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Sex and Mental Health: Why we don't talk about it, and why we should

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RESPECT

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Aim of the session

To highlight the pertinent issues related to sex and sexual safety for people who have mental health problems.

To identify barriers and facilitators to discussing sexual issues.

To identify some key evidence related to the topic



What are the issues?

- People with serious mental illness engage in sexual activity across the age range. It is an important part of health and wellbeing to express own sexuality in a way that is safe, and free from coercion or stigma.
- The right to a sexual relationship and family life is a fundamental human right.
- However, mental health care has an uncomfortable history with human rights in general, and specifically around sex and sexuality- specifically for women and those who were not heterosexual
 - Eugenic sterilisation
 - “Gay” conversion therapy
 - Pathologising female sexuality “promiscuousness”
 - Adoption of babies born to parents with mental illness
 - “Hysteria”- comes from idea that owning a uterus caused specific mental illness

What we know

- Mccann (2010) people with psychosis in CMHTs- aspire to have relationships, though those relationships tend to be abusive or exploitative; rarely (or never) discuss intimate relationships with their care coordinator
- Hughes et al (2016) systematic review of HIV, hepatitis B and C found people in psychiatric care had elevated rates of blood borne infections (far more than would be expected in the general population).
- Khalifeh et al (2015)- 6- to 8-fold elevation in the odds of sexual assault among both men and women with a serious mental illness (SMI) compared with the general population.
- Child sex abuse is a common experience amongst people with mental illness.
- Increased rate of un-intended pregnancy and abortion (Simoila 2018)
- Elkington 2010- sexual stigma has been identified as an issue for those with long term mental health problems and is linked to sexual risk taking and exploitation
 - Institutional – staff tell them to avoid intimate relationships and/or have children because of their mental health issues
 - Self- stigma
 - Interpersonal stigma

Why?

- Theories offered to to explain include:
 - Increased sexual risk taking or vulnerability to sexual assault during times when psychiatric symptoms are more troublesome
 - Co-morbid drug and alcohol problems (30-50% people with SMI)
 - Intoxication leads to poor planning/decisions
 - Risk for assault
 - Trading sex for drugs/alcohol
 - Previous experience of sexual abuse
 - Sexual stigma
 - Lack of social skills (assertiveness, negotiation re condoms etc)

Sexual safety inpatient wards- what do we know?

- Foley and Cummings (2018)
 - FOI to NHS trusts) between 2011 and 2015
 - they identified 32 assaults (20 were women and 12 were male victims).
 - 10 in patient's bedroom; 13 in communal areas
- Bowers et al (2014)-Part of a large study “safe wards”
 - Monitored incidents recorded during the first 2 weeks of admission
 - Sexual incidents were monitored
 - The most common behaviour was “exposure”, followed by public masturbation
 - Sexual harassment and assault was rare
 - No difference between mixed and single sex wards in N of incidents
- CQC report 2018
 - April and June 2017 Text mining routine data for anything related to “sexual incidents”
 - Of 60 000 incidents recorded, 1.2% were related to sexual behavior and about a third of these related to exposure and public masturbation.
 - There were 29 alleged rapes recorded.

In sum

- We should be concerned about the types of intimate partner relationships – coercion and control, sexual violence and/coercion
- Engaging in behaviours that increase risk of HIV and sexually transmitted behaviours and unintended pregnancy
- High levels of re-victimisation sexual assault and rape in people who use mental health services
- In inpatient settings , it is not uncommon to witness “inappropriate sexual behaviour” such as exposure or public masturbation.
- From the evidence, the frequent response is containment and PRN!
- These behaviours need to be differentiated from offences and require specific management- these people are unwell, may not be fully competent, and may also place themselves in positions of vulnerability
- Incidents occur in communal areas as much as in private areas (bathrooms/bedrooms)
- Incidents don't seem to be reduced in single sex accommodation – so its not the complete solution
- Sexual assault/ offences are rare but they do happen and possibly under-reported
- Evidence that patients and staff are perpetrators- men are more likely to be perpetrators but women also offend.



Issues and Strategies to improve sexual safety

- We need better interventions for sexually inappropriate behaviours – prevention, management with dignity and without shame, and also debriefing once a person is out of the acute phase
- We need a better awareness of what constitutes sexual offences- harassment, assault, rape, and how to investigate, and involve the police if necessary
- Disclosures of rape or assault not uncommon in mental health care, can seem “implausible” – all disclosures need to be met with belief- disbelief can do a lot of psychological harm
- People need to feel safe in our care- sometimes they can feel unsafe in the absence of sexual behaviours because of previous experience of assault and sexual trauma- this also requires some thought.



Improving staff response to sexual health and safety

- Studies in Australia and UK (Hughes and Gray 2008; Quinn 2011, Hughes 2018) consistently show that mental health staff are really concerned about sex as a topic. They are worried about upsetting, destabilising the person and therefore avoid the topic
- Brooker (2016) found that the question about sexual assault is not recorded in 40% of CPA records even though this is a required field to complete
- Study in Australia also found that mental health staff in a crisis mental health team avoid routine enquiry (McLindon, E. & Harms, L. (2011)
- However we can improve staff responses – Quinn and Happell (2012) found that training to desensitise staff regarding sex improved the number of conversations about the topic
- But we need more research around what would help staff to have more discussions and an organisational buy-in that supports this work
- If it becomes normal, it becomes less of an “issue”



Qualitative interviews with mental health staff (Hughes et al 2018)

- 4 focus groups- 2 in London; 2 in the north
- Asked 2 questions: what are the sexual health and relationship needs of people you work with AND what is your role in sexual health
- Main themes:
 - Tend not to discuss unless the subject is raised by service user
 - Identified that they were aware that there was significant sexual health and relationship needs (including risk of sexual violence)
 - Not wanting to ask- worried about upsetting, destabilising and being perceived as being abusive or predatory
 - Not knowing what to do with information
 - Its not part of assessment or encouraged by system/organisation

RESPECT

- NIHR HTA Feasibility RCT 2 arm: intervention in addition to treatment as usual v treatment as usual
- Setting: community mental health teams in 4 Trusts (Leeds, Barnsley, Camden and Islington, North East London and Brighton)
- Participants- people with serious mental health problems willing and able to give consent to participate
- Target 100 (25 in each site) (allowing for an anticipated 30% attrition)
- Follow-up at 3 and 6 months
- We recruited 72 people
- No adverse events- people reported feeling comfortable being asked about sex
- Intervention – improve knowledge re safer sex, improve motivation to adopt safer sexual practices and improve assertiveness skills in negotiating in sexual relationships
- Acceptable and feasible to offer a 3 x 1 hour sexual health promotion intervention to people with serious mental illness
- In qualitative feedback some participants stated it was the first time they had ever had a conversation about sexual health.

(in press, www.respectstudy.co.uk)



- NIHR funded national study of the effectiveness of sexual assault referral centres in meeting mental health and substance use needs of people who attend
- 40% of people who attend a SARC in uk have a pre-existing MH history. SA is associated with risk of PTSD
- However, SARC service specification makes minimal mention of mental health issues and most of the SARC workforce is not MH trained
 - Forensic medical (or nurse examiner)
 - Crisis workers
 - Follow up supportive counselling, not formal MH assessment
- 5 stages- evidence review, national survey of SARCs, prospective prevalence study, case studies, routine data analysis and final stage to develop tools to translate findings into tools to inform commissioners and providers
- Using a Realist approach- to identify what works for whom in what contexts and how (mechanisms)
- 3 year study – started June 2018
- Data collection in winter 2019-20.



Systematic Review

- 1) What are the approaches to the prevention, identification and treatment of mental health and substance misuse problems in different SARC service models?
- 2) What models of care in SARCs are effective regarding service users' mental health and substance misuse outcomes?
- 3) What are stakeholders' views and policy recommendations about how SARCs should prevent, identify and treat mental health and substance misuse problems for people following a sexual assault?

Electronic searches were conducted on the following bibliographic databases: PsycINFO, MEDLINE, IBSS and CINAHL, combining text words for SARCs adapted from an international overview of sexual violence services



Summary of Narrative Synthesis

- Lack of consensus on how best to identify mental health and substance use needs in SARCs.
- Identification based more often on clinical judgement than informed by standardised tools.
- Some SARCs offer in-house mental health support, but this tends to be “supportive counselling” rather than specific structured psychological interventions.
- When referring to other services most SARCs did not offer an active follow-up to promote service users’ engagement.
- Child Advocacy Centres (US, Turkey) and sexual assault services in Nordic countries were most likely to provide structured mental health support

Conclusion

- Mental health staff are skilled at having conversations about sensitive topics
- These skills are transferable to sexual safety and sexual health
- The consequences of avoiding the topic are really significant.
- Initiatives such as the NIHSI improvement project can help raise awareness of importance of the topic
- There is a need to include training and awareness raising in psychiatry, nursing and other professional training
- Closer links to relevant services such as sexual assault referral centres, sexual health services and family planning
- Needs to be part of the physical health, trauma informed and the recovery agenda



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