Holistic care in sexual health assessments

- Reya James

Delivering holistic care is of great importance when providing sexual health assessments as to ensure positive outcomes for the individual (Wright, 2012). Each person at some point of their developmental journey experiences a level of perceived risk taking behaviour, unfortunately usually resulting in anxiety provoking emotions through decisions made. The purpose of this case study response is to demonstrate an understanding and approach to the interlinking relationship of sexual and mental health issues identified within the case scenario. In order for this to occur, contributing risk factors will be analysed to provide an evidence based background to capture and highlight the link of both sexual and mental health issues. These risk factors include age group, alcohol use, risky sexual behaviour, neurovegetative symptoms, anxiety, and psychological stress increasing risk taking behaviour, will be also discussed. These identified behaviours and concerns will conclude with appropriate interventions and referrals For the purpose of this case study sexual assault will not be discussed, however is always a consideration until otherwise indicated.

Upon introduction, first impressions and the environment will set the tone for the assessment and determine the information given by the client (Health & Service, 2013). It is imperative to remain aware of cultural diversities and vulnerabilities during this process to ensure apposite assessments, screening and interventions are implemented. For example, due to the overwhelming higher rates of STI’s and BBV’s in comparison to the rest of the populace, sexual health remains a priority issue for Aboriginal communities (Bowring, Vella, Degenhardt, Hellard, & Lim, 2014; Kang, Skinner, & Usherwood, 2010;

Research, 2007; Thompson, Greville, & Param, 2008). As sexual health issues are sensitive issues to discuss, the initial introduction will alert the clinician to any barriers that may exist, allowing exploration into the involvement of communities groups, family members and other stakeholders that are appropriate to the client's cultural sensitivities. For example, female clients of particular cultural groups or sexual identity may require female only clinicians to conduct the assessment, the same can be applied to males if identified, sensitivity and objectivity is the key.

Establishing a therapeutic rapport is essential in building a trusting relationship in which the client feels safe, acknowledged and validated. Further to this is the provision of a non-judgmental and supportive environment maintaining privacy and confidentiality (Wright, 2012). Entwining a mental health assessment ensures ongoing risk assessment, incorporating protective factors, screening for co-morbidities and appropriate interventions such as education, harm minimisation and therapies. Whilst acknowledging the expressed concerns as a priority, this also provides the individual with an opportunity to ventilate and disclose contributing factors, disruption to daily functioning, and verbalise the experienced emotional dysregulation (French, 2010). Unfortunately this process may not proceed as planned if the appropriate screening questions are not asked.

It can be seen that some clinicians find it difficult to approach the subject of sexual health. Ambivalence towards the subject occurs, resulting in avoidance of the topic and sexual health concerns being less prioritised (Quinn, Happell, & Welch, 2013). Regrettably, this approach is likely to result in further deterioration of the client's mental health with continuation of risk

taking behaviours. Ultimately it is essential to identify the impending emotional crisis so timely and appropriate interventions can be implemented(Dykeman, 2005). With ‘ Chris’ presenting and requesting a check-up, this demonstrates a level of insight into the negative impact the occurrence has instigated.

‘ Chris’ is of an age group that is well documented as high risk relating to alcohol, illicit substance use and sexual risk taking behaviour (Aicken, Nardone, & Merce, 2010; Bowring et al., 2014; Searle, 2009; WHO, 2005). Among Australia’s population, the most commonly reported STI is genital chlamydia (Chlamydia trachomatis), with numbers increasing annually for those aged between 15-29 years (Kang et al., 2010). In addition to chlamydia, HIV, gonorrhoea, and syphilis are also higher within the indigenous population(Thompson et al., 2008). The research further identifies potential vulnerability and increased risk-taking sexual behaviour of young adults in Australia in particular lesbian, gay, bisexual and those questioning their sexual orientation (Bowring et al., 2014).

Screening tools and clinical management guidelines are commonly utilised to assist with identifying risk and determining examinations and investigations necessary for detection of STIs, BBVs and other sexual health issues including sexual assault(Health & Service, 2013). In relation to the case scenario, regardless of sexual orientation, a full STI screen is recommended due to the unknown factors of the incident (Health, 2010; Health & Service, 2013). Naturally this will depend on the individual and require education and positive reinforcement to be provided through each process as to ensure the decision is informed and awareness of potential results involved. Provision of

pamphlets and contact numbers for crisis lines allow the person time to process the information given during the assessment. Within Queensland Health Guidelines, contact numbers are available throughout the state should a referral to a sexual health clinic for further follow up, or in the case of sexual assault, referral to sexual assault workers is appropriate(Health, 2010). Recommendations can be provided in the form of self-initiated referrals for identified priority groups, such as providing contact details for groups that offer support and further information. For example, web based contact groups such as Sexually Transmissible Infections in Gay Men Action Group (STIGMA), and Gay and Lesbian Welfare Association provide support, information education, and opportunities for phone counselling.

It can be seen that the contributing factor of alcohol and/or other substances, reduces consideration of safe sexual practice, often leading to unprotected sex and the contracting of STD’s (Bellis et al., 2008). Moreover, the disinhibiting and cognitive altering actions of alcohol or substances can influence any sexual orientation, further contributing to potential adverse outcomes (Aicken et al., 2010; Bowring et al., 2014; Hughes, Szalacha, & McNair, 2010). The implications of the linkage have, as studies have shown, to be a globally contributing factor and increasingly expressed concern from a public health perspective (WHO, 2005). This is an opportune time to screen for alcohol and substance use, utilising motivational interviewing, insight into current risk taking behaviours and readiness to change can be established (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). The objective is for the client to make a commitment to change, through their own decision making (Johnstone, Owens, Lawrie, McIntosh, & Sharpe, 2010).

Other interventions include harm minimisation and education regarding the effects of alcohol, with referral to Alcohol and Other Drugs (AOD) service, detox and rehabilitation services if requiring this level of service. Ensuring these procedures are appropriately explained to the client, expressing empathy and actively listening, will help to reduce anxieties the person may be experiencing. The positive effect brief interventions has on alcohol consumption and reducing the average intake has been well researched and documented(Kaner et al., 2009).

Poor sexual and mental health impacts an individual’s sense of worth and wellbeing, which could ultimately result in feelings of isolation, persecution discrimination, and stigmatisation (Duncan, Hart, Scoular, & Bigrigg, 2001). For example, within a close rural community, sexual preference outside the accepted community norm may possibly lead to these poor outcomes, essentially resulting in an enduring negative emotional impact (Lewis, Derlega, Clark, & Kuang, 2006). Studies suggest the link between risky sexual health behaviour and mental health is associated with higher levels of anxiety, stress and depression(Searle, 2009). Searle (2009) further postulated difficulty in determining whether depression was a result of risky sex or risky sex was precipitated by a depressive episode.

Neurovegetative symptoms described by ‘ Chris’ such as disturbed sleep, increase of stream of thoughts needs to be explored further as to ascertain any underlying mental health issues(Kendrick & Simon, 2008). Levels of stress, depressive features, suicidal ideations, formal thought disorders, brief screening for mood disorders or psychotic episodes are all incorporated within the mental health assessment and captured during a mental status

examination(Health & Service, 2013). Utilising an intervention such as brief solution focussed therapy, helps to empower the client to make decisions that are future focussed based on their strengths (Evans & Evans, 2013). Instilling hope and building of resilience is essential to the clients recovery journey (Elder, Evans, & Nizette, 2012; Evans & Evans, 2013). Just as important is the support and follow up to ensure monitoring risk of relapse. Apart from family and friends, other resources are available to provide support.

Mental Health Nurses employed at GP clinics are an option through the Mental Health Nurse Incentive Program (MHNIP). This resource has been successful in reducing admissions, providing short term case management with the provision of interventions such as psychoeducation, counselling, psychotherapies, medication adherence, metabolic monitoring, and general support(Happell, Platania-Phung, & Scott, 2013). Referral to GP's for continuity of care and a Mental Health Care Plan (MHCP) is another option available. MHCP is a plan that is completed by the GP with the client in which issues are identified and referred for psychological and/or psychiatric management. Web based programs are also available such as Teleweb, Headspace, Lifeline, to name a few. There is always the possibility of a client expressing suicidal intent, in which, if meets the criteria under the Mental Health Act, may require detainment and transfer to a mental health unit

In conclusion, every person that presents for a health assessment requires a holistic approach in order to capture the issues and appropriately deal with them. Interventions will need to cover a variety of issues that may arise. The perceived stigma of STI's, concerns regarding future reproductive health,

psychosocial impact of diagnosis, distress and possibility of developing an enduring mental health issue, are all issues that need to be addressed throughout the assessment.

References

Aicken, C. R. H., Nardone, A., & Merce, C. H. (2010). Alcohol misuse, sexual risk behaviour and adverse sexual health outcomes: evidence from Britain's national probability sexual behaviour survey. *Journal of Public Health, 33* (2), 262–271.

Bellis, M. A., Hughes, K., Calafat, A., Juan, M., Ramon, A., Rodriguez, J. A., . . . Phillips-Howard, P. (2008). Sexual uses of alcohol and drugs and the associated risks: A cross sectional study of young people in nine European cities. *Public Health, 8* , 155-166.

Bowring, A. L., Vella, A. M., Degenhardt, L., Hellard, M., & Lim, M. S. C. (2014). Sexual identity, same-sex partners and risk behaviour among a community-based sample of young people in Australia. *International Journal of Drug Policy* (0). doi: http://dx. doi. org/10. 1016/j. drugpo. 2014. 07. 015

Duncan, B., Hart, G., Scoular, A., & Bigrigg, A. (2001). Qualitative analysis of psychosocial impact of diagnosis of Chlamydia trachomatis: Implications for screening. *BMJ: British Medical Journal, 322* (7280), 195-199.

Dykeman, B. F. (2005). Cultural Implications of Crisis Intervention. *Journal of Instructional Psychology, 32* (1), 45-48.

Elder, R., Evans, K., & Nizette, D. (2012). *Psychiatric and mental health nursing* (3rd edition. ed.). Chatswood NSW: Elsevier Australia.

Evans, N., & Evans, A.-M. (2013). Solution-focused approach therapy for mental health nursing students. *British Journal of Nursing, 22* (21), 1222-1226.

French, K. (2010). How to improve your sexual health history-taking skills. *Practice Nurse, 40* (2), 27-30.

Happell, B., Platania-Phung, C., & Scott, D. (2013). Mental Health Nurse Incentive Program: Facilitating physical health care for people with mental illness? *Int J Ment Health Nurs, 22* , 399-408.

Health, Q. (2010). Queensland Sexual Health Clinical Management Guidelines *Emergency Presentation* (pp. 1-18). Queensland: Queensland Government.

Health, Q., & Service, R. F. D. (2013). *Primary Clinical Care Manual* (8 ed.). Cairns: The State of Queensland.

Hughes, T., Szalacha, L. A., & McNair, R. (2010). Substance abuse and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine, 71* (4), 824-831. doi: http://dx. doi. org/10. 1016/j. socscimed. 2010. 05. 009

Johnstone, E. C., Owens, D. C., Lawrie, S. M., McIntosh, A. M., & Sharpe, M. (Eds.). (2010). *Companion to Psychiatric Studies* (8 ed.). Edinburgh: Churchill Livingstone.

Kaner, E. F. S., Dickinson, H. O., Beyer, F., Pienaar, E., Schlesinger, C., Campbell, F., . . . Heather, N. (2009). The effectiveness of brief alcohol interventions in primary care settings: A systematic review. *Drug & Alcohol Review, 28* (3), 301-323.

Kang, M., Skinner, R., & Usherwood, T. (2010). Interventions for young people in Australia to reduce HIV and sexually transmissible infections: a systematic review. *Sexual Health, 7* (2), 107-128. doi: http://dx. doi. org/10. 1071/SH09079

Kendrick, T., & Simon, C. (2008). Adult Mental Health Assessment. *InnovAiT: The RCGP Journal for Associates in Training, 1* (3), 180-186. doi: 10. 1093/innovait/inn013

Lewis, R., Derlega, V., Clark, E., & Kuang, J. (2006). Stigma Consciousness, Social Constraints and Lesbian Well-Being. *Journal of Counselling Psychology, 53* (1), 48-56.

Lundahl, B., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty five years of empirical studies. *Research on Social Work Practice, 20* (2), 137-160.

Quinn, C., Happell, B., & Welch, A. (2013). The 5-As Framework for Including Sexual Concerns in Mental Health Nursing Practice. *Issues in Mental Health Nursing, 34* , 17-24.

Research, N. C. i. H. E. a. C. (2007). *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance Report 2007* . Sydney: Commonwealth of Australia.

Searle, N. (2009). *Sexual Behaviour and its Mental Health Consequences.* (M. Sc. Project), Swansea University, Britain.

Thompson, S. C., Greville, H. S., & Param, R. (2008). Beyond policy and planning to practice: getting sexual health on the agenda in Aboriginal communities in Western Australia, Editorial. *Australia & New Zealand Health Policy (ANZHP),* pp. 1-8. Retrieved fromhttp://ezproxy. usq. edu. au/login? url= http://search. ebscohost. com/login. aspx? direct= true&db= a9h&AN= 35637237&site= ehost-live

WHO. (2005). *Alcohol Use and Sexual Risk Behaviour: A Cross-Cultural Study in Eight Countries* . Geneva.

Wright, G. (2012). Sexual health… This practice profile is based on NS622 McDougall T (2011) Mental health problems in childhood and adolescence. Nursing Standard. 26, 14, 48-56. *Nursing Standard, 26* (44), 59-59.

ANP5004 – Emergency Mental Health and Reproductive Health Care