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COMMENTARY

Reproductive and sexual health of women service users: what's the fuss?†

COMMENTARY ON... ADDRESSING THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF WOMEN WHO USE MENTAL HEALTH SERVICES

Kathryn Abel & Sian Rees

SUMMARY

Nearly a decade ago, the Department of Health published its strategic development plan for mental healthcare for women. It focused on the ways in which mental health services for women should be configured to take account of the context of women's lives and the complexity of their health needs. This commentary argues that attention to the reproductive and sexual health of women in mental healthcare is at the centre of a gender-sensitive and modern mental health service.

DECLARATION OF INTEREST

None.

Women and men with severe mental illness show significantly worse physical health and related mortality outcomes compared with the general population. Women with severe mental illness are doubly disadvantaged, experiencing both these health inequalities and the socioeconomic disadvantage of simply being a woman. Poor sexual and reproductive health exacerbates the difficulties these women already face and can significantly affect their quality of life. Addressing such health inequalities poses an often unanswered challenge to health services.

The timely article by Henshaw & Protti (2010, this issue) considers the sexual and reproductive health inequalities faced by women in mental health services and represents an opportunity for mental health practitioners to reflect and improve their practice. In order to do this, clinicians must understand the nature and extent of the problems women face and also the need to assess barriers within their own practice which prevent women accessing appropriate services. It is through this understanding that genuine gender sensitivity can be created in the delivery of care, as envisaged by *Into the Mainstream* (Department of Health 2002), the women's mental health strategy.

Understanding and awareness are the pre-requisites for change; clinical assessment and care planning are the primary vehicle for delivering it. Clinicians are equipped to seek detailed clinical information from their patients and to access information on current good practice in fields outside their own. It may still be hard, however, to feel confident to help women with severe mental illness to discuss their sexual and reproductive health, and to plan this aspect of care accordingly.

High rates of sexual abuse in women in psychiatric care create a further layer of complexity. Unsurprisingly perhaps, many mental health professionals may remain reluctant to ask about current or previous abuse, for fear of 'opening a Pandora's box'; worse, they may question the validity of women's abusive experiences. Initially, the woman may simply require a trusted witness with whom to share her experience. Sexual abuse training to equip staff to better meet the needs of women – and men – survivors is now taking place in the majority of mental health trusts, having been supported nationally by the Implementation of Violence and Abuse Policy Programme.

To achieve better reproductive and sexual health for women in psychiatric care, the changes required are often relatively straightforward, but they rely on an acceptance that these issues are the legitimate concern of mental health services. Sexual health is a key component of both mental and physical well-being. However, some mental health professionals may find it hard to see how this view relates to their core work. Breaking down the still prevalent mind/body dichotomy is

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†See pp. 272–278, this issue.

key to the delivery of genuinely holistic, person-centred care. Seeing the links between a history of abuse, depression and irritable bowel syndrome is just one example of how this process can lead to more appropriate care pathways for symptomatic women.

Changes in both ideology and practice are needed so that mental health practitioners recognise sexual and reproductive health as part of their core work. Without such acceptance, these topics will remain hard to deal with for women and workers alike. Accepting that a patient's sexuality and reproductive health are integral to their mental healthcare requires good working links with other clinicians in gynaecology, obstetrics, genitourinary medicine, as well as with primary care practitioners. Don't expect each new specialist trainee to conduct intimate and sensitive interviews with women; rather, keep this working within the core team and discuss in reviews regularly as part of care planning.

Ideological shifts are needed not just for clinicians. Equally important is the organisational response by mental health service providers. Sexual and reproductive health must be addressed within policies and training; sexual safety needs to be seen alongside physical safety. In recognition of this, the Department of Health has commissioned development of an e-learning resource which will help raise awareness and improve knowledge among mental health practitioners and managers.

Similarly, commissioners will need to include women with severe mental illness as a high-risk group in needs assessment and strategies for mainstream sexual and reproductive health services. Supporting this, contract service specifications for community and mental health services will need to include reference to sexual and physical health promotion and care for this group of women.

Fundamentally, however, to deliver change, women need to be consulted regularly – in an appropriate setting and in an appropriate manner – about how they wish to be supported to manage their reproductive and sexual lives: their fears, their risks, their concerns.

References

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Henshaw C, Protti O (2010) Addressing the sexual and reproductive health needs of women who use mental health services. *Advances in Psychiatric Treatment* **16**: 272–278.

'Dearest, I feel certain I am going mad again': the suicide note of Virginia Woolf

Selected by Femi Oyebode

Adeline Virginia Woolf (1882–1941) was an English novelist, essayist, diarist and letter writer. She was a member of the Bloomsbury Group. Known to have suffered from recurrent depressive episodes, she took her own life by drowning in the River Ouse near her home. This is her suicide note. Published in Quentin Bell (1973) *Virginia Woolf: A Biography. Volume 2. Mrs Woolf 1912–1941*. Hogarth Press.

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Dearest,

I feel certain I am going mad again. I feel we can't go through another of those terrible times. And I shan't recover this time. I begin to hear voices, and I can't concentrate. So I am doing what seems the best thing to do. You have given me the greatest possible happiness. You have been in every way all that anyone could be. I don't think two people could have been happier till this terrible disease came. I can't fight any longer. I know that I am spoiling your life, that without me you could work. And you will I know. You see I can't even write this properly. I can't read. What I want to say is I owe all the happiness of my life to you. You have been entirely patient with me and incredibly good. I want to say that – everybody knows it. If anybody could have saved me it would have been you. Everything has gone from me but the certainty of your goodness. I can't go on spoiling your life any longer.

I don't think two people could have been happier than we have been.

V.