After duplicates were removed 1235 titles and abstracts were screened as below.

Inclusion Criteria

Papers should only be published in English within a 20- year time frame, 1997-2017 to ensure only the most up-to-date information was captured. Studies were considered from any geographical location due to the dearth of evidence in this area.

Exclusion Criteria

The articles had to make explicit reference to the experiences of MHNs who worked in adult mental health services (18-64 years). Therefore, any studies which did not make explicit reference to mental health/psychiatric nurses or that had data including medical, allied health professionals or untrained staff were excluded from the review. Any studies which focused on sexuality within older adult mental health services were discounted due to of the specific sexual issues around dementia (Tarzia, Fetherstonhaugh & Bauer, 2012). In addition to this, studies which focused on sex offenders within the forensic mental health services were also excluded due to the expert knowledge and management strategies required to work with this client group. Studies that related to working in child and adolescent mental health services (CAMHS) were also discounted due to the additional complexities of puberty and legislation. Finally, any studies which focused on individuals with a diagnosed learning disability or cognitive impairment were omitted due to the complexities and variance of comorbidities. This screening process resulted in

resulting in 24 papers being assessed for eligibility.

These 24 papers were read in full. Of these, 17 were rejected due to them not meeting inclusion and exclusion on deeper review, for example, non-nurses being included in the sampling group (Hughes & Gray, 2009; Wright & Pugnaire-Gros, 2010) or the sampling group consisting of service users rather than registered MHNs (McCann, 2009; Davison & Huntington, 2010; McCann, 2010). There were many other papers focusing on or citing the difficulties nurses seem to have addressing sexual health within their practice but these focused on adult/ general nurses rather than MHNs (Dyer & Nair, 2012; Arikan *et al*, 2014; Hoekstra *et al*, 2012; Ho & Fernández, 2006; Saunamäki, Andersson & Engström, 2010). Some were relevant but discursive or CPD papers (Salkeld, 2015). The remaining seven papers were then assessed for quality.

Quality Assessment

The choice of studies determines the validity of the findings of the review. Glass (2000) argued that a broad approach should be adopted. This view suggests that a good review should recognise and include *all* studies, regardless of their perceived quality. However, this view is rarely applied now and so some form of methodological assessment of quality is undertaken. This approach has become the gold standard for systematic literature reviews. Following the selection of studies which met the inclusion criteria and aims of the review, the Critical Appraisal Skills System (CASP), (Critical Appraisal Skills Programme, 2013) was used to review the studies to ensure a robust and consistent approach.

Each study was given a quality score out of twenty. This was done by assigning zero, one or two marks to each CASP question. A zero was given if the paper

contained no information relating to the question, a score of one if the paper gave some information but lacked detail and a two was awarded if the paper fully addressed the question- this approach has successfully been used in recent papers also addressing issues of sexuality in clinical practice (McCann, Lee & Brown, 2016; Rushbrooke, Murray & Townsend, 2014). Studies gaining a score of 17 or more are considered to be of significant quality. Only one of the studies met this benchmark (Higgins, Barker & Begley, 2008).

The remaining 6 papers scored between 10-16, which indicates a lack of rigour in their chosen research processes (Quinn, Happell & Welch, 2013). Further, all but one of the papers was written by the same authors (Figure 1).

Figure 1 here

Characteristics of the selected studies

The 6 studies and 1 literature review that were identified as meeting the inclusion criteria and aims of the review are presented in table 1.

Table 1 here

All the studies were conducted in Australia with the exception of one which was carried out in the Republic of Ireland (Higgins, Barker & Begley, 2008; Quinn, Happell & Browne, 2011a; Quinn, Happell & Browne, 2011b; Quinn & Happell, 2012; Quinn, Happell & Welch, 2013; Quinn & Browne, 2009) The sample sizes are relatively small ranging from 10-27 participants. The six primary research studies all present qualitative data and the literature review does not specify which data extraction method was used. It does however present a qualitative synthesis, providing useful data for this review.

RESULTS

Five main themes were identified:

i) The (Not so) Therapeutic Relationship;

ii) Personal Values Dictating Professional Ones;

iii) Institutionalised Fear;

iv) Being Human;

v) Education- the answer but where is it?

The (Not So) Therapeutic Relationship

In terms of engagement with service users the importance of having an established rapport with the individual before addressing any issues around sexual health was explicitly highlighted by participants (Quinn & Happell, 2012; Quinn, Happell & Browne, 2011b). Conversely however, three studies found that MHNs firmly believed that service users should and would approach them if they had any sexually related issues to discuss, and while they would listen, they would not initiate a conversation around sexual health. There is no mention of whether these service users would be those with whom they already had an established relationship (Higgins, Barker & Begley, 2008; Quinn, Happell & Browne, 2011a; Quinn & Browne, 2009).

Higgins, Barker & Begley (2008) point to the conflict between the principles underpinning therapeutic relationships and the realities of MHN practice in sexual health. They suggest that where sexual health promotion is omitted with service the therapeutic relationship is incomplete. Conversely they suggested that discussing sexual health assisted therapeutic engagement. Along with others they state that it should be the responsibility of the MHN, not the patient to incorporate it as part of the existing or developing therapeutic relationship (Quinn & Happell, 2012; Quinn & Browne, 2009).

Spending time with service users puts MHNs in a unique position to address sensitive issues and discuss sexuality openly. MHNs can be well placed advocates, removing any shame or embarrassment service users may feel. However, this ideal was never met in the participants studied here. The nurses that said they did address it in their practice did so in an indirect manner (Quinn & Browne, 2009; Quinn, Happell & Browne, 2011b). Some participants never discussed it, and the realisation that they were not providing holistic, person centered care, occurred only after the research interview (Quinn, Happell & Browne, 2011a; Higgins, Barker & Begley, 2008).

Two studies highlighted the potential impact on the recovery of service users. When nurses don't broach sexual health, assessments are incomplete. Incomplete assessments detrimentally effect the quality of subsequent care and thus the possibilities of recovery (Quinn & Browne, 2009; Quinn, Happell & Welch, 2013). MHNs should help patients regain their sense of self, and sexuality is a large component of self (Quinn & Browne, 2009; Quinn, Happell & Welch, 2013). Instead, there was evidence to suggest that MHNs often took an authoritarian and punitive stance regarding the discussion of sexual health,

by branding it as inappropriate, therefore discouraging any conversation on this essential element of self (Higgins, Barker & Begley, 2008). This position represents the antithesis of the therapeutic alliance.

Personal Values Dictating Professional Ones

Some MHNs have been found to have conservative and rigid attitudes regarding sexuality and see it to be a subject of taboo, citing strong family values and linking sex with: negativity; sin; shame and embarrassment. Subsequent attitudes around service user sexuality appear to be dominated by personal not professional values. Three studies found nurses' personal values to be a significant factor in how MHNs engaged with service users (Higgins, Barker & Begley, 2008; Quinn, Happell & Browne, 2011a; Quinn & Browne, 2009). MHNs deliberately avoided any conversations around sexual health in order to protect themselves from any embarrassment or discomfort and instead refer service users to their colleagues, thus making the situation more comfortable for the nurse and simultaneously perpetuating the silence and stigma (Higgins, Barker & Begley, 2008; Quinn, Happell & Browne, 2011a).

Quinn, Happell & Brown (2011a) state that MHNs may find it difficult due to feeling uncomfortable with their own sexual identity or their personal beliefs around sexuality and sexual practices. They suggest that if nurses understood their own attitudes concerning sexuality, any potential biases would be reduced and communication on the subject enhanced. In other words MHNs should be encouraged to develop personal insights into their own sexual attitudes and sexual

awareness in a bid to improve practice (Quinn & Browne, 2009). Values were not being challenged by current nursing education, a position further reinforced in practice, as discussion of sexuality was 'partially invisible' (Higgins, Barker & Begley, 2008) and even as something dangerous that needs to be controlled (Higgins, Barker & Begley, 2008).

Institutionalised Fear

Participants described varied barriers to discussing sexual health in practice, and as alluded above there appears to be genuine fear expressed. All of the selected studies showed evidence of this. Higgins, Barker & Begley (2008) found that MHNs were worried that clients might sexualise the relationship between them if they addressed issues of sexuality, and did not want to risk putting themselves in that position. They were also fearful that they may be viewed as 'encouraging' service users to have sex by discussing it and may leave themselves open to allegations of misconduct. In the same group of participants there was also the issue of staff dynamics, with the more experienced staff not speaking about sex with service users and therefore junior colleagues who did feared they would have their practice questioned.

MHNs in the study conducted by Quinn, Happell & Browne (2011b) also expressed trepidation as to how the service users may respond to them, especially if the service user was older or of the opposite gender. When participants were presented with techniques to help them structure their approach to discussing sexual health, they reported that they helped remove 'taboos and fears'. However,

they did not always record these conversations in the notes as they were worried they may be taken out of context by colleagues (Quinn & Happell, 2012).

There is also fear surrounding treatment options. Three studies disturbingly found that MHNs do not or are reluctant to discuss potential sexual side-effects of psychiatric medication in case service users stop complying with the medication regime (Higgins, Barker & Begley, 2008; Quinn, Happell & Browne, 2011b; Quinn & Browne, 2009). This is despite clear guidance that sex education needs to be offered to service users around issues of medication and the possible sexual side effects in order to improve adherence (Quinn & Browne, 2009).

In summary, not discussing sex is an implicit institutional position, thereby making it even harder for those nurses willing to discuss it to do so. One unintended consequence was that patients were not told about potential side effects of psychotropic medication. In this case institutional fear resulted in iatrogenic harm.

Being Human

Three of the studies showed that some MHNs did not believe the service users they worked with were sexually active. Worse, some suggested that they shouldn't be (Higgins, Barker & Begley, 2008; Quinn, Happell & Browne, 2011a; Quinn & Browne, 2009). There appears to be an absence of MHNs willingness to acknowledge the sexual dimension of service users' lives, finding it a very challenging concept. One participant used the term 'these people' when discussing their discomfort with service users having sex (Quinn, Happell & Browne, 2011a). This is mirrored by the findings of Quinn & Browne (2009), who report that society

as a whole are uneasy with the thought that 'they'd' want to have sex when referring to mental health service users.

There seems to be a consistent theme that when sexuality is mentioned, a large number of staff tend to be very perturbed with the idea and believe that service users should be asexual with no right to sexuality, with one participant even joking that 'once you've got a mental illness it all goes away' (Quinn, Happell & Browne, 2011a). It was very clear that discussions around sexuality were not a major consideration in the delivery of holistic care (Quinn, Happell & Welch, 2013). That this was accompanied be a dehumanizing of the patients was particularly worrying.

Education- the answer but where is it?

All of the studies highlighted the importance of education, but more significantly the lack of it for MHNs on the subject of addressing sexual health in their practice.

A lot of the blame is directed towards the de-emphasis of sexual health in pre-registration nurse training (Quinn & Browne, 2009). It was suggested by Quinn & Browne (2009) that the nursing curriculum must begin to include detailed information on how to deal with human sexuality if successes in comprehensive and holistic care are to happen. They later went on to develop the 'five A's mnemonic to describe the process they saw the nurses in their studies go though: 'avoidance; awareness; applying; approval; and acknowledgement' (Quinn, Happell & Welch, 2013b)

There are calls for drastic changes in the education of MHNs, as sexuality and sexual issues are intrinsic in the assessment and care process, particularly when

working with individuals who have enduring mental health conditions. The education of MHNs has to be at the forefront of improving sexual health care (Quinn & Browne, 2009). Instead however, it was found that contemporary nursing education did not prepare student nurses to deal with sexuality in an effective manner. A lack of preparation and knowledge appears to remain evident as students become registered practitioners. In fact, pre-registration education seems to reinforce negative connotations by only exposing them to biomedical and deviant examples with no alternatives (Higgins, Barker & Begley, 2008).

That being said, three studies found that the introduction of brief training interventions in the workplace on sexual health with qualified MHNs had a marked improvement on practice. Despite the discussion of sexual health being a new concept to them, after the one to one education session there was a sense of enthusiasm to incorporate it into their practice, with participants now viewing sexuality as an essential part of peoples' 'wholeness as human beings' and important for recovery. The session appeared to increase understanding, knowledge and awareness, and afterwards participants reported incorporating it into their practice as it now felt like a legitimate topic to discuss. It was viewed by some as learning a new skill that just took practice to achieve clinical comfort with. Following the session, participants discussed the potential effects of psychiatric medications on sexual function and acknowledged the social stigma that can exist for the client group on finding and maintaining relationships with much more confidence, and admitted that their practice had changed from avoidance to inclusion (Quinn & Happell, 2012; Quinn, Happell & Browne, 2011b; Quinn, Happell & Welch, 2013). In two of the studies participants acknowledged the importance of

including sexual health in their practice but they didn't know how to and suggested that additional training would be beneficial (Quinn, Happell & Browne, 2011a; Quinn, Happell & Browne, 2011b).

There was hope from these findings that the small number of participants would continue to include it in their practice, with the conclusions being that MHN education is key. This is perhaps best encapsulated by the comment of one participant who has now fully incorporated it into their assessment practice- '*it's important to talk about sexuality and see where it leads to. It may not lead anywhere but then we ask about suicidality and not every consumer is suicidal*' (Quinn, Happell & Welch, 2013a, p 234).

DISCUSSION

There is very little well-designed research examining the preparatory education given to MHNs around sexual health. There is also a lack of robust evidence on the views and experiences of MHNs on the topic, so much more research is needed in order to provide generalizable conclusions. This review only found seven papers matching the inclusion criteria, and six of those were written by the same authors, seemingly about the same small cohort. The key finding is therefore that much more high-quality research is needed to inform this gap in knowledge.

That being said, the studies reviewed here gave a consistent and familiar bleak picture of MHNs viewing sexual health as unimportant (Higgins, Barker & Begley, 2008; Quinn, Happell & Browne, 2011a; Quinn, Happell & Browne, 2011b; Quinn &

Browne, 2009). These conclusions are in line with the wider literature discussing sexual health and nursing (Hoekstra *et al*, 2012; Arikan *et al*, 2014; Saunamaki, Andersson & Engstrom, 2010).

Several barriers contributed to the inhibition of discussion of sexual health: the personal values of MHNs towards individuals expressing their sexual needs and the reluctance to see mental health service users as sexual beings; anxieties around challenging the status quo of institutionalised ideals and the views of colleagues; and the lack of acknowledgement of sexual health in practice. There were no best practice examples to draw on, but Quinn, Happell & Welch, (2013b) reported favourable outcomes from the introduction of sexual health training sessions for MHNs in the workplace. This demonstrated change is both possible and desirable, but it requires action in relation to research; policy; education and practice. These will be discussed in turn.

Research

There is a clear requirement for further research. Apart from the studies included in the review there is an absence of research into what MHNs think or know about delivering care related to sexual health. There is literature examining sexual health provision from the service user perspective, and like the review here the results are almost universally negative (McCann, 2009; Higgins, Barker & Begley, 2005; Davison & Huntington, 2010; McCann, 2010; Elkington *et al*, 2012; Brown, Lubman & Paxton, 2008). Research is therefore clearly needed to help identify and test support mechanisms and interventions designed to improve practice.

The studies included in the review featured a small number of participants and with

the exception of one, were written by the same authors, focusing on the same geographical locale, with the same small cohort of participants. This is important because the training for nurses in Australia differs to other countries, and so the results may not be generalizable to other countries (Robinson & Griffiths, 2007), even if they were considered generalizable within Australia. Aside from any cultural issues in Australia registered nurses choose to specialise in mental health following completion of a generic nursing degree (Nursing and Midwifery Board of Australia, 2015), unlike UK for example, where mental health nursing remains an undergraduate specialism (NHS- Health Careers, 2017).

In addition to this, the study of Higgins, Barker & Begley (2008) was based in the Republic of Ireland, and by the researchers' own admission, some of the findings, particularly the strong personal attitudes around sexuality may be reflective of the local religious culture and not necessarily transferrable to MHNs elsewhere. In summary, there is a requirement for multi-centered national and international studies to establish whether the findings here are transferable.

Policy Development

There have been significant changes and developments in recognising the rights of people who experience mental health issues. As a result, there should be greater awareness and understanding of recovery and empowerment for people affected by mental ill-health, as recovery focused policy becomes practice (Hopkins, 2016). The therapeutic relationships MHNs establish with service users are thought to be central to recovery (Simpson *et al*, 2015; Wright & Jones, 2012; Waldemar *et al*, 2016). However, the findings of the review suggest that the underpinning values of the therapeutic relationship are at risk due to the lack of

engagement around sexual health. Furthermore, the *absence* of acknowledgement is the very antithesis of person centered care, which is the basis for any successful therapeutic relationship (Higgins, Barker & Begley, 2008).

As mentioned previously there is no official policy detailing the expected provision of sexual health within mental health practice in the UK. Best practice statements guide practitioners toward providing comprehensive care and are aspirational in nature (Tolmie & Rice, 2015), but they are often challenging to implement and are not subject to standardised scrutiny, meaning that their recommendations can fail (Teresi *et al*, 2013; Gichuhi & Gomersall, 2013). While the 2017-2027 Mental Health Strategy for Scotland (Scottish Government, 2017) discusses stigma and sexual orientation it does not explicitly mention the importance of sexual health. Given the body of evidence that exists around sexual health concerns for individuals experiencing mental health issues, particularly in relation to higher rates of STI and HIV transmission (Hughes & Gray, 2009; Elkington *et al*, 2012; Stewart *et al*, 2012) and being at greater risk of sexual exploitation (Brown, Lubman & Paxton, 2011; Higgins, Barker & Begley, 2006; Davison & Huntington, 2010; McCandless & Sladen, 2003) it is difficult to understand why it is not explicitly recognised as a priority in policy.

Education

In the UK the practice to theory ratio for undergraduate nursing programmes is 50/50 (NMC, 2010). The placements on the programme are not only to prepare the students to become registered nurses but to allow them to learn from practitioners who are experts in their field. Given the issues highlighted in the literature it would

seem that mental health students would greatly benefit from spending time within the specialist sexual health services, learning from staff who speak about sexually related issues on a daily basis. It would help normalise the process and most importantly allow them to see how to broach the subject in a constructive way. The work of Datillo (2005) suggests that the only way to ensure holistic assessment is for students to work in sexual health services during their training. While it would not be practical or appropriate for every student to attend the services, it should be an option where capacity allows.

The findings of Quinn, Happell & Welch (2013a & b) likened learning to include sexual health in practice to achieving clinical comfort in any other skill, such as taking a blood pressure. A session should therefore be integrated with other clinical skills teaching. It would be crucial that this session did not give the impression of a 'school-like' sex education class but instead be contextualised to mental health practice environments. There is a wealth of evidence to suggest that clinical simulation both improves confidence and leads to enhanced performance in real practice situations (Khalaila, 2014; Pittman, 2012; Stunden, Halcomb, & Jefferies, 2015) For instance, mental health students are taught to promote the use of sunscreen due to the high rate of photosensitivity amongst patients who are prescribed antipsychotic medication (White & Lenz, 2013). The information that sunscreen can rapidly degrade condoms (Crosby *et al*, 2006) should be included alongside this. Information such as this may seem rather basic but could have major impact as well as portraying an openness about sexual health to the service user.

Sexual health should be a thread running through undergraduate nursing curricula. This would normalise it. Further, it may support students to broach other sensitive subjects in a constructive way. For example Crossan & Mathew (2013) found guided educational interventions prepared student nurses to provide dignified, intimate personal care when they initially felt intimidated by the prospect. Similarly, the work of Luebbert & Popkess (2015) demonstrated that directed education enhanced the confidence of student nurses in competently assessing suicidality. In summary, if students viewed the promotion of sexual health and wellbeing as part of their job, and are given support in exploring their values in a safe and structured learning environment, then this should militate against avoidance of the topic when they qualify.

In relation to post graduate education MHNs and other practitioners working in adult mental health services should have the opportunity to undertake education and training on sexual health contextualised to their working environment. The evidence in the study presented by Quinn & Happell (2012) suggested that 40 minutes was enough to make a significant difference to practice and this was apparently sustained according to the results of their follow up study (Quinn, Happell & Welch, 2013b). Whilst an excellent example it is unrealistic to suggest that every MHN attend specifically designed training. Rather, it could be beneficial to introduce the concept of a sexual health ‘champion’ for example, where one or two colleagues attend specialist training per area and then cascade knowledge and training throughout their local area. The idea of champions originated with dementia care in Scotland, and their success led to the role being used in a variety of contexts from self- harm and continence training (NHS Education for Scotland,

2011b) to the evaluation of chaplaincy services (Snowden & Telfer, 2017).

Practice

All care services should recognise sexual health as an essential element of everyone's care. Service providers have the responsibly to challenge negative attitudes of staff and to ensure that individuals are not being unnecessarily marginalized (Higgins, Barker & Begley, 2008; Quinn & Happell, 2012; Quinn & Browne, 2009). Routine assessment documentation should include sexual health and be subject to regular audits to ensure that the recorded information is both appropriate and accurate. This will help ensure that meeting sexual health needs becomes part of routine practice (Darmer *et al*, 2006; Patel, 2010).

The review showed that nurses' personal feelings about sex and sexuality hindered engagement with service users. To mitigate this Buehler (2014) suggested that practitioners should be encouraged to explore their own thoughts and value base around sex and sexuality. This exploration should allow individuals to develop a heightened level of self-awareness and therefore uncover any potential insecurities or unhelpful judgements (Buehler, 2014). Hill (2008) pointed out that truly understanding one's own sexual identity can be extremely challenging but that personal sexual values play a vital role in how people relate to each other. Worthington *et al* (2002) published one of the first models attempting to illustrate the complexities of sexual identity- Heterosexual Identity Development: A Multidimensional Model of Individual and Social Identity- and recommended that it should be used for coaching students in disciplines such as teaching, nursing and psychology, where sexual discussions are essential. There have since been other models published which are more inclusive but the recommendation to use them in

discipline specific teaching remains the same (Glover, Galliher & Lamere, 2009; Deutsch, Hoffman & Wilcox, 2013).

Finally, mental health practice settings should already be running clinical supervision groups for MHNs as a matter of best practice. Issues around addressing sexuality could be a standard agenda item to review. This would allow for extensive discussion around complex scenarios; difficulties and anxieties; the sharing of good practice and an opportunity to identify training needs, all in a safe and confidential environment (Rice *et al*, 2007; Buus *et al*, 2011).

Strengths and Limitations of the Review

While every effort was made to be rigorous in relation to selection of papers and the quality review process, there is always the possibility that a different reviewer may have selected different papers. This was mitigated as far as possible by cross checking between the authors and through using a recognised quality appraisal tool throughout. Another potential limitation is the focus of this review. Because the focus was on the preparatory needs and experiences of MHNs, the findings may not be transferable to non MHNs delivering sexual health care. Relatedly, perhaps the exclusion criteria were too extreme. It is clear that there is a lot of literature discussing sexual health, but not specifically in relation to education and non-specialist mental health nursing. Widening inclusion criteria would have increased claims to generalizability. Nevertheless, it wouldn't have answered the research question.

This review has revealed a significant gap in the literature, a lack of evidence to support preparation of MHNs to address sexual health with service users. In

terms of the available evidence included within the review there were some noteworthy limitations, including the robustness of the study designs, but more significantly, all but one study were written by the same authors and carried out in the same geographical location, with considerable crossover of participants between the studies. Therefore, it is impossible to claim that the findings are a reflection of practice outside these areas. In addition to this, the most recent study is already four years old (Quinn, Happell & Welch, 2013b) and the most robust study in terms of CASP scoring is eight years old (Higgins, Barker & Begley, 2008). Again, this indicates the requirement for further research to see if the issues highlighted remain present in contemporary mental health settings, particularly as the more recent studies still seem to suggest that MHN attitudes have not altered in the last eight years.

CONCLUSION

Mental Health Nurses are significantly underprepared to explore sexual health needs of mental health service users. Targeted education initiatives appear to have a favourable effect on practice, but due to small sample sizes no definitive conclusions can be made. That being said, it is clear that there are numerous factors affecting the lack of sexual health provision for this client group, and they urgently need to be addressed if mental health services want to provide truly holistic care. MHNs need to recognise that they have a role in educating service users in areas such as relationships and safe sexual practices to help promote recovery.

Additionally, while it may be uncomfortable for some, reflection on personal views around sexuality seems integral to altering practice for the better. Further research is required, particularly within the UK, on both the attitudes of MHNs and the preparation given to undergraduate mental health nursing students on the subject of sexual health. Once this data has been collected, suitable models of education can be implemented and evaluated. The presence of recent, robust relevant data should also lead to changes in local and national policy, driving practitioners to address sexual health in a systematic manner and ultimately improve service provision. Only when this begins to happen can the term 'holistic care' be genuinely applied to contemporary mental health nursing.

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Table 1- Papers included in the review

Study Citation and Country	Aims	Sample	Data Collection Method	Key Findings	Recommendations	CASP Score out of 20
Qualitative Studies (n=4)						
Higgins, Barker & Begley (2008) Republic of Ireland	To develop a grounded theory to explain how MHNs respond to issues of sexuality in practice	27 MHNs (10 male, 7 female) working in an urban area	Comparative analysis and memo writing	Numerous findings: concerns of personal and professional vulnerability; lack of competence and comfort. Findings also suggest that nurses perpetuate discrimination and socially exclude clients	That the sexual rights of mental health service users should be part of the discourse of MHNs and all involved in the delivery of mental health services	17
Quinn, Happell & Browne (2011a) Australia	To investigate the practices of MHNs in relation to consumer sexuality	14 MHNs (6 males, 8 females) working in community and inpatient mental health settings for the same health trust	Individual semistructured interviews- Digitally recorded and verbatim transcription	That: sexuality is not an important priority; it is not seen as part of the nursing role and that the MHN's personal values around sexuality can add another layer of complexity	Further research to understand. There is also a need for education and training and to include it in the undergraduate curricula to assist nurses with understanding the importance and encourage confidence and comfort around it.	12

Quinn, Happell & Browne (2011b) Australia	To explore the practice of MHNs in relation to discussing sexual side-effects of psychiatric medication	14 MHNs (6 males, 8 females) working in community and inpatient mental health settings for the same health trust	Individual in-depth interviews adopting a conversational approach, digitally recorded and verbatim transcription. The Ritchie and Spencer (1994) five-step approach was then used to analyse the data	That only 4 participants discussed sexual side-effects with clients. There was no consideration of women or olden men. MHNs reluctant to address side-effects due to fears of non-compliance with treatment plans	Finding strategies to improve nurses' comfort around addressing sexual issues is an 'urgent' priority. That an acknowledgement of sexual health must be embedded into practice from assessment through the entire treatment trajectory- it should become routine.	16

Quinn & Happell (2012) Australia	To explore the experiences of MHNs' use of the BETTER model	14 MHNs (6 males, 8 females) working in community and inpatient mental health settings for the same health trust	Individual in-depth interviews followed by a 40 minute education session. The Ritchie and Spencer (1994) five-step approach was then used to analyse the data.	Two major findings emerged. There was a greater awareness of the importance of the topic and as a result it became part of practice. However, the model was seen to be a vehicle to this and not the driver.	Sexuality should be included in both undergraduate and postgraduate curricula- by embedding the initial importance and then specific focus at postgraduate level. Sexuality should also be incorporated into professional development programmes for nurses.	14
Quinn, Happell & Welch (2013a) Australia	To evaluate if participants sustained practice change following a previous sexual health education intervention	10 MHNs (3 male, 7 female) working in community and inpatient mental health settings for the same health trust	Individual conversational interviews- Digitally recorded and verbatim transcription	Practice had changed as a result of the education session. Participants acknowledged that they needed to see the whole person to promote recovery which included their sexuality.	That such brief education sessions should be viewed as a cost-cutting training method which can lead to sustained practice change.	14

Quinn, Happell & Welch (2013b) Australia	To summarise all research to date and evaluate if participants sustained practice change following a previous sexual health education intervention	14 MHNs (6 males, 8 females) working in community and inpatient mental health settings for the same health trust	Overview of all previous research (above) evaluating the effectiveness of a structured education programme	Education had led to awareness and some practice change. Acknowledgement from participants that sexual concerns should be part of MH practice	The Five A's framework, developed by the first author should be rolled out	14
Literature Review (n=1)						
Quinn & Browne (2009) Australia	To identify articles exploring sexuality in relating to mental health consumers and the care provided by MHNs	72 articles	3 databases and the internet were searched using a combination of 5 search terms	MHNs are in a unique position to address sensitive issues such as sexuality but nursing attitudes prevent thisw.	There needs to be work done to help engage MHNs with the topic and to legitimise it being addressed in the mental health services.	10

Figure 1. PRISMA 2009 Flow Diagram