Why you should read this article
- To recognise that sexual health is an integral part of a holistic mental health nursing assessment
- To be aware of a new model that aims to support mental health nurses to discuss sexual health with service users
- To count towards revalidation as part of your 35 hours of CPD, or you may wish to write a reflective account (UK readers)
- To contribute towards your professional development and local registration renewal requirements (non-UK readers)

Using the STARTER model to talk about sex in mental health nursing practice

Rachel Luby

Abstract
People with mental illness are more likely to contract sexually transmitted infections and blood-borne viruses than the general population. They are also at higher risk of becoming victims of domestic or sexual violence and of having an unplanned pregnancy. Despite this, the sexual health of people with mental illness is often overlooked in the healthcare environment. This has an adverse effect not only on morbidity and mortality but also on quality of life and recovery outcomes.

This article introduces a systematic approach for including sexual health enquiry and promotion in holistic mental health nursing practice. It is relevant for staff who work in inpatient and community settings.

The STARTER model is a step-by-step tool that has been designed by the author for mental health nurses to encourage conversations about sexual health. It considers that mental health nurses may be limited by lack of training, and by personal or organisational barriers, but encourages them to look at how these can be overcome, as well as when it is necessary to refer to external agencies that can provide support and services that may be more appropriate for the individual patient.

Introduction
Sexual health is not just the epidemiology of sexually transmitted infections (STIs). It encompasses a wide range of interrelated themes such as sexual identity, expression, assault, reproduction and contraception (Royal College of Nursing (RCN) 2018). The World Health Organization (WHO) (2006) defines...
sexual health as ‘a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled’.

For people with severe mental illness, sexual health as defined by WHO is often a state to which they can only aspire. This population is more likely to engage in high-risk sexual behaviours including unprotected intercourse, involvement in the sex trade and being with multiple partners (Kaltenhalter et al 2014, Hughes et al 2016). The prevalence of unplanned pregnancy, human immunodeficiency virus (HIV), hepatitis and STIs is also higher than in the general population (Academy of Medical Royal Colleges 2011, Department of Health 2016, Hughes et al 2016), as is the prevalence of domestic and sexual violence (Care Quality Commission (CQC) 2018, Royal College of Psychiatrists (RCPsych) 2019). Sexual dysfunction is thought to affect as many as 73% of those who take neuroleptic or antidepressant medications (Higgins et al 2010, Montejo et al 2010).

These disparities between people with mental illness and those without affect each of the Five Ps of sexual health: partners, practices, prevention of pregnancy, protection from STIs, and past history of STIs (Centers for Disease Control and Prevention 2015). They are due in part to: a lack of knowledge; access to assessment, screening and information; the symptoms and vulnerabilities of mental illness; and social adversity (McCann 2010, Tiwana et al 2016). All are reflected in the premature morbidity and mortality of those with mental illness (Mental Health Taskforce 2016, Moore 2018). However, the disparities are also due to the reluctance of mental healthcare professionals to move beyond recognising sexual health as an area of need to taking steps to improve outcomes: while 75% of mental health nurses recognise that sexual health is part of their role, fewer than 10% include it in their practice (Hughes et al 2018).

Sexual health provision and promotion in inpatient and community mental healthcare settings are described as ‘neglected’, ‘sketchy’ and ‘variable’ (Hughes et al 2018). Mental health nurses cite a reluctance to broach the subject of sexual health: concerns about lack of confidence, training and knowledge; personal discomfort; and an unfounded fear that they will destabilise the patient because discussing sexual health history and current behaviour with them may have a negative effect on their mental health (McCann 2010, Tiwana et al 2016, Hughes et al 2018).

To support mental health nurses to overcome these barriers and take much needed action, the author has developed a model that not only legitimises conversations about sexual health but also provides nurses with a linear yet flexible method of assessing, planning, implementing and evaluating care. It offers nurses an opportunity to reflect on their assumptions and encounters, provides an evidence base for each step in the process and encourages nurses to identify areas where they require further knowledge.

Using models to discuss sexual health

Mental health nurses have the greatest contact with service users (Tranter and Robertson 2019) so, if they are to improve the sexual health outcomes of people with mental illness, they must overcome the barriers that prevent them from ‘talking about sex’. The use of models to discuss sexual health is one method.

In oncology care, a brief educational intervention called Fex-Talk, which aims to enhance nurses’ readiness to discuss fertility and sexuality with patients living with cancer, was found to increase nurses’ understanding about patients’ needs and to support them to overcome obstacles to initiate such discussions with patients (Winterling et al 2019).

Similarly, the BETTER model (Mick et al 2004) (Box 1) was designed to support nurses to assess the sexuality concerns of patients with cancer.

The 5-As framework for including sexual concerns in mental health nursing practice (Figure 1) focuses on developing awareness rather than skills (Quinn et al 2013). The framework’s premise is that, by knowing more about the sexual concerns of people

<table>
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<th>Box I. The BETTER model</th>
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<tr>
<td>» Bring up the topic</td>
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<tr>
<td>» Explain that you are concerned with quality-of-life issues, including sexuality. Although you may be unable to answer all questions, you will want to convey that patients can talk about their concerns</td>
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<td>» Tell patients you will find appropriate resources to address their concerns</td>
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<td>» Timing might not seem appropriate now but let patients know they can ask for information at any time</td>
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<tr>
<td>» Educate patients about the side effects of their cancer treatments</td>
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<td>» Record your assessment and interventions in patients’ medical records</td>
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(Mick et al 2004)
with mental health issues, nurses move from avoiding conversations to approving of them, applying this knowledge to practice and recognising that sexual health is part of their role.

The PLISSIT model (Annon 1976) is another useful tool that conceptualises the different layers of input that may be required to support a patient to resolve sexual health issues (Figure 2). It emphasises the importance of creating the right conditions to discuss matters of a sexual nature, giving the person permission to ask questions, offering facts, making specific suggestions and, when necessary, referring to specially trained counsellors, sex therapists or external sexual health providers.

**The STARTER model**

The STARTER model (Box 2), which was developed by the author, is designed specifically for mental health nurses to increase their awareness of the needs of people with mental illness while improving their knowledge and overcoming personal and professional barriers to including sexual health in their practice.

The rationale for each step in the STARTER model and the time out activities in this article are discussed to support you to understand why you should include sexual health in your practice, and to support you to grow in confidence and competence as it becomes part of your everyday practice.

It is important to transition to assessment, acknowledging that the questions may seem personal and may be challenging to answer but that they will connect the patient’s mental health needs to their overall sexual and reproductive health. This can be done by discussing their symptoms, medications or recovery goals. Normalise the assessment, ensuring that you give approval, for example by using one of the following statements:

» ‘I ask all patients the following questions...’
» ‘As part of gaining an overall understanding of what support you may need...’
» ‘We are aware that people with mental health difficulties may be more likely to...’
» ‘You may be familiar with healthcare professionals asking about...’

Reassure the patient that the information they provide is confidential and will be shared with external agencies only with their permission or if there are concerns that they or others may be at risk of harm. Also make clear you are asking these questions to ensure that you can provide the best care you can and so you can develop an overall assessment of the person and their strengths and challenges. Emphasise that good sexual health is part of overall health and well-being.
1. Start the conversation as soon as possible. Include sexual orientation, gender identity and the patient's relationship status in the initial assessment.

People with severe mental illness can convey their perceptions of sexual health and intimacy, have a desire for romantic relationships and view these as a significant part of the recovery process. The literature recognises that patients want nurses to initiate conversations about this topic, so the onus is on you to start the conversation (McCann 2010).

It is important to ask patients about their sexual orientation and gender identity because people denied the freedom to live in the gender with which they most identify are at risk of depression, self-harm, post-traumatic stress, and suicide ideation and attempts, as well as homelessness and a low degree of satisfaction with life (Hidalgo et al 2013). In addition, an individual who identifies as lesbian, gay or bisexual is more likely to present with symptoms of depression, anxiety, self-harm or drug or alcohol misuse, which are often linked to experiences of homophobic and transphobic bullying (NHS 2017).

The Sexual Orientation Monitoring Information Standard provides classifications for NHS and local authority social care providers to record a person's sexual orientation (NHS England 2017). This information can be used by policymakers, commissioners and providers to identify health risks and needs better (NHS England 2017).

The recording of a person’s sexual orientation also supports mental healthcare staff to undertake preventive and early intervention work, such as referral to lesbian, gay, bisexual, transgender and queer or questioning support groups, and discussions about accepting sexuality, coping with other people’s reactions, transitioning, hostility or rejection from friends or the community, and the effects of bullying and discrimination.

The outcomes of such work and discussions can lead to referrals for psychological input when a need is identified.

2. Tell the patient they have permission to talk freely about their sexual health history, sexual safety and sexual health concerns. Ask about the Five Ps: partners, practices, prevention of pregnancy, protection from STIs, and past history of STIs (Centers for Disease Control and Prevention 2015), and include domestic and sexual violence.

Sexual health is complex and, while it is becoming less of a taboo, discussions on sex, sexual health, expression and violence are uncommon in healthcare settings. Convey interest in your patient’s past sexual experiences, their current situation, and their hopes and aspirations for the future regarding sexual experiences and intimacy. This provides a basis for accurately assessing knowledge, risks and need in this area.

The Five Ps is a systematic method for eliciting information in the main areas of sexual health that can support you to assess knowledge, risks and need (Centers for Disease Control and Prevention 2015). This information can support you to gain a better understanding of the patient’s sexual health history and also identify if they require external referral, extra support or information.

The relationship between mental illness and sexual violence is complex and bi-directional; it predisposes to and maintains mental illness (O’Dwyer et al 2019). After any disclosure, it is vital to enquire about the support the person needs so they can feel safe from harm and create the conditions for healing. This can involve acknowledging that many practices can mimic past experiences of helplessness and powerlessness in the mental health setting. These practices include restraint, enforced medication and seclusion, detention under the Mental Health Act 1983, pressure to accept treatment, enhanced observations or the labelling of traumatic stress reactions or coping mechanisms. Discuss individual triggers with the patient.

### Box 2. The STARTER model

» Start a conversation as soon as possible. Include sexual orientation, gender identity and the patient’s relationship status in the initial assessment

» Tell the patient they have permission to talk freely about their sexual health history, sexual safety and sexual health concerns. Ask about the Five Ps: partners, practices, prevention of pregnancy, protection from sexually transmitted infections (STIs), and past history of STIs (Centers for Disease Control and Prevention 2015), and include domestic and sexual violence

» Acknowledge your views, biases and assumptions and those of the patient. Be objective and make clear that you will do your best to support them

» Refer to external services and agencies for extra support as soon as a need is identified

» Talk about symptoms and sexual side effects and the patient’s hopes and aspirations for the future

» Enhance the knowledge and understanding of yourself and the patient in areas with which you are unfamiliar

» Reflect on and record each conversation and return to the topic at regular intervals
person and ensure that you respond accordingly. If working in an inpatient environment or with patients who may have future inpatient admissions, nurses can work towards becoming trauma-informed practitioners by empowering service users. They can do this through discussions about personal choice and collaboration, asking:

» Whether patients prefer to be nursed in a same- or mixed-sex environment.

» How, in instances where restraint is proportionate, reasonable and necessary, patients would prefer it to be done so it is least traumatising or retraumatising.

» Whether patients have a gender preference for professional contacts and chaperones.

» What support the patient needs to understand their response to trauma, or how some of their coping mechanisms may be linked to their experiences of trauma.

People with mental illness are also at risk of being traumatised or retraumatised in hospital settings, where sexual violence is described as ‘commonplace’ (CQC 2018, RCPsych 2019). It is vital that ward cultures promote sexual safety and sexual well-being, and actively encourage disclosure (CQC 2018).

TIME OUT 2

Download the Sexually Transmitted Diseases Treatment Guidelines at cdc.gov/std/tg2015/tg-2015-print.pdf (Centers for Disease Control and Prevention 2015). With reference to the Five Ps listed on page 3, ask about a patient’s partners, practices, prevention of pregnancy, protection from STIs, and past history of STIs. This can be the same patient as in time out 1 or a different one in your care.

3. Acknowledge your views, biases and assumptions and those of the patient.

Be objective and make it clear that you will do your best to support them.

Obstacles to sexual health provision include a nurse’s own moral values, religious beliefs, upbringing and customs, and concerns about any mismatch between them and the patient in terms of age, culture or gender (McCann 2003, Hughes and Gray 2009, Quinn and Browne 2009, Quinn et al 2013, Hughes et al 2018). The view that sexual health is not a priority for mental health nursing practice is another barrier (Quinn et al 2011, McClure 2012, Salkeld 2015).

It is important to recognise how your culture, religious views, age, gender and experiences can shape how you approach conversations about sexual health and to appreciate how your views may influence your practice. Registered nurses have a duty to recognise diversity and individual choice (Nursing and Midwifery Council (NMC) 2018). You should strive to ensure that you are as objective and non-judgemental as possible.

People with mental illness have the right to have their sexual health choices and concerns discussed and addressed with thoughtfulness and sensitivity. Use supervision and reflective practice opportunities to support you to do this when necessary, including when there are concerns about boundaries, for example when a patient is behaving in an inappropriate or sexually uninhibited way.

It is also important to recognise how the patient’s moral values and beliefs, family, religious and cultural norms are likely to be strong predictors of their comfort and willingness to discuss sexual health. If such issues arise, offer them the option of speaking to another member of staff with whom they may feel more comfortable or more able to identify.

TIME OUT 3

Discuss with a colleague the personal barriers that prevent conversations about sexual health. Identify the three that you think are most likely to be cited by mental health professionals and consider together ways in which they can be overcome.

4. Refer to external services and agencies for extra support as soon as a need is identified.

Organisational issues identified in the literature as obstacles to talking about sexual health include access to external genito-urinary medicine services, to staff who are trained in phlebotomy to offer tests for blood-borne viruses, and to pregnancy testing (Hughes et al 2018). Access to phlebotomy or sexual health screening should not be obstacles to providing effective care and treatment. The Code (NMC 2018) states that timely referrals should be made to other practitioners when action, care or treatment is required.

The National Institute for Health and Care Excellence (NICE) (2019) quality standard on sexual health focuses on preventing STIs and describes high-quality care in this area.

Brook (www.brook.org.uk), a sexual health and well-being charity for people under 25, for example, can identify local services for contraception, support about ‘chemsex’, that is sex that involves recreational drugs, typically mephedrone, GHB/GBL and methamphetamine, that can lead to psychological and physiological dependence, and abortion referrals. The charity offers a wealth of information and free training for professionals including e-learning on sexuality, sex and consent, health and well-being.

The NHS (2020a, 2020b) website lists local and national sexual health information, support...
and contraception services. NICE (2016) has also published a quality standard on domestic violence and abuse, which includes identifying and supporting people experiencing these.

Patients should be offered immediate advice and support and you must ensure that they take all reasonable steps to protect them from further harm by following your organisation’s policies for escalating disclosures and for reporting safeguarding concerns.

External organisations that support victims of domestic violence, their family and friends and the agencies that work with them include the lesbian, gay, bisexual and trans domestic violence charity Broken Rainbow UK, which provides safety plans, access to help, advice and chat services that are available seven days a week. ManKind supports male victims of domestic violence and abuse across the UK, whether they are in heterosexual or same-sex relationships. Women’s Aid is a national charity that supports women and children who are victims of domestic abuse and provides advice on housing, safety planning and working with the police.

TIME OUT 4

Identify local services
Visit the NHS (2020a, 2020b) website to identify your local services for sexual health, information and support. Think of ways in which you can ensure that this information is accessible to your client group.

5. Talk about symptoms and sexual side effects and the patient’s hopes and aspirations for the future.

While a patient should be given permission to raise any concerns they may have, be prepared for in-depth discussion of areas such as sexual safety, the meeting of romantic and sexual needs, challenges in sexual or gender identity and sexual side effects.

Perceived sexual side effects have been identified as one of the reasons for non-adherence to psychotropic medication (Higgins et al 2010, Quinn et al 2011). Sexual side effects can adversely affect a person’s quality of life and willingness to take medication, which can result in non-adherence to treatment and the consequences of relapse. Up to 53% of people with a diagnosis of schizophrenia, for example, cite the side effects of medication as the main treatment issue (Schizophrenia Commission 2012).

It can be challenging to separate concerns that are due to symptoms of illness from those that are due to side effects of medication. It is important therefore to discuss symptoms of the illness as well as sexual side effects of medications before they are prescribed and during medication reviews, as well as strategies for successfully managing any challenges. As well as sexual functioning, consider the wider psychological and social consequences of medication such as the effect on self and body image.

When discussing relationships, convey the message that you will do your best to support the patient to achieve their goals. Positive sexual health is known to have a beneficial effect on historical emotional and psychological issues, improve mental health and enhance the recovery process. It also motivates positive behaviour (Tiwana et al 2016). It is vital to convey that you will do your best to ensure the person’s human rights are protected on the ward and in the community, and that this involves respect for family and private life and expression of sexuality in a way that supports and empowers them.

TIME OUT 5

If you are working with patients who are prescribed antipsychotic or antidepressant medications, ask one of them to complete either the self-rating Glasgow Antipsychotic Side-effect Scale (Waddell and Taylor 2008), which detects the side effects of atypical and second-generation antipsychotics, or the self-report Antidepressant Side-effect Checklist, which assesses side effects from antidepressants (Uher et al 2009).

If you are working in child and adolescent psychiatry or a learning disability setting, an adapted version of the Glasgow Antipsychotic Side-effect Scale for use with those aged between 12 and 18 may be preferred (Oxford Health NHS Foundation Trust 2017).

With the Glasgow Antipsychotic Side-effect Scale, pay particular attention to the score and level of distress caused by sexual side effects, which are explored in questions 17 (‘The areas around my nipples have been sore and swollen’) through to 20 (‘Men only: I have had problems getting an erection’). Agree a plan for monitoring/review with the patient and consider referral to external services or discussion with the prescribing team.

When you become more confident, you may wish to progress to using the Changes in Sexual Functioning Questionnaire (Clayton et al 1997), which can be used to track changes in sexual functioning over time and is most effective when used before medication is started to differentiate between medication side effects and symptoms of the patient’s mental state.

6. Enhance your and the patient’s knowledge and understanding in areas with which you are unfamiliar

Sexual health training is not mandatory in the nursing curriculum and there are no national nursing standards for sexual and

Consider the knowledge that you and the patient have already and where this can be developed. Higher education institutions, sexual health charities, the Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists (fsrh.org/home), and the British Association for Sexual Health and HIV (bashh.org) provide several training courses at varying levels, cost and content for those wishing to improve their knowledge of sexual health.

Sexwise (sexwise.fpa.org.uk) is produced by the national sexual health charity FPA for the National Health Promotion Programme for Sexual Health and Reproductive Health. It provides inclusive, evidence-based sexual and reproductive health information that is accessible to professionals and the public.

TIME OUT 6
In a free e-learning course, the Social Care Institute for Excellence (2011) explores the main aspects of sexual and reproductive health in the context of mental illness. The course (scie.org.uk/e-learning/sexual-health) still provides relevant and valuable guidance for practice. Enrol and complete a module in an area of interest or one in which you require further training. The modules are: sexual health matters for mental health; managing reproductive health; supporting people who experience abuse; safer relationships and safer sex; physical health, mental health and sexuality; genito-urinary health; and unprotected and risky sex. Allow 30 minutes for this activity.

7. Reflect on and record each conversation and return to the topic at regular intervals. Effective communication between professionals involved in the care of people with mental health issues is vital as it avoids duplication or fragmentation of care. It is important to ensure that any referrals, discussions and outcomes are documented and shared while considering confidentiality and people's right to privacy. With care plans and risk assessments, include information about your discussions and local sexual health services/support, and ensure that the patient can access these. Reflect on each encounter you have in which you discuss sexual health; you may wish to use a reflective cycle such as Gibbs (1988) to support this.

Return to the topic of sexual health at agreed intervals: during care planning, ward rounds or reviews of care.

Be aware that a patient may at first feel uncomfortable about discussing their sexual health, or they may be too unwell to engage due to acute symptoms of their illness. However, as the therapeutic relationship is established, rapport is built, symptoms are managed better and conversations normalised, and the patient's willingness to discuss their sexual health is likely to improve.

TIME OUT 7
Develop a basic 'sexual health' care plan template using a style with which your patients are familiar. Use it to record the conversations you have had with a patient in your care using the STARTER model. It can be the same person as in Time Outs 1, 2 and 5, or a different one. Discuss with them who they would like the care plan to be shared with and how often it will be reviewed.

Now you have completed time outs 1-7, read the fictionalised case study, which shows how each step in the STARTER model can be applied in practice.

Implications for practice
Nurses and organisations must overcome obstacles if they are to include sexual health in their practice and thereby reduce the disparities in sexual health between those who have severe mental illness and those who do not.

This article provides a model that nurses and other professionals can use to overcome these barriers by starting conversations about sexual health, discussing patients' concerns, being aware of their own prejudices and discomfort, and returning to the topic as rapport develops between them and the patient and the subject becomes normalised. It recognises the need to support patients to access external services and provides sources of further information and learning for nurses and those for whom they care.

Although the article is written predominantly for mental health nurses, many of the themes apply to other fields of nursing, so the article has wider relevance and implications for practice.

Conclusion
Sexual health is an area of disparity for people with severe and enduring mental illness that has a significant adverse effect on physical health, sexual safety, quality of life, medication adherence and recovery outcomes.

The term sexual health goes beyond definitions that involve the presence or
absence of STIs and includes the right to safe, respectful and pleasurable experiences and the human need for intimacy, love and affection.

Those living with severe mental illness deserve to be cared for in a way that includes opportunities to discuss sexual health, is trauma informed (O’Dwyer et al 2019), offers education and information as well as strategies to cope with or overcome sexual challenges, and is in cooperation with their practitioners.

Nurses, as the healthcare professionals who have the most contact with patients with mental illness in secondary care (Tranter and Robertson 2019), are in an ideal position to deliver these interventions.

A number of individual, procedural and organisational barriers may deter professionals from approaching the subject of sexual health. However, there are tools available to support them in this area, including the STARTER model, developed by the author and aimed at mental health nurses. This model encourages staff to start conversations as soon as possible, to consider the many aspects of sexual health, sexuality and sexual identity, to acknowledge areas they can improve with expert support, and to share their enhanced knowledge with patients. It also encourages them to reflect on their practice, until the unfamiliar becomes the familiar.

It is time to ‘talk about sex’: to tackle the taboo, overcome the obstacles and put personal objections aside to meet our professional obligations.

Case study

John (a pseudonym), an inpatient nurse on an acute female ward, is keen to improve the physical health outcomes of those in his care. He has previously avoided conversations about ‘sex’ with female patients. However, after reading this continuing professional development article, he realised that the STARTER model could support him to overcome barriers. He had also established a rapport with one patient, Sarah (a pseudonym), in previous care planning sessions. Sarah is 22 years old.

John began the conversation by acknowledging that sexual health can be a difficult subject to talk about. He confirmed that Sarah felt able to tell him if she was uncomfortable about answering any of the questions, if they evoked a difficult memory or if she wanted further clarity.

He began the assessment by asking if she was already familiar with questions about sexual orientation, which she was. He felt that this question helped to normalise the conversation as Sarah was familiar with the topic. Sarah said that she identified as heterosexual. John then introduced Sarah to the Five Ps of sexual health (Centers for Disease Control and Prevention 2015) and found that Sarah had been with multiple partners and had not been protecting herself from sexually transmitted infections (STIs).

John acknowledged that Sarah’s sexual practices were different from his own but reminded himself that, as long as she felt safe and was consenting, he should not judge her (Nursing and Midwifery Council 2018). However, he felt it important to educate Sarah about using protection and to offer to refer her to the local sexual health clinic, which he located using the NHS (2020a, 2020b) website.

He identified a female chaperone who could escort Sarah to the clinic, and they booked an appointment online. John also asked Sarah if she had any experience of sexual violence or domestic abuse, which she said she had not. He informed Sarah that some patients do not feel safe from sexual harm when on an inpatient ward, but Sarah said this had not concerned her since admission, and she felt able to tell him if she had any concerns.

Sexual side effects

During a later conversation about the side effects of medication, John and Sarah used the Antidepressant Side-effect Checklist (Uher et al 2009) to identify sexual side effects. Sarah was concerned that, since she began taking antidepressant medication in the community, she had experienced a lack of interest in sex on most days, which she found distressing. John explained that this could be a symptom of her low mood or a side effect of the medication she had been prescribed. They agreed that this could be monitored by completing the checklist fortnightly and discussing the findings with the consultant psychiatrist in Sarah’s ward round.

John wanted to enhance his and Sarah’s knowledge about STIs and contraception, so he printed information from the Brook website (brook.org.uk). The website also had a facility for locating free contraception services for under 25s and he printed a list for Sarah to take when she was discharged.

John and Sarah developed a sexual healthcare plan. This included: their discussions; Sarah’s views, including her aim to have only protected sex and her goal of finding a long-term partner; and details of the local sexual health and contraception services. They agreed that the plan could be shared with Sarah’s community mental health nurse and reviewed fortnightly while she was in hospital.

John used the Gibbs (1988) reflective cycle to review his use of the STARTER model. He felt he could enhance his knowledge of unprotected and risky sex, so enrolled on the e-learning module provided by the Social Care Institute for Excellence (2010). He also reflected that using the STARTER model and the Five Ps legitimised the conversation about sexual health and allowed him to overcome his initial embarrassment and fears about the gender difference between him and Sarah. He also asked Sarah to complete the Changes in Sexual Functioning Questionnaire (Clayton et al 1997), feeling it would empower her to track her sexual function while in hospital and when discharged to the community.
Talking about sex in mental health practice

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. The definition of sexual health includes:
   a) A positive approach to sexuality
   b) Presence of sexually transmitted infections (STIs)
   c) Multiple partners
   d) Unprotected intercourse

2. Which of the following is not one of the 'Five Ps' of sexual health?
   a) Partners
   b) Protection from STIs
   c) Promiscuity
   d) Prevention of pregnancy talk

3. What percentage of mental health nurses include sexual health in their practice?
   a) 10%
   b) 25%
   c) 40%
   d) 75%

4. Which of the following is an organisational barrier to discussing sexual health?
   a) Religious beliefs
   b) Access to genito-urinary medicine services
   c) Age
   d) Gender

5. What percentage of people taking antidepressant medication experience sexual dysfunction?
   a) 25%
   b) 52%
   c) 73%
   d) 80%

6. Why might mental health nurses be reluctant to discuss sexual health?
   a) Lack of knowledge and training
   b) Concerns about patient confidentiality
   c) Workplace policies
   d) Fear of being sued

7. How might nurses work towards becoming trauma-informed practitioners?
   a) Not considering if patients have a gender preference for chaperones
   b) Asking patients if they would prefer to be nursed in a mixed or same-sex setting
   c) Not encouraging disclosure of sexual violence in the clinical setting
   d) Not considering how the patient’s history may affect their current behaviour

8. Staff can support the development of a ward culture that promotes sexual safety by:
   a) Documenting and reporting all sexual safety incidents
   b) Considering that sexual harassment can occur by mobile phone as well as in person
   c) Providing accessible information about sexual well-being
   d) All of the above

9. A self-report tool to assess the side effects of medication is:
   a) Global Assessment Scale
   b) General Assessment Score
   c) Glasgow Antipsychotic Side-effect Scale
   d) Glasgow Assessment Scale

10. Mental health nurses should:
    a) Discuss sexual health once only on initial assessment
    b) Document and share discussions about sexual health with colleagues
    c) Decide to avoid any discussion of sexual health
    d) Decline to discuss sexual health because they do not have the time

How to complete this assessment
This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question.
You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently. When you have completed the quiz, cut out this page and add it to your professional portfolio. You can record the amount of time it has taken you to complete it.
You may want to write a reflective account. Visit rcni.com/reflective-account
Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements. Go to rcni.com/cpd/test-your-knowledge
This multiple-choice quiz was compiled by Lisa Berry
The answers to this quiz are:
1. a 2. c 3. a 4. b 5. c 6. a 7. b 8. d 9. c 10. b

This activity has taken me __ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:
Excellent □ Good □ Satisfactory □ Unsatisfactory □ Poor □
As a result of this I intend to: ____________________________________________