Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____

Zoe K. Philip Date

Psychiatrists' Perceptions of the Barriers and Facilitators to Sexual and Reproductive Health Care of Adult Women with Severe Mental Illness in an Outpatient Setting

By

Zoe K Philip
Master of Public Health

Hubert Department of Global Health

_____

Dabney P. Evans, PhD, MPH
Committee Chair

_____

Silke von Esenwein, PhD
Committee Member

Psychiatrists' Perceptions of the Barriers and Facilitators to Sexual and Reproductive Health Care of Adult Women with Severe Mental Illness in an Outpatient Setting

By

Zoe K. Philip

Bachelor of Arts: Economics
Connecticut College
2010

Thesis Committee Chair: Dabney P. Evans, PhD, MPH

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2016

Abstract

Psychiatrists' Perceptions of the Barriers and Facilitators to Sexual and Reproductive Health Care of Adult Women with Severe Mental Illness in an Outpatient Setting
By Zoe K. Philip

Background: Women of reproductive age living with severe mental illnesses are less likely to receive critical preventive services, and are more likely to suffer from sexually transmitted infections. Mental health care settings function as the main point of access to the health care system for these women. Consequently, there is a need for psychiatrists to be better equipped to handle the sexual and reproductive health needs of their patients.
Goal: The purpose of this research project is to better understand psychiatrists' perspectives on providing sexual and reproductive healthcare to women seen in a psychiatric outpatient setting, focusing on barriers and facilitators.
Methods: This study utilized qualitative, structured in-depth interviews to understand the psychiatrists' perspective. The study included resident and attending psychiatrists who have worked at or currently work at Grady Behavioral Outpatient Center. The interview topics included the psychiatrists' perceptions of their role in providing STI testing, STI treatment, and safe sex education.
Results: Psychiatrists reported a variety of factors that affect whether, and to what extent, they provide or connect patients with sexual and reproductive health services. The Social-Ecological Model provides a useful framework to understand the interaction between the individual, interpersonal, organizational, community, and policy levels of influence.
Discussion: The most significant barrier to sexual and reproductive health care for women with severe mental illness is a fragmented health care system. Psychiatrists working in outpatient settings are uniquely positioned to either provide or connect their female patients with important STI services, and safe sex education. Additionally, healthcare models that integrate medical and mental health services may provide a solution to addressing the health disparities in this population.
Implications: This study provides an opportunity to understand the factors that inhibit and facilitate care for this population in mental health settings, thus improving sexual and reproductive health outcomes.

Psychiatrists' Perceptions of the Barriers and Facilitators to Sexual and Reproductive Health Care of Adult Women with Severe Mental Illness in an Outpatient Setting

By

Zoe K. Philip

Bachelor of Arts: Economics
Connecticut College
2010

Thesis Committee Chair: Dabney P. Evans, PhD, MPH

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2016

Acknowledgements

This research study would not have been possible without the help of so many people and one charming cat. Thank you to Drs. Dabney P. Evans, Silke von Esenwein, Martha Ward, and Sarah Cook, for you guidance and expertise throughout this process. You all have inspired me to advocate for women's health and mental health awareness. Thank you to Dr. Wooten for agreeing to let me work at the Grady Behavioral Outpatient Center.

Thank you to all of the Grady residents and attending physicians for participating in the survey and providing much needed insight into the psychiatric and medical care of your patients

Thank you to "Team Grady" and my MCH cohort (Nassira Bougrab, Adriana Bracho, Candace Girrod, and Darby Ford) for your encouragement, humor, and passion. In particular, thank you Darby Ford and Jesse Zatloff for transcribing interviews and reviewing drafts. I couldn't have done any of my work without all of you.

Thank you to Rin Mauer for inspiring me when I felt overwhelmed with all of the work. Thank you to Ana Choban for helping me to set goals and make progress during this process and reminding me that in pursuing public health I need to look after my personal health.

Thank you to my entire family (especially Abi) and all of my friends, who supported me in ways I can't even express.

***

Dedicated to all of the women seeking mental health care at Grady Health Systems and to Mr. Biggles, the cat that kept "the watch" over me during the entirety of my thesis-related work.

TABLE OF CONTENTS

1 INTRODUCTION 1

1.1 RESEARCH GAP 2
1.2 PURPOSE STATEMENT, RESEARCH QUESTION AND AIMS 2
1.3 SIGNIFICANCE STATEMENT 3
1.4 DEFINITION OF TERMS 3
1.5 SUMMARY 4

2 LITERATURE REVIEW 6

2.1 SEVERE/ SERIOUS MENTAL ILLNESS 6
2.2 SOCIETAL-LEVEL FACTORS 7
2.3 FRAGMENTATION OF CARE 7
2.4 ACCESS TO MEDICAL SERVICES 8
2.5 SEVERE MENTAL ILLNESS AND HEALTH SCREENINGS 9
2.6 SEVERE MENTAL ILLNESS AND HEALTH OUTCOMES 10
2.7 SEXUAL RISK FACTORS 10
2.8 SEXUALLY TRANSMITTED INFECTIONS 12
2.9 GRADY BEHAVIORAL OUTPATIENT CENTER PATIENT POPULATION 13
2.10 PROFESSIONAL STANDARDS 14
2.11 PROVIDER BARRIERS 14
2.12 2015 PSYCHIATRIST SURVEY 15
2.13 THE SOCIAL-ECOLOGICAL MODEL 16
2.14 SEXUAL AND REPRODUCTIVE HEALTH RESEARCH PROJECT 18
2.15 SUMMARY 20

3 METHODS 21

3.1 STUDY SAMPLE 21
3.2 IN-DEPTH INTERVIEW GUIDE 22
3.3 STUDY SITES 22
3.4 GRADY MEMORIAL HOSPITAL AND BEHAVIORAL HEALTH OUTPATIENT SERVICES 22
3.5 DATA COLLECTION 23
3.6 DATA MANAGEMENT AND DATA ANALYSIS 23
3.7 LIMITATIONS 24
3.8 SUMMARY 24

4 RESULTS 25

4.1 BACKGROUND INFORMATION ON PARTICIPANTS 25
4.2 PHYSICIAN RESPONSIBILITY FOR SEXUAL AND REPRODUCTIVE HEALTH CARE 26
4.3 PSYCHIATRIST'S ROLES 28
4.4 PSYCHIATRIST COMFORT LEVEL 31
4.5 PATIENT-PHYSICIAN RELATIONSHIP 32
4.6 PATIENT-RELATED FACTORS 33
4.7 PATIENT DIAGNOSIS 34
4.8 PHYSICIAN TRAINING 35
4.9 POWER DYNAMIC WITH ATTENDING PSYCHIATRISTS 37
4.10 TIME MANAGEMENT 38
4.11 REFERRAL PROCESSES 40

4.12 RESOURCES: EQUIPMENT, TREATMENTS, AND SUPPORTING STAFF 43
4.13 ELECTRONIC MEDICAL RECORD 44
4.14 LIABILITY 45
4.15 SOCIAL ECOLOGICAL MODEL 48
4.16 STRENGTH AND LIMITATIONS 51
4.17 SUMMARY 52

5 DISCUSSION 54

5.1 CONTRIBUTIONS TO THE LITERATURE 54
THE SOCIAL-ECOLOGICAL MODEL 56
5.2 FRAGMENTATION OF CARE 57
5.3 RECOMMENDATIONS AND IMPLICATIONS 58
5.4 ALTERNATIVE MODELS FOR CARE 61
5.5 FUTURE RESEARCH 62
5.6 PUBLIC HEALTH IMPLICATIONS 62
5.7 CONCLUSION 65

6 REFERENCES 66

7 APPENDIX A: RECRUITMENT E-MAIL 71

8 APPENDIX B: IDI GUIDE 72

TABLE OF FIGURES AND TABLES

FIGURE 1: SOCIAL-ECOLOGICAL MODEL 17
FIGURE 2: RESEARCH PROJECTS AND INTERVENTIONS FOR WOMEN'S SRH CARE IN A PSYCHIATRIC OUTPATIENT SETTING 19
FIGURE 3: BACKGROUND INFORMATION ON INTERVIEW PARTICIPANTS 25
FIGURE 4: SOCIAL ECOLOGICAL MODEL - BARRIERS AND FACILITATORS TO PROVIDING SRH CARE 48

TABLE 1: SEXUAL AND REPRODUCTIVE HEALTH RESPONSIBILITIES REPORTED BY PARTICIPANTS 31

1 Introduction

For the first time since 2006, CDC reports the rates of three preventable STIs—Chlamydia, Gonorrhea, and Syphilis—are on the rise (Centers for Disease Control and Prevention, 2016). CDC recommends that providers test and treat their patients for STIs and counsel patients on safe sex practices as part of routine care (Centers for Disease Control and Prevention, 2016). Untreated STIs, such as chlamydia and gonorrhea, can result in pelvic inflammatory disease, infertility, and other infections damaging to the reproductive system (Centers for Disease Control and Prevention, 2015c). Women with SMI are more likely to engage in sexually risky behaviors and have higher rates of STIs (Hughes, Bassi, Gilbody, Bland, & Martin, 2015; Matevosyan, 2009; McKinnon, Cournos, & Herman, 2002; Meade & Sikkema, 2005; Rosenberg et al., 2001; Rothbard et al., 2009). Despite increased known risk factors for STIs, women with SMI have lower rates of receiving standard STI testing, including pelvic exams and pap smears than the general population (Happell, Scott, & Platania-Phung, 2012; Meade & Sikkema, 2005; Rothbard et al., 2009). For many patients with SMI, mental health care acts as their main point of access to the health care system (Brunette, Drake, Marsh, Torrey, & Rosenberg, 2003; De Hert, Cohen, et al., 2011; Druss, von Esenwein, Compton, Zhao, & Leslie, 2011). Psychiatrists working in outpatient settings are uniquely positioned to either provide or connect their female patients with important STI services, and safe sex education, and thus need to be equipped to address this known health disparity.

This study aims to understand the facilitators and barriers to providing care from the perspective of a subset of providers at the frontlines of mental healthcare– the psychiatrists. Unfortunately, a variety of barriers limit discussions of sexual and reproductive health between psychiatrists and their patients (SRH) with their patients (Agenor & Collins, 2013). Due to the

high rates of HIV infection, STIs, sexual activity, and drug use in persons living with SMI, clinicians in psychiatric settings are in a unique position to ensure that their patients connect with the appropriate resources for prevention, risk assessment, and treatment (McKinnon et al., 2002).

1.1 Research Gap

Women with SMI are not receiving important SRH services, regarding STI testing and treatment (Happell et al., 2012). Currently, there is insufficient qualitative information on mental health providers' perceptions of whether, and to what extent, they can provide these specific medical services (Agenor & Collins, 2013; Quinn, Happell, & Browne, 2011). Comprehensive sexual and reproductive (SRH) medical care requires that the medical system and mental health system work closely together (Druss, 2007), creating a need to understand what enables and what inhibits psychiatrists from directly providing or connecting their female patients of reproductive age to SRH care. The findings from this study will help to guide interventions and facilitate change.

1.2 Purpose Statement, Research Question and Aims

The purpose of this research project is to better understand psychiatrists' perspectives on providing sexual and reproductive healthcare to women seen in a psychiatric outpatient setting, focusing on the barriers and facilitators. There are four primary research questions:

1. What is the current role of psychiatrists in providing sexual and reproductive health care to their female patients of reproductive age at Grady Outpatient?
2. What are the facilitators and barriers to providing STI testing at Grady Outpatient?
3. What are the facilitators and barriers to providing STI treatment at Grady Outpatient?
4. If they do provide it, how do psychiatrists incorporate safe sex education into their workflow?

1.3 Significance Statement

Women with SMI experience significant SRH health disparities, including high rates of STIs and inadequate preventive and screening services. Patients with SMI typically access medical care via their mental health providers (Brunette, Drake, Marsh, Torrey, & Rosenberg, 2003; De Hert et al., 2011; Druss, von Esenwein, Compton, Zhao, & Leslie, 2011). Thus, there is an opportunity for psychiatrists to address unmet SRH needs of their female patients with SMI in an outpatient setting. This study provides important data on how psychiatrists can undertake this role. Findings from this research will help to identify areas of intervention and help to improve the provision of SRH services to female patients with SMI. These interventions are critical to addressing barriers to the provision of essential SRH care for a vulnerable population. Interventions developed from the data could be a model for other mental health outpatient settings to better address the SRH needs of their female patients.

1.4 Definition of Terms

The Federal definition of **SMI** was established in 1993 by the Substance Abuse and Mental Health Services Administration Center for Mental Health Services. The Federal Register Notice included the following definition:

"Adults with a serious mental illness are persons: (1) age 18 and over, (2) who currently or at any time during the past year, (3) have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III-R, (4) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities…All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects" (Federal Register Volume 58 No. 96 published Thursday May 20).

Sexual and Reproductive Health - Sexual and reproductive health is a broad term that in the context of this study will refer to the prevention, screening and treatment of sexually transmitted infections (STIs). This includes counseling patients on safe sex practices (condoms), testing for STIs, and STI treatment.

Barriers to SRH care include any kind of social or environmental factors or processes that prevent psychiatrists from being able to provide and/ or connect patients with SRH care.

Facilitators to SRH care include social or environmental factors or processes that help psychiatrists to provide and/or connect patients with SRH care.

Residents are graduate medical students, who have earned their MD via a medical school program, and must completed anywhere from three to seven more years of professional training, depending on their medical specialty (Amercan Medical Association, n.d.). Senior physician educators supervise residents.

Attending physicians are responsible for the care of a patient. These physicians supervise medical students and residents in patient care (attending physician).

1.5 Summary

In order to understand the physician perspective in providing SRH services to their patients, this study utilizes qualitative in-depth interviews. Both resident and attending psychiatrists who either have worked at or currently work at Grady Behavioral Outpatient Center were invited to participate in the study. The interviews covered topics on STI testing, STI treatment and safe sex counseling. Psychiatrists reported a number of barriers and facilitators to

care, including psychiatrist, patient, systems, community and policy level-factors. The Social Ecological model explains how these factors interact with each other to affect whether a psychiatrist provides or connects their patients to SRH services. Ultimately, psychiatrists have an important role to play in improving SRH outcomes for their female patients of reproductive age.

2 Literature Review

Worldwide, sexually transmitted infections (STIs) constitute a major burden of infectious disease, with an estimated 1 million STIs acquired every day (World Health Organization, n.d.). Other common sexual and reproductive health (SRH) concerns for women include endometriosis, uterine fibroids, gynecologic cancers, interstitial cystitis, polycystic ovary syndrome, and sexual violence (Centers for Disease Control and Prevention, 2015a). Research suggests that women living with SMI are a particularly vulnerable population, with increased risk for acquiring STIs (McKinnon et al., 2002) and established sexual risk behaviors (Hughes, Bassi, Gilbody, Bland, & Martin, 2016; McKinnon et al., 2002; Rosenberg et al., 2001). However, mental health providers typically act as the only point of access to medical health care for women with SMI (Borba et al., 2012; De Hert, Cohen, et al., 2011; Millar, 2008). Thus, mental healthcare providers may offer an important intervention point for women with SMI.

2.1 Severe/ Serious Mental Illness

Definitions of serious, or severe mental illness differ slightly across organizations and associations but generally agree on three major elements: (1) the duration of the disorder (anytime during the past year), (2) meeting diagnostic criteria, and (3) whether it interferes with major life activities (Federal Register Volume 58 No. 96 published Thursday May 20; National Institute of Mental Health, n.d.). According to the 2014 National Survey on Drug Use and Health, 4.1 percent, or about 9.8 million adults, had an SMI in the previous year (Center for Behavioral Health Statistics and Quality, 2015). While the percentage of the US population is relatively small, these persons suffer from negative health outcomes disproportionately to those without SMI (De Hert, Cohen, et al., 2011; De Hert, Correll, et al., 2011). There are a variety of factors that contribute to the poor outcomes for women with SMI.

2.2 Societal-Level Factors

Societal level factors also contribute to STI transmission in women with SMI (Agenor & Collins, 2013; Collins et al., 2008). Stigma and discrimination affect the ability of patients with SMI to access medical care (Lawrence & Kisely, 2010; Ostrow, Manderscheid, & Mojtabai, 2014). In a study assessing perceptions of seeking medical care among people with SMI, 28 percent of the participants reported having difficulty in accessing medical care (Ostrow et al., 2014). Of this group of participants, 45 percent attributed their difficulties to stigma (Ostrow et al., 2014).

Along with social stigma, having an SMI can result in socioeconomic consequences, such as unemployment, poverty, poor housing and small social networks, which further impact physical health and physical health behaviors (Robson & Gray, 2007). For example, research indicates that strong social support networks are associated with less HIV risk behaviors (Meade & Sikkema, 2007; Randolph et al., 2007). In addition, Randolf et al. (2007) found that women with SMI reported fewer sexual risk factors and fewer unsafe sexual encounters when they had strong social support networks. Fragmentation of care also impacts the health of women with SMI who need to access medical services (Druss, 2007).

2.3 Fragmentation of Care

There is no standard measure for fragmentation of care (Frandsen, Joynt, Rebitzer, & Jha, 2015). Researchers have looked into a wide variety of topics on fragmentation of care and health outcomes, experiences and processes, including in primary care, migration between hospitals, and ectopic pregnancies (Frandsen et al., 2015; Galanter et al., 2013; Stulberg, Dahlquist, Jarosch, & Lindau, 2016). In the study on ectopic pregnancies, the researchers defined fragmentation of care as patients being sent to two or more facilities for a single episode of illness (Stulberg et al., 2016). Fragmentation in health care systems contribute to the poor quality

of health care for women with SMI (Druss, 2007). Druss (2007) described four types of separation between medical and mental health care: (1) geographic, (2) financial, (3) organization, and (4) cultural. The researcher advises that each of these levels suggest potential solutions to improving the quality of care. For example, the geographical level of separation may benefit from co-locating mental health and primary care services in the same location (Druss, 2007). Co-location of services offers a possible solution to low quality care by increasing access to services, reducing stigma, and increasing continuity of care for patients with SMI (Lawrence & Kisely, 2010).

2.4 Access to Medical Services

There is debate over whether patients with SMI truly have access to and utilize primary care services properly (Lawrence & Kisely, 2010). Research suggests that patients with SMI are likely to overuse medical emergency room services (Druss, 2007; Hackman et al., 2006). In general, increased mental health symptoms in patients results in increased difficulty in accessing medical care (Lawrence & Kisely, 2010; Ostrow et al., 2014). One qualitative study of low-income, urban women with SMI conducted interviews on healthcare access and utilization, psychiatric health, social networks, social support, sociocultural beliefs, and socioeconomics factors (Borba et al., 2012). Women reported several barriers that hindered their ability to access medical services, including having an SMI, lower health-seeking behaviors when not feeling mentally well, lack of continuity of providers, lack of socioeconomic resources, and feelings of discrimination from medical healthcare providers (Borba et al., 2012). Some women reported that their physicians sometimes saw medical complaints as related to their SMI diagnosis or were not real (Borba et al., 2012). On the other hand, factors that facilitated medical care included having access to quality mental health services, building a relationship and trust with a mental health provider, having a provider who monitored both their mental and medical healthcare,

access to socioeconomic resources, and continuity of providers, and social support from community groups, family, and other patients living with SMI (Borba et al., 2012). Furthermore, the trust developed with a mental health care provider facilitated patients' trust in other healthcare providers and resulted in more engagement with the healthcare system (Borba et al., 2012). In particular, women who trusted their mental health providers trusted them when they made referrals to other providers (Borba et al., 2012). Access to medical care is just one of the important factors contributing to better health outcomes for women living with SMI.

2.5 Severe Mental Illness and Health Screenings

Patients with psychiatric disorders are more likely to have lower rates of receiving preventive services than those without psychiatric disorders (Druss, Rosenheck, Desai, & Perlin, 2002). Women with SMI are less likely to receive important STI screenings, including pelvic exams and pap smears than the general population (Happell et al., 2012). In general, patients with SMI have important medical health care needs, but receive lower quality of care (Maj, 2009). Furthermore, patients with co-morbid psychiatric and substance use disorders have an even lower rate of receipt of preventive services (Druss et al., 2002). Druss et al. (2002) reviewed medical charts of 113,505 veterans who had chronic conditions and had attended three general medical visits between 1998 and 1999. Data was collected on eight preventive services, including two measures of immunization, four on cancer screening, and two measures of tobacco screening and counseling. The prevention index created from these measures was calculated as the proportion of services received over the services for which the patient was eligible. The study found that patients with psychiatric disorders on average received 60 percent of those services, as compared to the patients without either psychiatric disorders of substance use disorder, whom received 66 percent of those services (Druss et al., 2002). Of particular note, is that the presence of psychiatric or combined psychiatric diagnosis with substance use disorder, predicted a lower

likelihood of screening for cervical cancer (Druss et al., 2002). In addition to low rates of preventive screenings, patients with SMI are also likely to suffer from more negative health outcomes than the general population (De Hert, Cohen, et al., 2011; De Hert, Correll, et al., 2011).

2.6 Severe Mental Illness and Health Outcomes

Literature shows that patients with SMI are more likely than the general population to have excess mortality and mortality due to physical illness (De Hert, Cohen, et al., 2011; De Hert, Correll, et al., 2011). Research of schizophrenic patients indicate that lifestyle factors, such as smoking, diet, lack of exercise, substance use and unsafe sex contribute to increased mortality and morbidity (Brown, Birtwistle, Roe, & Thompson, 1999; Lambert, Velakoulis, & Pantelis, 2003). In a systematic literature review, Happell et al. (2012) found that patients with SMI generally receive between 20 to 30 percent less screenings for breast, colorectal, and cervical cancers and infectious diseases immunizations. In addition, findings about inadequate screening for HIV and hepatitis led the researchers to recommend that mental health providers identify patients at high risk and screen patients for infections diseases (Happell et al., 2012). Moreover, many factors converge and result in poor access and quality of healthcare for this population (De Hert, Correll, et al., 2011; Parks J, 2006). In a systematic literature review, De Hert, Cohen, et al. (2011) found that there are significant barriers to the recognition and management of physical diseases in patients with SMI that could be grouped into five categories: (1) patient and illness-related factors, (2) treatment related factors, (3) psychiatrist-related factors, (4) other physician related factors, and (5) service-related factors.

2.7 Sexual Risk Factors

The majority of adults with SMI are sexually active and engage in sexual risk behaviors that can result in sexually transmitted infections, HIV, and other blood borne infections (Meade

& Sikkema, 2005). The majority of persons with SMI engage in HIV transmission risk behaviors (Carey, Carey, Maisto, Gordon, & Vanable, 2001; Meade & Sikkema, 2005). Meade and Sikkema (2005) found that around half of persons with SMI reported multiple partners and never using a condom in the past year; about one third reported at least one STD in their life time (32.94%, n=17 studies); and about one fifth reported participating in sex trade in their lifetime (22.43%, n=5 studies) (Meade & Sikkema, 2005).

Additionally, research indicates that the risk of acquiring STIs can increase with co-morbid substance use disorder (SUD) (De Genna, Feske, Angiolieri, & Gold, 2011). In a cross sectional study, exploring the relationship between SUD and risky sexual behavior in women living with borderline personality disorder (BPD), data showed women with comorbid SUD and BPD had a 64 percent prevalence of self-reported STDs ($p<0.05$) as compared to 31 percent ($p<0.05$) for those without comorbid SUD and BPD (De Genna et al., 2011) found. In addition, logistic regression modeling determined that higher BPD dimensional scores and African American race were risk factors for any STD (OR 2.10, 95% CI 1.08 - 4.07; OR 1.05, 95% CI 1.01–1.09) (De Genna et al., 2011).

A few research studies indicate that psychiatric symptoms are associated with sexual risk factors (McKinnon et al., 2002; Meade & Sikkema, 2005). One study found that psychiatric conditions that include positive and excited symptoms and a diagnosis of schizophrenia are associated with these behaviors (McKinnon, Cournos, Sugden, Guido, & Herman, 1996). Another study of schizophrenic patients found that sexual activity was associated with greater psychopathology, that increased positive symptoms were associated with multiple partners, and that few patients reported consistent condom use (Cournos et al., 1994).

Women with SMI tend to engage in high levels of sexual risk behaviors, including low use of contraception (Matevosyan, 2009), unsafe sex, multiple partners, transactional sex, and having sex with partners they suspected were having sex with others (Randolph et al., 2007). When compared to their male counterparts, women with SMI are more likely to have a history of STDs, multiple sex partners, have unprotected sex, and trade sex (McKinnon et al., 2002; Meade & Sikkema, 2005). Many factors influence these risk behaviors, including psychiatric diagnosis, social relationships, substance use, cognitive-behavioral factors, and child hood abuse (Meade & Sikkema, 2005). Engaging in these sexually risky behaviors puts women with SMI at risk for STIs (Meade & Sikkema, 2005).

2.8 Sexually Transmitted Infections

Untreated STIs, such as chlamydia and gonorrhea, can result in pelvic inflammatory disease, infertility, and other infections damaging to the reproductive system (Centers for Disease Control and Prevention, 2015c). Furthermore, women often cannot detect any symptoms when they have either of these two infections (Centers for Disease Control and Prevention, 2015c). Other consequences of STI infections include mother to child transmission of several STIs (e.g., syphilis), cervical cancer, increased susceptibility to further STI infection, and multi-drug resistant gonorrhea (World Health Organization, n.d.).

There is very little information about the prevalence of STIs in populations with SMI (Hughes et al., 2016). However, several studies indicate that women with SMI are at higher risk than the general population of acquiring HIV, Hepatitis B, and Hepatitis C (Hughes et al., 2016; McKinnon et al., 2002; Rosenberg et al., 2001). Unfortunately, HIV testing is not routine in most mental health settings (Senn & Carey, 2009). A meta-analysis of HIV infections in psychiatric settings, found that that the prevalence of HIV amongst patients with SMI (6.9%) was higher than the national average (0.4% at the time of the review) (McKinnon et al., 2002). A more

recent systematic review and meta analysis, found a pooled a similar prevalence of HIV in patients with SMI in the US of 6.0 percent (95% CI 4.3-8.3) (Hughes et al., 2015). Mckinnon et al (2002) concluded that, due to the high rates of HIV infection, STDs, sex, and drug use in persons living with SMI, clinicians in psychiatric settings are in a unique position to ensure that their patients connect with the appropriate resources for prevention, risk assessment, and treatment. Concerning patterns of low STI testing rates emerged in a study of adult women with SMI at the Grady Behavioral Outpatient Center (Bougrab, Bracho, Ford, Girod, & Philip, 2015).

2.9 Grady Behavioral Outpatient Center Patient Population

Approximately 61 percent of the patients at Grady Adult Outpatient Behavioral Health Center are uninsured (Gault, 2011). About 84.2 percent of the patients are African American (Gault, 2011). A 2012 survey of the patients revealed that over one-third of the patients had been seen in Grady Hospital's emergency room within the past year (Ward, 2013). In addition, about 35 percent of the patients did not have a primary care provider (Ward, 2013).

A 2015 retrospective chart review of 168 women of reproductive age living with SMI at Grady Behavioral Outpatient Center revealed that patients are not receiving STI tests as recommended by CDC (Bougrab et al., 2015). About 44 percent of the patients had received an HIV test. In addition about 70 percent of the patients had not receive a gonorrhea/chlamydia test. In addition, while 82 percent of the patient had a primary care provider assigned to them in the Electronic Medical Record (EMR), only 12 percent of the patients had received the recommended well woman exams within the previous year, which include critical preventive services, such as STI screening (Bougrab et al., 2015). Healthcare providers, including psychiatrists, can play a key role in facilitating these SRH services for their female patients with SMI (Centers for Disease Control and Prevention, 2016).

2.10 Professional Standards

CDC recommends that providers talk to their patients about sexual health, test patients for STI's using the recommended schedule, and treat diagnosed STIs (Centers for Disease Control and Prevention, 2016). Talking about sexual heath with patients includes taking a sexual history as part of routine care, counseling patients on safe sex and different prevention options, and utilizing counseling messages to alleviate concerns about positive test results (Centers for Disease Control and Prevention, 2016). CDC provides in-depth screening recommendations for different patient populations (Centers for Disease Control and Prevention, 2016). However, limited research indicates that there are barriers affecting the ability of mental health care providers to offer SRH care to their female patients (Agenor & Collins, 2013; Quinn et al., 2011).

2.11 Provider Barriers

One qualitative study of mental health care providers in an outpatient setting found that training, treatment priorities, comfort level with addressing sexuality, and attitudes towards the sexuality of women with SMI influenced whether and to what extent they discussed sex and HIV with their patients (Agenor & Collins, 2013). Psychiatrists reported that, due to their disciplinary training they sometimes do not introduce these issues unless a patient brings them up (Agenor & Collins, 2013). For example, in the study, one psychiatrist described that in their training they learned not to introduce issues, except for the most important issues. Instead, providers reported that, with women with SMI, they focused on "the basics", which included symptom management, social and economic needs, and basic social functioning (Agenor & Collins, 2013). Moreover, the more severe the SMI, the less of a priority sex and sexuality became during appointment (Agenor & Collins, 2013). Psychiatrists also expressed concern over maintaining patient-provider boundaries when discussing sex, with their primary concern being upsetting or

making the patient uncomfortable (Agenor & Collins, 2013). Research on mental health nurses supports this finding, with the additional concern over sexual misconduct allegations with patients of the opposite sex (Quinn et al., 2011). In addition, mental health nurses feared offending patients with certain cultural backgrounds (Agenor & Collins, 2013). Also, fear of patients with certain psychiatric disorders having negative reactions to discussion around sex contributed to provider discomfort (Agenor & Collins, 2013). However, mental health providers felt that it was their responsibility to educate patients, such as clarifying myths, about the risk of HIV (Agenor & Collins, 2013). Survey research conducted at the Outpatient Center supports some of these findings, revealing the gap in the provision of SRH services to women with SMI.

2.12 2015 Psychiatrist Survey

In 2015, researchers surveyed psychiatrists at the Outpatient Center to learn how often and to what extent psychiatrists address the SRH concerns of their female patients of reproductive age (von Esenwein & Cook, 2016, October/November). Psychiatrists reported discussing sexual activities during appointments in the context of psychiatric medications (von Esenwein & Cook, 2016, October/November). About half of the psychiatrists reported rarely referring patients for STI testing. If they did refer, psychiatrists reported referring female patients for STI testing for four main reasons: (1) the patient presents with symptoms (83%; n=15), (2) the patient engages in risk behaviors (61%; n=11), (3) the patient had recent unsafe sex (56%;n=10), and (4) the patient asks the provider about testing (56%; n=10) (von Esenwein, 2016).

In addition, psychiatrists reported regularly discussing condom use with their female patients (von Esenwein & Cook, 2016, October/November). Barriers to discussing SRH care included limited time and prioritization of other topics during appointments (von Esenwein & Cook, 2016, October/November). Evidence from the survey suggests that there is a missing

knowledge base on SRH and an absence of relevant training. The Social-Ecological Model provides a visual display of the complex interactions of different factors affecting the provision of SRH services to women with SMI (Centers for Disease Control and Prevention, 2015b; Glanz & Rimer, 2005; McLeroy, Bibeau, Steckler, & Glanz, 1988).

2.13 The Social-Ecological Model

1. The Ecological Perspective is useful for understanding the barriers and facilitators by psychiatrists. This approach helps to reveal the interaction that these physicians have their physical, social and cultural environments, by organizing these factors into three "levels of influence": (1) the intrapersonal level, (2) the interpersonal level, and (3) the community level (Glanz & Rimer, 2005). This approach explains the "interdependence" each level of influence and across the levels of influence and how those interactions behavior (Glanz & Rimer, 2005). It also explains how individual behavior affects *and* is by the different levels, also known as "reciprocal causation" (Glanz & Rimer, 2005). The interdependence of the levels of influence is best visualized through the social-ecological (Glanz & Rimer, 2005; McLeroy et al., 1988).

Researchers of a larger Sexual and Reproductive Health program developed at Emory University and in partnership with Grady Health Systems can use the identified areas of intervention to improve the SRH outcomes of women living with SMI.

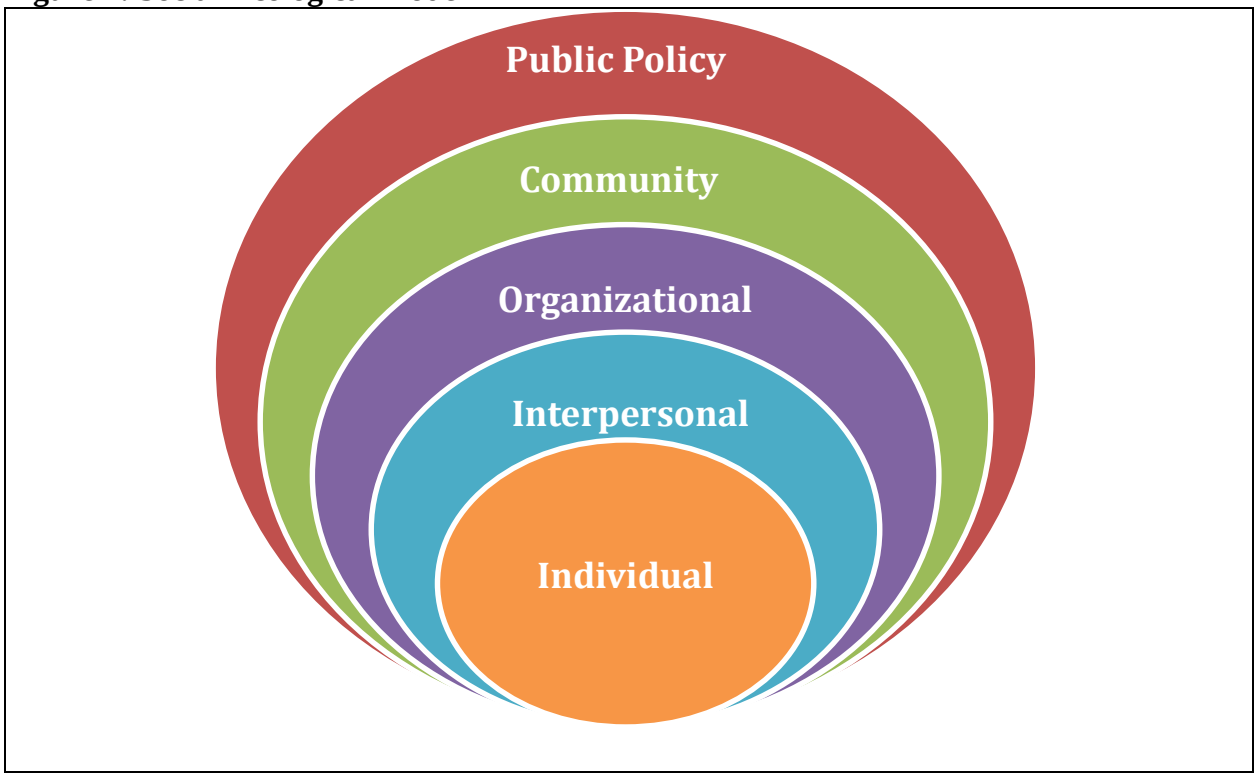
Figure 1 presents the Social-Ecological model and helps to identify the areas for intervention for the following "levels of influence" (Centers for Disease Control and Prevention, 2015b; Glanz & Rimer, 2005; McLeroy et al., 1988):

2. Intrapersonal/ Individual characteristics
3. Interpersonal
4. Organizational

5. Community
6. Policy

Researchers of a larger Sexual and Reproductive Health program developed at Emory University and in partnership with Grady Health Systems can use the identified areas of intervention to improve the SRH outcomes of women living with SMI.

Figure 1: Social-Ecological Model

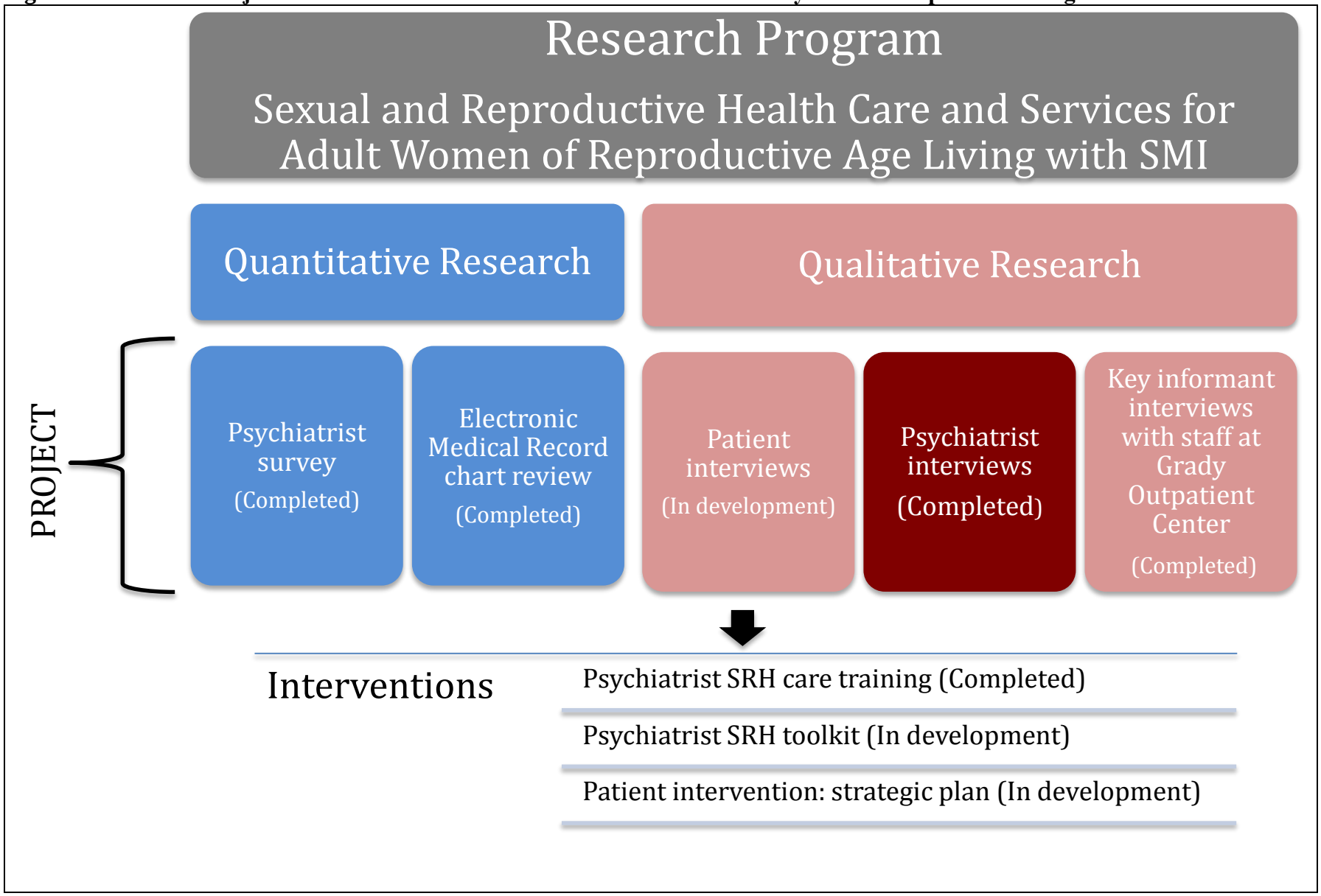


Sources: Adapted from Glanz and Rimer (2005) and Centers for Disease Control and Prevention (2015b).

2.14 Sexual and Reproductive Health Research Project

The psychiatrist qualitative research project is couched in a larger research program aimed at improving sexual and reproductive health care for adult women of reproductive age living with SMI. The research team includes Drs. Silke von Esenwein, Martha Ward, and Sarah Cooks. Figure 2 presents the research project and its components. Researchers performed a retrospective EMR chart review to describe the patient population and their usage of SRH services. The program has both quantitative and qualitative research projects. In 2015, researchers conducted a survey for psychiatrists at the Grady Outpatient Center to learn about their views and practices. An individual interview guide is currently under development to collect data on patient perceptions of SRH care. The psychiatrist interviews from this research study provide critical data to understand the provider perspective of SRH care of women with SMI. The data generated from the qualitative and quantitative research have identified gaps in knowledge and services and have shaped and will shape interventions at the patient, provider, and systems-levels. Thus far, the researchers have developed a psychiatrist SRH care training for psychiatry residents, with accompanying resources, as well as a psychiatrist toolkit with possible workflow steps to guide SRH care during appointments. At the patient-level, one researcher has created a strategic plan for patient education about different SRH topics. In addition, the strategic plan calls for a re-modeling of the psychiatrist electronic medical system notes template and clarification of the Outpatient Center's policy on provider's use of labs for STI testing and specific STI treatments. This qualitative study provides insight into psychiatrists' perceived barriers and facilitators to providing SRH services to their adult female patients.

Figure 2: Research Projects and Interventions for Women's SRH Care in a Psychiatric Outpatient Setting



2.15 Summary

The State Mental Health Authority (SMHA) proposes that there be two "guiding principles" in the improving health care outcomes for people living with SMI: (1) overall health is essential to mental health; and (2) recovering includes wellness (Parks J, 2006). Studies have already established that persons with SMI are significantly more likely to have preventable physical illnesses than the general population but are *less* likely to have a primary care provider (Brunette et al., 2003; De Hert, Cohen, et al., 2011; De Hert, Correll, et al., 2011; Druss et al., 2011). There is an urgent need for psychiatrists in the outpatient setting to assess and treat the physical health of their patients, including their sexual and reproductive health. Psychiatrists; perspectives on their current involvement in the SRH care of their female patients will help to understand their current practices and to identify and asses the feasibility of strategies.

3 Methods

This study used semi-structured individual interviews with psychiatrists working at Grady Behavioral Outpatient Center in Atlanta, GA. The interview questions specifically asked about psychiatrists' experiences when working with female patients with SMI of reproductive age (15-40). The purpose of the interviews was to characterize the perception of what facilitates and hinders the ability of psychiatrists to incorporate sexually transmitted infection (STI) testing and treatment and safe(r) sex practices education into their workflow.

3.1 Study Sample

The inclusion criteria for the sample frame includes attending or resident psychiatrists that have worked at the Behavioral Health Outpatient Center at Grady Memorial Hospital within the last three academic years, employed by either Emory University School of Medicine or Morehouse School of Medicine (n=39). Three resident and three attending psychiatrists participated in the study. This study used purposive sampling (Hennink, 2011) in order to learn more about psychiatrists' experiences in an outpatient setting. However, there was also an element of convenience sampling (Marshall, 1996); restricting recruitment to those who had worked within the past three years allowed for a larger sample frame by including psychiatric residents who had recently cycled through the Outpatient Center as part of their training, and who were easy to contact since they were still residents with the Schools of Medicine.

Limited demographic information was collected during the interview on participants' gender, current year of residency, and number of years of experience at the Outpatient Center. The participants included four male and two female psychiatrists. The participants were three attending psychiatrists and three resident psychiatrists. Four psychiatrists has fewer than 2 years of experiences at the Outpatient Center.

The research study is a part of larger study on SRH. It received IRB approval by Emory University's IRB via amendment on November 19, 2015 (Study No.: IRB00078443).

3.2 In-depth Interview Guide

The in-depth interview (IDI) guide was developed to ascertain psychiatrist experiences and views on incorporating sexual and reproductive health services into their workflow. The interview guide includes questions that examine the barriers and facilitators to incorporating services addressing sexual health into their practices. Questions centered on STI testing and treatment, safer sex education, and standard of care (See Appendix B: IDI Guide).

3.3 Study sites

Interviews were conducted in three locations in private offices: (1) the Adult Grady Behavioral Outpatient Center (Outpatient Center) at Grady Memorial Hospital, located at 10 Park Place NE, Atlanta, GA; (2) Morehouse Healthcare, located at 1800 Howell Mill Road Atlanta, GA; and (3) Grady Hospital, located at 80 Jesse Hill Junior Drive SE, Atlanta, GA. The Outpatient Center serves as the outpatient psychiatric care center for Atlanta's safety net hospital.

3.4 Grady Memorial Hospital and Behavioral Health Outpatient Services

Emory University School of Medicine and Morehouse School of Medicine provide all of the physicians working at Grady Memorial Hospital, one of the public hospitals in the Southeastern U.S. (Emory University School of Medicine, n.d.). About 85% of the physicians are affiliated with Emory University and the remaining 15% are affiliated with Morehouse (Emory University School of Medicine, n.d.). Outpatient services at the Outpatient Center are at a separate location from the main hospital in Atlanta, located at 10 Park Place, close to public transportation (Miller, 2012). The Outpatient Center houses a primary care clinic that provides care to patients at the center with the most serious mental health issues and a history of not

showing up for appointments (S.R. Pace, personal communication, January 29, 2016). Due to the presentence of the primary care clinic, physicians the Outpatient Center is equipped with a lab on site, with the capacity to provide testing and limited treatment STIs. Patients referred to the primary care clinic can receive other types of SRH care, such as pap smears, from or under the direct supervision of a physician who is double board certified in internal medicine and psychiatry. However, most psychiatrists seeing patients at the center do not perform physical exams on their patients.

3.5 Data Collection

Multiple recruitment strategies were used, in order to recruit the sample. E-mails were sent to the clinicians who were current attending psychiatrists at the Outpatient Center and to psychiatric residents in their second through fourth years (See Appendix A: Recruitment E-mail). In addition, as psychiatrists were interviewed, they were asked to recruit other psychiatrists who fit the inclusion criteria ("snowball" technique (Hennink, 2011)). Finally, a member of the research team went to the Emory School of Medicine's mandatory didactic trainings to announce the study to Emory psychiatric residents. Psychiatrists received $25 gift cards to Target for participating in the interview.

Interviews occurred over a two-month period (December 2015 through January 2016) and were conducted by one researcher, trained in qualitative methods. After each interview, a summary was written of the interaction in order to record important information, ideas and thoughts. The interviews were tape recorded and transcribed verbatim.

3.6 Data Management and Data Analysis

This analysis was conducted using inductive thematic analysis (Guest, MacQueen, & Namey, 2016). The tape recordings were transcribed verbatim and de-identified of any personal information. MAXQDA was used to organize and analyze the data. Once transcripts were

uploaded onto the software, they were then read several times and memos were created to begin exploring possible codes, ideas, and questions. Codes were developed throughout the project and the transcripts were next coded using the software. Finally, themes were categorized into the five levels of influence of the Social-Ecological Model.

3.7 Limitations

Researchers recruited psychiatrists from a unique psychiatric outpatient center, which has a lab and the capacity to address specific sexual and reproductive health needs, including STI testing for chlamydia, gonorrhea, syphilis, and HIV and some treatment. Therefore, the ability of psychiatrists to provide STI testing and treatment is very different from a typical psychiatric outpatient unit. In addition, the small number of providers interviewed may not be representative of the perceptions and experiences of other residents and attending psychiatrist. The urban public sector study setting is not representative of other psychiatric outpatient environments and patient populations seeking care.

3.8 Summary

This qualitative research study explores the psychiatrist perceptions on providing SRH services to female patients of reproductive age in an outpatient setting at an urban, safety net hospital. One researcher conducted interview with six psychiatrists using a semi-structured interview guide. The interview guide asked specific questions about the facilitators and barriers to STI testing and treatment, safer sex practices counseling, and the standard of care. The interviews were recorded and transcribed verbatim. The researcher analyzed data by developing codes and creating themes to explore the study question. The results provide information on the major themes that emerged from the data and contribute to understanding the complicated issues with providing comprehensive, person-centered care to female patients living with SMI.

4 Results

The data from this study includes a variety of perceptions, beliefs, and experiences, identified by psychiatrists, affecting the provision of sexual and reproductive health (SRH) services for women at the Grady Behavioral Outpatient Center (hereafter referred to as the Outpatient Center). The different factors act as barriers, facilitators, or both to SRH care and were classified into the five levels of the Social-Ecological Model (individual, interpersonal, organization, community, and policy level). The findings will help to identify and target future interventions to improve SRH health outcomes for women with SMI.

4.1 Background Information on Participants

The researcher interviewed six psychiatrists who had varying experiences working at the Outpatient Center. Two female and four male psychiatrists were interviewed. Three are attending psychiatrists and three are residents. Four of the psychiatrists had less than two years of experience at the Outpatient Center. **Figure 3** presents information on the psychiatrists interviewed.

Figure 3: Background Information on Interview Participants

	Number of Psychiatrists (n)
Years Associated with Outpatient Center	
0-1 year	3
1-5 years	1
20+	1
Unknown	1
Gender	
Male	4
Female	2
Physicians	
Attending	3
Resident	3

Psychiatrists revealed a variety of barriers and facilitators that contribute to providing SRH care to a vulnerable population that may not be receiving this care otherwise. Several of the major themes that emerged revealed that different factors acted as both a facilitator and a barrier, depending on the context.

4.2 Physician Responsibility for Sexual and Reproductive Health Care

When asked which medical specialty[1] was the most responsible for the provision of sexual and reproductive health of adult women with SMI, many of the interviewees felt that it was not their primary responsibility as psychiatrists. Psychiatrists identified OB/GYN and primary care specialists as types of physicians were seen as the most responsible. For example, one participant noted that primary physicians can provide women's health but that it may be clinician dependent, while women's health is the purpose of an OB/GYN appointment. There was argument about the continuity of care that can be provided by a primary care physician. Another physician made the following point:

> *"But there are patients that get better and then they don't really need to see a psychiatrist, so then there would be a discontinuation there. So the primary care doctor is someone who stays with you lifelong. You know, just like when you're a kid, a pediatrician stays with you from birth until, I think now, its 23. So, primary care doctor would be the most responsible person. "*

On the other hand, many psychiatrists believed that there are certain aspects of SRH they should address during their appointments. One of the attending physicians believes that there are *specific aspects* of SRH care of which different stakeholders are responsible. In general, he

[1] A specialty or a subspecialty is a branch of the medical field in which a physicians specializes and receives advanced training and practice in via residency programs and fellowships.

explained that the patients themselves must play a role in their care. In terms of STI testing, he believes that primary care physicians and OB/GYN physicians are responsible *for screening and treating*. However, he also noted that it was essential for physicians to provide patients with information about the teratogenic effects of specific psychiatric medications. One participant agreed that it was not the responsibility of psychiatrists to test or treat STIs in their practice, unless the practice was set up specifically to address women's health issues as well as psychiatric care.

Another participant made a distinction between the ideal and reality, due to resource and time constraints.

> *"I think that doctors are all responsible for it. We should be at least, {.} uh, whether we are psychiatrists, obstetricians, or {.} you know, {.} um, {.} EMT doctors. Uh, but I think that's, that's you know, that's not the reality of it because of time and limited resources and all of those things."*

He also added that he believe that psychiatrists might have more of a responsibly than other specialties. He explained that, "A lot of people consider psychiatry to be a primary care specialty. That's-- there's a push towards that right now, so."

Another important consideration is the population that the psychiatrists serve. One of the attending physicians noted the increased responsibility due to the context of the patients attending the Outpatient Center. She said the following:

> *"So (…) I think it depends on the setting of the psychiatrist. Um, so in the setting such as this, where patients may or may not have primary care available then, I think the patients*

have the opportunity to have a longer term relationship with the psychiatrist here in this setting than they do with other providers and so that's a context for sort of, having this conversation and raising awareness and education about the…(…) But in another setting where they have better access to more options in healthcare I think the role diminishes."

Another participant expressed that she is aware that she might be the only physician that sees her patients and that she has an important responsibility to educate and counsel. This knowledge dictates her perceived responsibility as a physician. She described,

"Um, I think that our role is to, one, introduce the idea. A lot of our patients don't see other physicians, especially if they're young women of childbearing age. Um, they don't have any reason to see other physicians. So I think that {.} as the only the physician that they're seeing, we should introduce these ideas um, that you, {.} um, have options in terms of your sexual health. Um, and then the second is, what I hope I'm doing, which is inquiring about contraception, um, and safe sex practices, um, especially in light of prescribing medications. {.} And then, {.} um, then intimate partner violence. {…}.

Perceptions of physician responsibility for SRH care varies greatly amongst psychiatrists, and the answers are complex and nuanced.

4.3 Psychiatrist's Roles

"You know, I think we view our place very much as a psychiatric, um, clinic."

- Participant 4

Amongst psychiatrists there are a great variety of descriptions of what the standard of care is in terms of providing SRH services in an outpatient setting. The complexity and nuance in

providing SRH care ranges depending on the topic discussed. In general, the majority of psychiatrists felt it was there responsibly to provide education and counseling on safe sex practices and pregnancy and the toxic effects of some psychiatric medications. Meanwhile, STI testing and treatment were more divided, with some psychiatrists being willing to provide these services themselves and other preferring to refer patients to OB/GYN or primary care, or even a mixture of both. For the majority of psychiatrists interviewed, prescribing medications with potentially teratogenic effects is a trigger for discussing SRH with patients. Patients need to use a form of contraception if they want to be sexually active while on this medication. Psychiatrists reported that it is their responsibility to provide counseling on this issue. Some psychiatrists felt comfortable prescribing contraception directly, whereas others scheduled appointments with PCPs or OB/GYN.

Two of the interviewees explicitly did not think that STI testing and treatment services fell under the standard of care for psychiatrists. One resident felt that he would need to know more about the legal environment and was concerned that the standard of care was not well defined (see

Physician Responsibility for Sexual and Reproductive Health Care section). The other psychiatrist discussed the importance of having specific training and resources. In particular, he explained that he could not do a full workup on a patient if he had concerns about an STI (e.g., a cervical exam), which he believed was irresponsible care. However, he did feel that it was his job and responsibility to provide the patient with information so that they knew a full workup was important for their health. He also acknowledged his responsibility to encourage and direct patients to a PCP for their SRH concerns. However, in cases where he did not think the patient

would go to a referral, he felt that it was psychiatrist's responsibility to provide all the SRH services that they could.

The resources of the clinic also affect the perceptions of the standard of care for SRH. For example, the Outpatient Center offers lab services to collect blood samples for HIV and syphilis testing, and can collect urine samples to test for chlamydia and gonorrhea. In addition, the primary care clinic provides treatment for syphilis, gonorrhea and chlamydia on site. However, despite having these resources available, non-psychiatric issues typically take a back seat to mental health. One participant explained the ranking in priorities for different aspects of health.

> *"…and so that the other attendings and the, the um, vibe there is that this is a place for psychiatric issues, um, not for primary care and {.} not for {.} even though we have a lab and scale, things like that, the focus of that is for med issues, psychiatric issues. And so even when we, um, are addressing sexual health, it is, um, in the setting of psychiatric care or issues."*

Participants were asked to explain what they thought the standard of care was in terms of the SRH of female patients of reproductive age with SMI. **Table 1** presents the psychiatrist reported SRH responsibilities in an outpatient setting.

Table 1: Sexual and Reproductive Health Responsibilities Reported by Participants

Answering SRH questions
Checking women of childbearing age know about the teratogenic effects of specific psychiatric medications
Checking women of childbearing age on teratogenic medication are using contraception
Counseling and education patients on contraception, STIs, condoms, and risk factors
Discussing pregnancy planning
Discussing the sexual side effects from certain psychiatric medications
Explaining SMI diagnoses in relation to hyper sexuality and impulsivity, if necessary
Helping to get patients a PCP
Referrals for primary care and gynecological appointments scheduled for patients
Referrals for contraceptives the physician is not familiar with
Sexual assault cases
Taking a sexual history, especially during the first intake appointment

4.4 Psychiatrist Comfort Level

Psychiatrists have different levels of comfort providing SRH care to patients. Psychiatrists reported that their level of comfort was determined by training and modeling and encouragement from supervising physicians. Specific training and experience typically increases comfort. In a more extreme example, one participant noted that if someone has done internal medicine training as well, then they would probably feel comfortable testing and treating STIs. The interviews revealed that several psychiatrists feel comfortable testing for STIs but prefer to make referrals for treatments. One resident physician had the following to say about the psychiatrists at the Outpatient Center.

> *"Um, I mean, I think that most people here, with the tests available, would feel comfortable testing for it, um, if the patients was willing to do that".*

Another area of discomfort for some psychiatrists includes discussions around sex and contraception. One attending physician raised concerns about residents being uncomfortable asking patients if they are on birth control and questions if they are concerned that their patient trades sex for money. She described the following situation:

"Um, I think, I think it also takes some time for people to get comfortable asking their patients about sex and I don't know that the residents – I mean, I know that the PY2s that I supervise are very uncomfortable doing it. And so often, I'm the person going in and asking…"

However, she does think that, with time, the residents do become more comfortable discussing these issues, if the residents are encouraged to ask these important questions by their attending physicians.

4.5 Patient-Physician Relationship

For some psychiatrists, there is concern that providing specific sexual and reproductive healthcare to patients could overstep the boundaries in their patient-provider partnership. For example, two physicians expressed concerns with performing a cervical exam on their patients, explaining that it, "…totally changes the kind of relationship" they would have with their patients. Interestingly, this concern was expressed by the attending physicians with the longest clinical experience, but was noticeably absent from the interviews with the residents and a new attending psychiatrist.

Developing a good patient-physician relationship is important to quality care and can encourage better interactions. One attending psychiatrist discovered that she had more power over spacing her appointments and this helped to facilitate better relationships with her patients. This ability was contingent on her being given a small caseload to start with so that her schedule was not full. She noted that another new attending physician had received about 300 patients when she started her new position, whereas she began with less than 10. When she realized she did not have to have follow up appointments every three months, she decided to start scheduling more frequent appointments in order in order to get to know her patients better. She found that

by doing this, her patients were more likely to show up to their appointments regularly and she developed a better relationship with her patients. As a caveat, this provider can no longer make appointments as regularly because her schedule has filled.

4.6 Patient-Related Factors

Patients, an important stakeholder in the outpatient setting, play a critical role in SRH health outcomes. Some of the factors are ones that they can control, while others are more difficult. Disclosure of activities and medical symptoms by patients is a key facilitator to addressing concerns. When patients bring up any risk factors, psychiatrists do feel that it is their role to address them, with safe sex counseling, referrals, and if the psychiatrists feel comfortable, STI testing and treatment. For example, one participant noted that he will ask his patients if they would like to be tested when the patient brings up unprotected sex, new sexual partners, a history of positive STIs, or if they have a history of impulsivity. In addition, he feels that it is his responsibly to answer any sexual health questions his patient asks.

However, a patient's comfort with specific providers can alter the information that they choose to share. One male resident discussed the possibility that female patients may feel more comfortable discussing their SRH concerns with female psychiatrists than male psychiatrists. The resident expressed his concern in the following way:

> *"Um, maybe they can open up a little bit more with a female. But then they only see me, you know."*

Patients not showing up or running late acts as a barrier to SRH care as psychiatrists are particularly constrained by time. Even though patients can still have an appointment at the Outpatient Center if they are running late by no more than 15 minutes, the ability to tackle

different issues diminishes if they are late; there is only really time to address medication management.

Another issue, specific to STI testing, is that the patient may refuse to get the tested. One of the resident physicians has had patients who do not want to get tested and so he always provides education on safe sex and STIs and reminds patients that there are treatments available. There is nothing a physician can do if a patient does not want to get tested.

In addition, one psychiatrist noted that patient follow-up can be difficult. Results from STI tests do not happen on the same day as the test. Thus, the psychiatrists will need to contact the patient with the results and decide the most appropriate way to follow-up. Whether it is another appointment for a prescription or referral depends greatly on which psychiatrist. However, another appointment places an important barrier on the patient. One attending physician explained, "But that means, you know, that means they have to make another trip, will have to make another trip, another bus fare, usually at the other clinic they have to pay a co-pay.

4.7 Patient Diagnosis

Patient diagnoses can affect whether SRH comes up or not during an appointment. In some cases, psychiatric symptoms can severely inhibit the ability of a physician to discuss this topic. For example, one psychiatrist described an instance in which a patient really did not want to discuss whether she was sexually active and was offended that her psychiatrist would ask. Due to this specific concern, the psychiatrist made an agreement with the patient to let her know if things changed in the future, so that the psychiatrist did not have to ask every appointment. In some instances psychiatrists also need to communicate with other specialties about psychiatric symptoms when they are providing SRH, like if a patient is particularly paranoid. In addition,

patients who may have a limited cognitive ability still need the same information but it might need to be explained differently.

Additionally, certain diagnoses act as a cue for psychiatrists to discuss SRH issues, like in the instance of hyper sexuality and mania. For example, diagnoses like bipolar disorder, which can result in poor impulse control, can act as a trigger for discussions about safe sex. One psychiatrist described an appointment with a patient with hypomania, and how he screened her for syphilis, HIV, chlamydia, gonorrhea and hepatitis because she was having unprotected sex. Other trigger warnings for these conversations include substance use disorder, financial issues, and prostitution. Participants but they did not address how the SMI symptoms can affect the ability of the patient to access SRH services.

4.8 Physician Training

Some psychiatrists feel more or less comfortable with different aspects of SRH care due to levels of training, which made them more likely to address SRH issues. One physician noted that there is a push for primary care in psychiatry but that he did not feel that they have the training necessary to address all of these issues. In the interviews, many psychiatrists discussed ways in which they did not feel that they had the information to perform some of the SRH care, such as treating STIs or prescribing a particular contraceptive. Making referrals is one of the ways in which psychiatrists handle discomfort or lack of knowledge. For example, one attending physician feels comfortable prescribing some birth control methods, but if her patient wants

Depo Provera™[2]or an implant[3], she will refer her patients to OB/GYN. Lack of adequate training also plays a role in the discussion surrounding physician responsibility and SRH (See Physician Responsibility for Sexual and Reproductive Health Care section). Another barrier to SRH care is specific to attending physicians. Some psychiatrists do not stay up to date with screenings and treatment and some feel that they are out of practice. When asked about treating STIs, one participant described that she did not "…see it frequently enough to remember how to treat." The two other attendings noted similar issues with treating STIs. One of the more experiences psychiatrist had the following to say: *"…that's not anything I've done in 24 years. Um, since medical school, I couldn't begin to tell you, kind of, antibiotics and antifungals."*

In addition, there can also be differences in the training received during residency, based on the program and the supervision. The hospital has relationships with several different medical schools and their residency programs, and psychiatrists reported differences in training. For example, one attending psychiatrist worries that her residents were not taught to ask about SRH when interviewing patients. She said, "… I don't think that asking about safe sex or contraception is forced in the same way that asking about suicide is." She also noted that Emory University School of Medicine resident physicians have an extra year of training before they rotate through the Outpatient Center. Meanwhile, Morehouse School of Medicine resident physicians have only worked at the city's veteran's hospital, where the vast majority of the patients are male. Because of this, she felt that the Morehouse residents had missed an opportunity "…to have supervision about asking specifically, um, female or women's

[2] Depo Provera is a form of contraception injected intramuscularly every 13 weeks.
[3] An implant is inserted into the upper arm and is an effective birth control method for up to three years (Zieman, Hatcher, & Allen, 2015)

reproductive issue questions or female mental health questions." Essentially, via this training, the resident develops a standard interview that "ignores" the issues that affect women. That being said, the attending physician also felt that, while the Emory residents did see a more equal number of female and male patients, the first two years of training did not seem to emphasize women's mental health and reproductive health issues. She described that they have, "…likely come across this issue, they haven't had direct supervision about it. And they don't really, they're not really encouraged to ask about it I think, until they reach the Outpatient clinic." Finally, she also felt that the likelihood that a resident would ask about SRH of their female patients depended on their supervisor. The attending physicians never complete a training on how to supervise residents. In fact, one of the attending psychiatrists explained that, "Day 2 of being an attending, I like marched into Dr. [[Last name]] office and I'm like "I don't know what you were doing all those years that you were supervising me, but how do I do it now?"".

Despite concerns over training, some psychiatrists reported utilizing technology to tackle their lack of information. When performing clinical duties as either a resident or as an attending, information on treatment is readily available, with both Google and the UpToDate® phone app being mentioned as ways to look up the appropriate treatments for STIs.

4.9 Power Dynamic with Attending Psychiatrists

Another factor affecting the delivery of SRH services is the power dynamic between attending psychiatrists and residents. Attendings act as a resource for residents to ask any medical questions and to discuss patient cases. However, ultimately, attending physicians do have the final call on the treatment plan. One resident pointed out that, "It's also the attending providers levels of comfort with—like if I wanna test and treat somebody, {.} you know, I uh, that may not happen because of {.} it would put—it'd make the attending liable for what

happens and if the attending doesn't feel comfortable that I—then it's not going to happen…". This dynamic can act as either a barrier or facilitator in the SRH care of a patient.

Due to this power dynamic, there is a real opportunity for attendings to provide support for residents and model effective strategies for providing SRH care to a vulnerable population. An attending psychiatrist discussed how risk factors such as substance use and prostitution are triggers for her to discuss SRH with her patients. Because she noted that some of her residents felt uncomfortable or did not think to broach these topics, she recognized that it was part of her job to teach residents what to look for in their interactions with patients. She pointed out the following role she has an attending physician:

> **"***Um, I'm hoping that if I keep bring it up they'll, they'll ask. Um, but same story - I'll kind of go in and ask. And I think it's easier for me to do it partially because I feel like I'm modeling for the resident…"*

4.10 Time Management

> **"**I can tell you the, the biggest reason why it doesn't happen is because of time."
>
> -Participant 3

Time management is about tradeoffs. All of the participants described tightly scheduled appointments, with a breakdown of how many minutes they could spend on different aspects of their appointments. The psychiatrists described two kinds of appointments at the Outpatient Center: (1) the new patient appointment and (2) the medication management appointment. New patient appointments usually run about one hour long and allows psychiatrists to complete important screenings, a physical review of symptoms, social histories and other topics. Medication management appointments are typically about 30 minutes long and are more

focused. The following excerpt describes the difficulty with time management in a medication management appointment.

> *"I can usually address two issues with the patients and I'm assuming that they're going to bring in one or two things. Um, so, that interview is usually about 20 to 25 minutes, um, the last—the 5 to 10 I take to either ask any miscellaneous questions or to go over {.} um, what we're doing with their medications with them."*

This barrier is further amplified if patients have a lot of complex issues or if they are late to their appointments, thus reducing the likelihood that SRH care can be provided.

Due to time constraints, psychiatrists must prioritize the issues they attend to during appointments. With such tightly managed time during an appointment, psychiatrists are forced to select the most critical issues to address and discuss. Often times, this means that SRH issues fall to the wayside.

The following excerpt demonstrates the thought process of one psychiatrist in how to prioritize issues during appointments:

> "*Um, this, if we were to take care of primary care issues or sexual health issues, that would be at the cost of other mental health issues. Um, some brief counseling or some behavioral activation or smoking cessation or whatever. Um, and so I think that there's the sense that it's a psychiatric appointment, let's take care of psychiatric things, and if there's a lot of primary care things going on that can't be addressed very quickly or GYN issues that can't be addressed very quickly, then they need go to another physician for that because we don't have time to do that."*

Another determining factor in prioritization is how acute an illness is. One resident summed up why STI testing often did not happen during his appointments:

> *"I know there's just, our patients are very, very sick here. Um, {.} and, {.} you know, STI testing may not be one of those things that's going to keep them out of the hospital {.} um, or be the most emergent thing that's going to keep them out of the hospital, prevent them from dying in the near future, or prevent them from developing a chronic disease immediately."*

In order to manage time, one psychiatrist created a system with her new-patient note templates to make sure that she reviews important issues. The template is a list of all the information she wants to ask all of her patients. If a patient does not raise specific issues, she will go through and ask those questions. In addition, she bolds the information she wants to discuss in her next appointment.

4.11 Referral Processes

Referrals provide an opportunity for patients to receive SRH care from another physician. Psychiatrists reported using referrals for contraceptives, STI testing, STI treatment and other medical issues. Referring patients for SRH care occurs when the psychiatrist cannot or will not perform these services themselves. Time constraints, lack of knowledge, lack of comfort, liability, resources and ease of the process all play a role in referrals. For example, one psychiatrist described that she would use referrals when patients reported concerning symptoms, such as genital urinary symptoms. She reported referring when she does not feel she has the time or the knowledge.

In some cases the referral process is simple and facilitates easy set-up of appointments for patients, while in other cases it can prove to be complicated, change the course of action, or even prevent specific appointments from occurring. Psychiatrists can use the "Physician Line" to call and schedule appointments for patients. This process can usually result in a next day appointment for the patient without putting the burden of scheduling on the patient, thus reducing the number of steps needing to be taken. However, the referral process does sometimes place an insurmountable barrier on the patient, (discussed further in the Patient-Related Factors section).

Furthermore, there are problems in referring for different specialties at the Outpatient Center. One psychiatrist reported serious difficulties with making gynecological appointments for her patients. The following exchange demonstrates her work around:

> *Participant: It's easy to make primary care appointments, and it's really [laughs] hard to make GYN appointments. So I usually just end up making primary care appointments and sending primary care a message saying that [laughs] these are mostly--*
>
> *Interviewer: Mmhmm.*
>
> *Participant: Um, this patient is interested in XYZ contraception or has had a current UTI or whatever. Um, and then [laughs] they'll kind of figure out how to refer because I haven't had any luck doing it.*

In addition to challenges in the process itself, there are also important questions about the insurance status (e.g., Medicaid, Medicare, uninsured) and need for financial assistance (i.e., a Grady Card[4]). These questions play a role in whether the patient can go to the main hospital or might need to go to a free clinic.

Besides referrals to other hospital departments, psychiatrists can also make referrals to clinics located at the Outpatient Center. Because there is a primary care clinic located there psychiatrists are able to see if their patient can go to that clinic. In fact, a psychiatrist recommended having a women's reproductive health clinic at Outpatient because that process would simplify referral processes for handing SRH care. Having to refer to the main hospital decreases the chances that the referral will occur. She explained, "It also creates a lot of hoops that we have to jump through."

[4] A Grady Card indicates to staff at Grady Health Systems that a patient will be receiving services at a discounted cost. In order to be eligible for card, a patient must undergo financial counseling and be located in Dekalb or Fulton County (Grady Health Systems, n.d.)

4.12 Resources: Equipment, Treatments, and Supporting Staff

Several resources contribute to the ability of psychiatrists to provide STI testing and treatment for bacterial STIs on site. Some of the participants noted that having a laboratory to run samples and access to treatments at the Outpatient Center contributed to the ease with which they could provide services instead of making a referral. One psychiatrist explained that, "…the patient doesn't have to go anywhere else. I can tell them, 'hey, we can do it today, now, and get it done' and within a few days I get the result in my email so I don't miss it." However, one of the attending psychiatrists noted how unusual it is to have these kinds of resources available in an outpatient setting; the presence of the primary care clinic directly facilitates this kind of care. However, even though resources are available, psychiatrists reported referring to OB/GYN or primary care instead. For example, one psychiatrist described ordering an HIV test on site, but typically make referrals for any other SRH complaints.

Nurses and phlebotomists also act as critical resources in the delivery of SRH services to patients in an outpatient setting. Psychiatrists reported these staff members as the clinical professionals collecting testing samples and giving injections to patients. The presence, scheduling, willingness of these staff member to participate in collecting urine samples, draw blood, and deliver some of the STI treatments (e.g., treatment for syphilis) help psychiatrists to provide this care. One provider explained how he uses these services at the Outpatient Center:

> ***"****So I put in the orders and then I take them over to the area to be tested and then pretty much the same day, within the half hour, that's done…"*

However, the same psychiatrist noted that nurses are not always available at the clinic. He found this to be problematic because he finds it difficult to gets patients to come back for screening or treatment. He explained the following situation:

"Um, well like some illnesses you want treated as fast as possible, like chlamydia, gonorrhea, syphilis. I mean they can come back in, but the difficulty is that they can't get the treatment on the same day but then if it's like a Friday, then after that I have to make sure they can come back on a Monday but then at the same time that short of a notice, then the nurses might not have availability. So that's another issue."

While these supporting clinical staff members greatly facilitate the ability of psychiatrists to manage some SRH services, sometimes scheduling disrupts the efficient flow of work. Nonetheless, no amount of resources are useful if the staff members are unclear on what is available and what they can use. At the Outpatient Center, there is confusion surrounding what STI testing services are available on site and if the medications for treating STIs are available to use, if the patients are not a part of the Primary Care Clinic.

4.13 Electronic Medical Record

Grady's electronic medical record (EMR) system, called Epic, manages patient records and allows psychiatrists to communicate with other providers, check notes, keep track, find out results of labs, and review patients medical history. The system is useful for communication between physicians and provides information on patient's history and contact information. EPIC is helpful in terms of communicating difficult SMI diagnoses to doctors when referrals are made, if the provider believes the other physician may need to better understand how to communicate with patients. One participant described the following case:

"Um, well, I would say, I guess, that the EPIC, you know, communicates, you know, if I can see who the person went to, you know, if I wanted to touch base with that provider this lady's particularly paranoid, you know, I could send an EPIC message, that kind of

thing, to give them a heads up. Things like that. It helps facilitate the communication part."

In another example, a different provider described using the EPIC messaging system to let a PCP know that an STI test was positive, so that the PCP could follow up on the result.

Physicians can also harness the EMR system in unique ways to collect critical information on patients. As aforementioned, one psychiatrist reported creating her own template note for making sure she could collect all of the important information on the patient. In this way she was able to track gaps in knowledge and follow-up with specific questions to the patient. In addition, she bolded specific sections of her note as a way to indicate to herself that she needs to follow-up on specific aspects at the next appointment. She explained, "it's not really based off of anything, it is, um, over time these are the questions –I mean most of it is the stuff that you have to have in a note and you need to know about a person. Um, but for myself there's a lot of things that I'll forget to ask if—and frequently patients don't volunteer and so having it kind of written out for me". She noted that she frequently forgot legal history, military background, and trauma without this technique.

Because of the usefulness of the EMR system, several psychiatrists made recommendations to the interviewer about ways to change it to remind themselves to incorporate SRH care into their practice.

4.14 Liability

The legal ramifications of diagnosing and treating conditions that a physician has not trained for specifically do raise concerns for some psychiatrists. In this study, liability came up as a concern only in terms of actively screening and writing prescriptions for STIs. Liability

concerns were not raised in terms of providing education, counseling, or making referrals. In essence, some psychiatrists see STI screening and testing as out of the scope of their practice and potentially leave them at risk of litigation. One physician did mention legal issues in terms of counseling patients on the teratogenicity of specific psychiatric medications. However, all of the participants brought up their obligations to have this discussion with their patients as an accepted part of their practice as psychiatrists.

Half of the psychiatrists interviewed expressed concern about liability. One resident discussed his concerns with providing services to patients out of his scope of care:

> *Um I think it depends on the legal environment, like what is considered standard of care in a state and what would be considered a violation of that or going beyond on that because there's a lot of legal uh things that can come out if you uh treat people in ways that are not up to like the OB/GYN standard of care."*

Due to liability concerns, this physician typically refers his patients to OB/GYN or primary care. Another psychiatrist further clarified that "…most people think about liability in terms of an action that goes, that should not have been taken rather than an action that should have been taken". When discussing liability, one resident noted that he would want to know more about the legal precedents in court in the state, "for providers operating outside of what is considered the standard of care for the field as a whole." Essentially, the lack of a definition of the standard of care for the field as a whole makes liability a large concern for him. The following excerpt exemplifies his perceptions on liability and psychiatry.

> *I don't feel like I could just create a standard of care based on my personal experiences. I think it's a lot bigger than that. I think that uh there are too many potential problems*

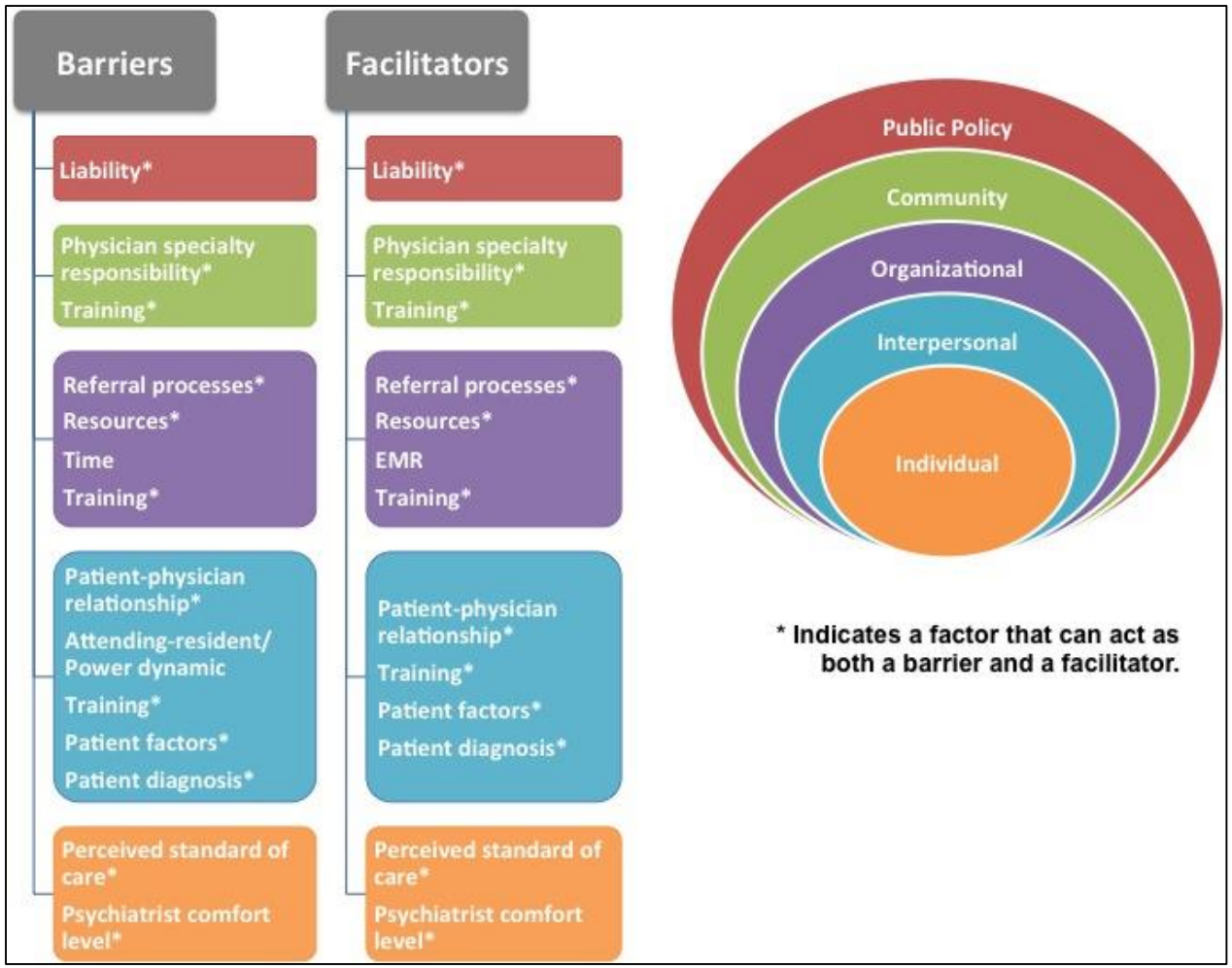
coming out of that for me to-- coming out of that for me to find that on my own. And, so, I think I need to go on what they set out there. If I'm going to act in a way beyond what is kind of what is the general standard of care um I think most people have a sense of what's appropriate for psychiatrists and what's not. But I think when you start getting into like antibiotics, of if you get into to other things that are not typically prescribed by a psychiatrists um there would be some reluctance to do that uh and part of that concern for not knowing {.} um know what the legal repercussions that would be.

The remaining psychiatrists in the study did not express these concerns. For these psychiatrists, other factors acted as deterrents for them providing STI testing and treatments, including time and lack of knowledge. Psychiatrist 4 did not feel concerned about prescribing treatment for STIs and liability because she trusted the UpToDate application to help her choose the appropriate treatment and felt that she was more "medically minded" than other psychiatrists. One of the residents said, "I don't think about it at all, because I, I usually {.}, um, I usually figure if I'm doing something that's looking out for the best interest of my patients, I'm not going to get in trouble for it." Finally, an attending physician explicitly noted that she did not believe that liability was the reason that she did not screen and treat for STIs; for her, this was more of an issues of training and lack of knowledge.

4.15 Social Ecological Model

The psychiatrist-identified factors that affect SRH provision to patient fall under the five levels of influence of the Social-Ecological Model.

Figure 4: Social Ecological Model - Barriers and Facilitators to Providing SRH Care



The individual level factors are included in the innermost, orange circle (See .

Figure 4). At this level, individual attitudes, knowledge and perceptions influence behavior (Glanz & Rimer, 2005). Psychiatrists reported that comfort level and their perceived standard of care are both factors that affect SRH care. The comfort level of the psychiatrists directly impacted whether they would order STI testing on site, prescribe medication or make referrals. In addition, psychiatrists reported varying levels of comfort with providing SRH services based on their training and knowledge. In some cases, discomfort around SRH topics meant psychiatrists did not ask patients SRH questions during appointments. In addition, psychiatrists varied greatly on their definition of the standard of care, in terms of SRH, that they were willing to provide to patients. Both of these individual level factors can act as a barrier or a facilitator to SRH care, depending on the individual.

The interpersonal level (blue in .

Figure 4) represents the processes and groups, which contribute to social identity and roles and provide support (Glanz & Rimer, 2005). At this level, the stakeholders include patients and other physicians. The interpersonal level factors surround the individual level factors and depict the interplay between the two levels of influence. Interview participants identified the patient-physician relationship, training, and patient factors as both barriers and facilitators to SRH care. For this level of influence, training includes the supervision and teaching between the residents and their attending physicians. Psychiatrists also reported the power dynamic between attending physicians and residents as a potential barrier to care because the attendings could override decisions to provide SRH care at the Outpatient Center. The patient factors include characteristics of the patients, such as SMI diagnosis, which impact the discussions between psychiatrist and patient in the outpatient setting.

The organizational level (purple in .

Figure 4) includes the policies, processes, and resources at the institutional level - the Outpatient Center, for the purposes of this study (Glanz & Rimer, 2005). At this level, referral processes, a variety of resources, short appointment times, the electronic medical record, and trainings during residency play a role in SRH care. The referral process can go both ways - it can help to make critical SRH appointments for patients or it can be burdensome and potentially a deterrent. Access to equipment and treatments, the presence of nursing staff, and the use of the EMR facilitate on-site services for psychiatrists. However, scheduling issues with nursing staff limit availability and can sometimes interact with patient's ability to attend follow-up appointments and receive critical treatments. All of the psychiatrists discussed ways in which time management hinders their ability to prioritize SRH care into their appointments.

The community level of influence (green in .

Figure 4) includes social networks and norms amongst groups and organizations (Glanz & Rimer, 2005). For the purposes of this research, the community level includes Grady Memorial Hospital, other hospital systems, and psychiatry and medical communities. Psychiatrists reported that referral processes, resources, and training all helped to facilitate and inhibit the provision of SRH care. Some of the referral processes are complicated but the use of referrals helps to connect patients to needed SRH services. In particular, the EMR facilitates care via communication and information management. All psychiatrists reported that time management was a large barrier to incorporating SRH care into their appointments.

The public policy level (red in .

Figure 4) encompasses the four other levels of influences. It includes local, state and federal policies that affect SRH care in outpatient settings (Glanz & Rimer, 2005). At the public policy level, concerns over liability pushes some psychiatrists to refrain from providing STI testing and treatment on site. Concerns about psychiatrist responsibility and a lack of knowledge and training directly contribute to apprehension over liability. However, liability also acts as a facilitator to ensuring providers alert patients to the teratogenic effects of some psychiatric medications. All psychiatrists reported this spontaneously, even though the questionnaire did not ask about contraception and pregnancy risk specifically. It typically came up in discussion surrounding their responsibility for SRH care.

4.16 Strength and Limitations

One of the strengths of qualitative research is that it directly allows the stakeholders in the study an opportunity to voice their opinions, concerns, and to provide suggestions for improvement. This type of participatory research is important for understanding the complex interplay of factors affecting the SRH care of patients in an outpatient setting. The qualitative data from this study helps to contextualize findings from a 2015 study of the psychiatrists at the Outpatient Center (von Esenwein & Cook, 2016, October/November) to better understand the nuances around SRH services, referral practices, and prescribing practices. While this data provided important insight into psychiatrists' practices, the survey could not establish the context, perceptions, and reasoning behind these practices.

Due to time constraints and difficulties in participant recruitment, saturation was not reached during data collection; six interviews were conducted and new themes were continuing to emerge in the final interview. The interview guide was developed to be around 45 minutes in length, but some interviews were short and did not go into as much depth as others. The interviews completed took between 24 and 75 minutes long. Though there were few interviews,

the participants had a variety of characteristics, which allowed for diverse perspectives, in terms of gender, different stages of training, and different medical school and residency affiliations. There also may be selection bias. Participants were recruited predominately by e-mail and there may have been something different about the psychiatrists who responded and agreed to interviews. Therefore, there may be several important views missing from the data.

One participant did not consent to being recorded. The interviewer took notes during the interview instead. During analysis there was no verbatim transcript to reference. In attempting to summarize the information learned during the interview, these notes may incorporate the interview moderator's perceptions, or interviewer bias.

The data from this research was collected from psychiatrists who have had experience in the behavioral outpatient services site at Grady Memorial Hospital. This outpatient center is unique because of the Primary Care Clinic housed there, with access to a lab and treatments it may not otherwise have. It will not be possible to determine how these differences at the Outpatient Center affect the main findings. However, the questions developed for the interview guide were meant to ask about ideas, processes, and scenarios that can occur in other urban, community mental health centers. Also, data from psychiatrists who have a unique outpatient experience will provide insight into a setting where psychiatrists *can* theoretically provide SRH services, but does not happen. Ultimately, the data from this study help to highlight the barriers to SRH care *besides* lack of physical resources.

4.17 Summary

The themes reflect psychiatrists' perspective on the facilitators and barriers to providing SRH services to their patients. The overall message is that there is a conflict between ideal care and the reality of resources and time constraints. There are also a variety of perceptions on responsibility and standards of care. Many of the themes were not solely facilitators or barriers,

but had components of both depending on the psychiatrist and their experiences. Identification of inefficiencies, realities, and gaps in care may help to identify ways to improve the provision of SRH services for women with SMI. Women of childbearing age, living with SMI, are particularly vulnerable to poor SRH health outcome and psychiatrists in outpatient settings are uniquely positioned to take ownership by facilitating or performing some of these critical services. The following sections will discuss the major factors affecting SRH care for female patients of reproductive age living with SMI and the implications of and limitations for this research.

5 Discussion

Dr. Ronald D. Stevenson, a Canadian physician affiliated with Vancouver General Hospital noted that, "[f]or an area of life and health that is so fundamental and pervasive, professional ignorance or inattention to possible sexual problems does not meet current standards of psychiatric practice" (Stevenson, 2004). The purpose of this research project was to better understand psychiatrists' perceptions and behaviors surrounding sexual and reproductive (SRH) health services in an urban psychiatric outpatient setting for adult women living with severe mental illness (SMI). There are many factors affecting healthcare services for patients with SMI, including patient-related factors, provider-related factors, and system-level factors (Druss, 2007; Lawrence & Kisely, 2010). Many of these factors affect the inclusion and extent of SRH care by psychiatrists in an outpatient setting and both facilitated and inhibited the provision of these services. The Social-Ecological model portrays the interplay of these factors and identifies key areas for intervention and improvement. The data from this study supports and adds to previous findings on barriers to medical care. Findings support an integrated care model to improve SRH outcomes in women with SMI.

5.1 Contributions to the Literature

This study supports findings from Agenor and Collins (2013) on the mental health providers' perceptions of barriers to SRH services for women with SMI. This study and the presented research found previous medical training, treatment priorities during appointments, and a general discomfort with addressing sexuality. Agenor and Collins (2013) specifically interviewed other mental health providers besides psychiatrists--nurses, social workers, and psychologists. The researchers found that attitudes towards the sexuality of women with SMI influenced to what extent they discussed sex and HIV with their patients, if discussed at all (Agenor & Collins, 2013). Meanwhile, this research study found that providers experienced

barriers to care due to concerns for liability, perceptions of psychiatrists' responsibility for the SRH of patients, difficult referral processes, and confusion over hospital policy and resources. Findings also suggested commonalities between psychiatrists and mental health nurses working with patients with SMI in an outpatient setting. While psychiatrists reported concerns with making patients uncomfortable by talking about sex, mental health nurses from a research study by Quinn et al. (2011) reported concerns over sexual misconduct allegations with patients of the opposite sex. Overall, the present study confirms themes of medical training experiences, prioritization due to time constraints, and provider discomfort discussing sex in terms of providing SRH medical care. It also adds new findings in terms of concerns for legal consequences, perceptions of provider responsibility, difficult referrals, and confusion over policies and available resources.

Findings from the current study included very little overlap with patient reported qualitative data on similar topics about accessing medical care (Borba et al., 2012). Borba et al. (2012) found that women reported themes related to SMI symptoms, continuity of providers, socioeconomic resources, discrimination from medical healthcare providers, access to quality mental health services, trust of providers, monitoring of both their mental and medical healthcare, and social support. In the current study, psychiatrists reported that having multiple appointments could act as a barrier to SRH care. Two of them explicitly made the connection to socioeconomic resources. However, psychiatrists did not indicate that trust, discrimination, and continuity of providers as barriers to care. While the lack of overlap between findings does not necessarily mean that providers were not aware of these barriers and facilitators, it may suggest a gap in provider knowledge about the extent of difficulties patients experience when navigating the healthcare system. Additionally, Borba et al. (2012) found that providers monitoring both the

mental *and* medical care of patients acts as facilitator to accessing medical services for patients. Thus, there is a need for psychiatrists to fill this role, and understanding their perceived barriers is an important step to improving SRH care of patients.

The Social-Ecological Model

The findings from this study identified barriers and facilitators at each level of influence in the Social-Ecological model. The factors affect the behavior of the psychiatrists, which is, in this case, the extent to and the manner in which they provide or connect adult women with SRH services. All of these factors interacted interdependently - one influenced the other. For example, a psychiatrist may believe that it is not their professional responsibility to test for STIs and treat them at the Outpatient Center (the individual level) and so they do not incorporate these services into their practice. The perception of the psychiatrist's responsibility could be based on experiences with patients that show up late to appointments (intrapersonal level), resulting in time management issues (organizational level). The psychiatrist may also have had a supervisor during residency that did not model the provision of SRH services to their patients *and* who has not reviewed updated STI testing and STI treatment since medical school (community level). Finally, the psychiatrist may also worry that prescribing treatment for an STI, without adequate training, would make them liable to be sued (policy level). All of these factors would influence the psychiatrists' final decision not to provide SRH services on site. Multiple interventions targeted at each of the levels of influence could help support psychiatrists in providing and better connecting their patients with SRH services.

However, the findings from this study make a strong case for targeting interventions at the community and policy levels in order to positively influence SRH health outcomes. Possible interventions include trainings for attending psychiatrists on incorporating SRH services into

their practice and standardizing training for supervision of residents. In addition, there needs to be a clarification of psychiatrists' responsibility for SRH services by medical associations, health organizations, and health care centers.

5.2 Fragmentation of Care

The separation between the provision of medical and mental health care services results in hardships for all stakeholders involved in SRH care in outpatient settings (Druss, 2007). Data from this study suggest that, while the psychiatrists have access to some STI screening services and treatments on site, they will send patients to other departments at the main hospital instead of performing these services themselves. In some cases, psychiatrists *do* feel comfortable testing for chlamydia, gonorrhea, and syphilis, but they will send their patients elsewhere for the treatment. In this scenario, fragmentation of care occurs because patients have to make multiple appointments to handle a single case of illness, such as symptoms indicative of a STI.

Druss (2007) described four types of separation between medical and mental health care: (1) geographic, (2) financial, (3) organization, and (4) cultural separation. Three of the four types of separation came up in this study. Geographic separation occurs because the mental health services and medical services are located in separate buildings. This type of separation inflicts additional barriers on patients including "…motivation, time, and money" (Druss, 2007)., which have been confirmed in both this study and others (Agenor & Collins, 2013; Borba et al., 2012; Quinn et al., 2011). However, only one psychiatrist brought up time and money as a barrier to care for patients, indicating a possible lack of awareness of patient population barriers.

Organizational separation occurs due to breakdown of communication and a lack of coordination between medical and mental health care (Druss, 2007). Psychiatrists discussed issues with referral processes and information discrepancies about what medical services they

can provide on-site. The end result is a lack of ownership for the patients' medical health needs. If the mental health provider is a patient's access point for medical care (Borba et al., 2012; De Hert, Cohen, et al., 2011; Millar, 2008) *and* they do not have a primary care physician (Borba et al., 2012), they may not get their SRH needs met. Cultural separation occurs when medical and mental health providers separate care for particular illnesses and disorders, instead of actively recognizing the interaction between psychiatric and medical needs (Druss, 2007). Due to a variety of factors, psychiatrists reported prioritizing the mental health needs and any acute needs of their patients. Fragmentation of care at both the community and policy level contribute to substandard SRH outcomes for women with SMI

5.3 Recommendations and Implications

Getting psychiatrists involved in SRH care may encourage a reduction in discrimination and stigma surrounding discussions of sex and increased patient participation in STI screening. In this study, one participant described how some of the residents she supervised did not ask patients key SRH questions and that she believed they were uncomfortable discussing sex with patients. In addition, she noted that differences in training during residency programs might contribute to discomfort or a lack of awareness by residents. Because the training of residents is heavily dependent on the supervision of attending physicians, efforts should be made to clarify the key information on SRH care psychiatrists should learn during residency.

At the organizational level, findings from this study can inform future trainings for residents and for the content in continuing medical education courses by defining the gaps in knowledge and exposing psychiatrists' perceptions' of SRH care. Currently, resident physicians learn how to be an attending physician to other residents via the modeling of their supervisors. Attending physicians should be provided training on how to supervise residents, especially in terms of addressing the sexual history of their patients.

In addition, residents may not establish a standard interview that includes SRH, due to a lack of exposure to this topic in rotations and during supervision by attending physicians. For example, several participants reported concerns over inadequate training to provide treatments for STIs. Providing a note template that specifically asks about this care would facilitate compilation of SRH related medical information in the electronic medical record. At a minimum, psychiatrists should learn to collect a sexual history from their female patients. CDC recommends that physicians ask their patients about "the 5 P's": (1) partners, (2) practices, (3) protection from STIs, (4) past history of STIs, and (5) pregnancy prevention (US Department of Health and Human Services and Centers for Disease Control and Prevention, n.d.). Discussing these topics can create an opportunity for risk reduction counseling (US Department of Health and Human Services and Centers for Disease Control and Prevention, n.d.). Better training for physicians on providing or connecting patients to SRH care could fill knowledge gaps (individual level of influence), and potentially increase provider comfort with SRH care (individual level of influence), and increase alleviate concerns over liability (policy level of influence).

At the organizational and community level, urban hospital systems, such as Grady Memorial Hospital, can aid psychiatrists in connecting female patients with SRH services by streamlining their referral processes. One psychiatrist reported sending patients to primary care, only for them to then be directed to OB/GYN because she could not figure out the process after it had changed. Streamlining referral process can aid physicians in providing quality care to their patients. When barriers such as time management, complex medical case management, or physician discomfort make on site provision of care impossible, an efficient referral system will ensure that patients do not have to attend unnecessary appointments.

In addition, this research suggests the presence of a specialized clinic can facilitate STI testing and treatment by the psychiatrists (depending on psychiatrists' comfort level with performing and being responsible for these services). Psychiatrists reported that having a Primary Care Clinic located at the Outpatient Center acted as an important facilitator to SRH care for patients who meet the criteria for participation in this specialized clinic. However, clarification on access and availability of these resources is critical (organizational level). Several participants in the study were not aware of their ability to utilize the lab and treatments provided via the Primary Care Clinic. Addressing confusion over SRH resources should be a priority in outpatient settings that are considering merging mental healthcare and medical care services.

Prevention screenings have already found a place in psychiatric care. In 2003, the American Diabetes Association (ADA), the American Psychiatric Association (APA), American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity convened and wrote a consensus statement recommending screening and monitoring for cardiovascular disease risk factors and metabolic conditions for patients prescribed antipsychotic drugs (American Diabetes Association; American Psychiatric Association; American Association of Clinical Endocrinologists; North American Association for the Study of Obesity, 2004). If these cardio metabolic screenings can be a part of regular care in an outpatient setting, there may be mechanisms and procedures already in place for SRH screenings, as well. At the policy level of the Social-Ecological Model, APA, in collaboration with other relevant associations, should consider convening to discuss the data surrounding SRH health of their female patients of reproductive age. Specifically, they should clarify and provide guidance and

recommendations for psychiatrists on the standard of care for SRH services in psychiatric outpatient settings.

5.4 Alternative Models for Care

While ideally women with SMI would have a primary care physician to manage their medical care, mental health providers often act as the only access point to healthcare to patients with SMI (Borba et al., 2012; De Hert, Cohen, et al., 2011; Millar, 2008). Due to the large number of barriers psychiatrists face in the outpatient setting, there are two alternative models to care that may support the providing of SRH services to their female patients. The 'reverse' integrated care model, identified by Maragakis et al. (2015), recommends integrating primary care services into mental health settings due to the barriers to care for patients with SMI, via embedding primary care practitioners there. This patient-centered model, with the outpatient setting acting as the principal point of contact could be the most practical model for addressing the needs of women with SMI (Alakeson, Frank, & Katz, 2010). Specifically, the Outpatient Center could consider embedding a primary care physician for *all* of their patients (as the Primary Care Clinic has limited spots available) to provide medical care, including SRH care. Given that the infrastructure (labs, appointment rooms, office space, etc.) already exists, this should be a relatively low cost effort. Since it is currently not efficient for psychiatrists to rely on referrals, based on the data collected in this study, a more integrated care model could provide a solution to improve SRH outcomes for women with SMI.

Another model, medical care management, has been shown to be an effective tool for managing primary care for patients with mental illness (Druss et al., 2010). One study designed an intervention in which a care manager addressed various barriers at three different levels for patients living with mental illness: (1) patient, (2) provider, and (3) system levels (Druss et al.,

2010). The researchers found that the intervention more than doubled the proportion of patients receiving evidenced based preventive services (70.5% compared to 35.6% for the control group), increased mental health related quality of life, increased the likelihood of a patients having a usual source of care and improved care of cardio metabolic conditions (Druss et al., 2010). An adapted care manager model, for use mental health outpatient settings, could improve health outcomes (including SRH outcomes) in women with SMI (Alakeson et al., 2010). This could be especially helpful for women who lack social support, financial resources, distrust medical providers, and experience discrimination (Alakeson et al., 2010; Borba et al., 2012). Under this facilitated referral model, the care manager would help to link patients with appropriate resources and coordinate their follow-through with appointments and referrals (Druss, 2007).

5.5 Future Research

Future research should focus on gathering qualitative data on patient barriers and facilitators to SRH care in an outpatient setting. Not only will this add to the body of literature on the SRH of female patients with SMI, but it will also provide much needed insight into patient level factors for mental health providers. In the future, researchers should collect data from the other stakeholders in an outpatient setting to better understand their needs. In particular, information on the needs and perceptions of patients in an outpatient setting would provide guidance in addressing barriers or reinforcing facilitators. Furthermore, research on the interactions between patients and providers may reveal gaps in SRH care.

5.6 Public Health Implications

- This study contributes to the growing body of literature about SRH and women with SMI. Participants answered questions on their level of participation and perceptions of

providing SRH care to women living with SMI. Answers to these questions will help to provide context to SRH care in mental health outpatient settings.

- Getting psychiatrists involved in SRH may encourage a reduction in stigma surrounding discussions of sex and participation in STI screening. One participant described some of the residents she supervised did not ask patients key SRH questions and that she believed they were uncomfortable discussing sex with patients. In addition, she noted that differences in training via residency programs may contribute to the provisions of SRH care by residents because they may have more experiences with women with SMI because they have completed specific rotations.
- This study sheds light on the critical role attending psychiatrist can play on training the resident psychiatrist to provide and connect patients with critical SRH services. The findings show that psychiatrists benefit from attendings modeling behavior, providing evidence for training attendings to include SRH services in their practice.
- This research may increase the attention paid to SRH services for women with SMI. The findings indicate that psychiatrists feel a general discomfort with discussing sex with their female patients. Given that women with SMI are less likely to receive critical preventive services, are more likely to suffer from sexually transmitted infections, *and* mental health care often functions as the main point of access to the health care system, psychiatrists should be better equipped to handle the SRH needs of their patients. These findings shed light on this gap in care.
- This research may contribute to a "cultural shift" amongst medical professionals in understanding the importance of SRH care. Several psychiatrists did not feel responsible for the SRH care of their patients, and believe that other subspecialties should provide

that care. However, research shows that mental health providers may be the only point of access for patients with SMI (De Hert, Cohen, et al., 2011).

- Findings from this study can inform future trainings for medical students, residents, and the content for continuing medical education courses by defining gaps in knowledge and understanding some psychiatrists' perceptions of SRH care. Several participants reported concerns over inadequate training to provide treatments for STIs. In addition, residents may not establish a standard interview that includes SRH due to particular rotations and supervision by attending physicians who already do not assess patients for SRH issues.
- Reducing barriers to psychiatrists playing a role in SRH care will benefit more than the target population of this research study. Improvements to care in outpatient clinics will likely benefit all patients attending those facilities because STI testing and treatment, safe sex education, referrals for SRH services are services that men can benefit from as well. Psychiatrists reported creating their own ways to address some of the barriers and For example, one participant reported creating a note template to remind herself to ask about SRH.
- The integration of SRH services and education into a psychiatric outpatient setting can act as a model for integrating other important preventive services into this setting, as well. Psychiatrists reported that having a Primary Care Clinic located at the Outpatient Center acted as an important facilitator to SRH care for specific patients, meeting the criteria for participation. For some psychiatrists, the presence of the Primary Care Clinic also facilitates STI testing and treatment at the Outpatient Center. However, clarification on access and availability of these resources is critical. Several participants in the study

were not aware of their ability to utilize the lab and treatments provided via the Primary Care Clinic.

- The symptoms caused by severe mental illnesses themselves can act as a barrier to health care, thus making targeted interventions for this population critical to improving health outcomes for patients. Participants reported certain mental health diagnoses, such as Bipolar Disorder, as having symptoms (e.g., impulsivity and hyper-sexuality) that trigger conversations about safe sex. However, literature suggests that psychiatric symptoms can also prevent patients from seeking medical care (Ostrow et al., 2014). Psychiatrists can both identify patients whom may have symptoms of mental illness that affect their SRH and identify patients to navigate the healthcare system more efficiently

5.7 Conclusion

Physical and mental health are seamlessly interconnected, and there has been a call for psychiatrists to incorporate the treatment of physical health problems of their patients (De Hert, Correll, et al., 2011; Lawrence & Kisely, 2010). This study contributes to the growing body of literature about SRH and women with SMI. The Social-Ecological Model provides a useful model for understanding the psychiatrist reported barriers and facilitators to SRH care found in the data. Recommendations include physician training and clarification of procedures and policies at the organizational, community, and policy level. Integrated care models offer a possible solution to the poor SRH outcomes and inadequate SRH services for women with SMI. There needs to be a "cultural shift" amongst medical professionals to understand the importance and complexity of SRH care for this population. With physical and mental illness inseparably intertwined, it follows that psychiatrists should play a role in the SRH concerns of women with SMI.

6 References

Agenor, M., & Collins, P. Y. (2013). Preventing HIV among U.S. women of color with severe mental illness: perceptions of mental health care providers working in urban community clinics. *Health Care Women Int, 34*(3-4), 281-302. doi: 10.1080/07399332.2012.755983

Alakeson, V., Frank, R. G., & Katz, R. E. (2010). Specialty care medical homes for people with severe, persistent mental disorders. *Health Aff (Millwood), 29*(5), 867-873. doi: 10.1377/hlthaff.2010.0080

Amercan Medical Association. (n.d.). Requirements for Becoming a Physician. Retrieved March 24, 2016, from http://www.ama-assn.org/ama/pub/education-careers/becoming-physician.page

American Diabetes Association; American Psychiatric Association; American Association of Clinical Endocrinologists; North American Association for the Study of Obesity. (2004). Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care. *27*, 596-601.

attending physician. (n.d.) Farlex Partner Medical Dictionary. (2012). Retrieved March 20 2016 from http://medical-dictionary.thefreedictionary.com/attending+physician.

Borba, C. P. C., DePadilla, L., McCarty, F. A., von Esenwein, S. A., Druss, B. G., & Sterk, C. E. (2012). A Qualitative Study Examining the Perceived Barriers and Facilitators to Medical Healthcare Services among Women with a Serious Mental Illness. *Women's Health Issues, 22*(2), e217-e224. doi: http://dx.doi.org/10.1016/j.whi.2011.10.001

Bougrab, N., Bracho, A., Ford, D., Girod, C., & Philip, Z. (2015). Preventive and Reproductive Health Care in Adult Women with Severe Mental Illness: A Retrospective Chart Review at Grady Outpatient Behavioral Health Clinic (Unpubished) (Emory University Rollins School of Public Health, Trans.).

Brown, S., Birtwistle, J., Roe, L., & Thompson, C. (1999). The unhealthy lifestyle of people with schizophrenia. *Psychol Med, 29*(3), 697-701.

Brunette, M. F., Drake, R. E., Marsh, B. J., Torrey, W. C., & Rosenberg, S. D. (2003). Responding to blood-borne infections among persons with severe mental illness. *Psychiatr Serv, 54*(6), 860-865. doi: 10.1176/appi.ps.54.6.860

Carey, M. P., Carey, K. B., Maisto, S. A., Gordon, C. M., & Vanable, P. A. (2001). Prevalence and correlates of sexual activity and HIV-related risk behavior among psychiatric outpatients. *J Consult Clin Psychol, 69*(5), 846-850.

Center for Behavioral Health Statistics and Quality. (2015). *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from* http://www.samhsa.gov/data/. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm - fn4.

Centers for Disease Control and Prevention. (2015a, July 8, 2015). Common Reproductive Health Concerns for Women. Retrieved March 30, 2016, from http://www.cdc.gov/reproductivehealth/womensrh/healthconcerns.html

Centers for Disease Control and Prevention. (2015b). Social Ecological Model. Colorectal Cancer Control Program (CRCCP). Retrieved March 16, 2016, from http://www.cdc.gov/cancer/crccp/sem.htm

Centers for Disease Control and Prevention. (2015c, Novermber 17). STDs and Infertility. Retrieved February 28, 2016, from http://www.cdc.gov/std/infertility/

Centers for Disease Control and Prevention. (2016, March 10, 2016). How Healthcare Providers Can Talk. Test. Treat. Retrieved March 31, 2016, from http://www.cdc.gov/std/sam/2016-providers.htm

Collins, P. Y., Elkington, K. S., von Unger, H., Sweetland, A., Wright, E. R., & Zybert, P. A. (2008). Relationship of stigma to HIV risk among women with mental illness. *Am J Orthopsychiatry, 78*(4), 498-506. doi: 10.1037/a0014581

Cournos, F., Guido, J. R., Coomaraswamy, S., Meyer-Bahlburg, H., Sugden, R., & Horwath, E. (1994). Sexual activity and risk of HIV infection among patients with schizophrenia. *Am J Psychiatry, 151*(2), 228-232. doi: 10.1176/ajp.151.2.228

De Genna, N. M., Feske, U., Angiolieri, T., & Gold, M. A. (2011). Race and sexually transmitted diseases in women with and without borderline personality disorder. *J Womens Health (Larchmt), 20*(3), 333-340. doi: 10.1089/jwh.2010.2104

De Hert, M., Cohen, D. A. N., Bobes, J., Cetkovich-Bakmas, M., Leucht, S., M. Ndetei, D., . . . U. Correll, C. (2011). Physical illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level. *World Psychiatry, 10*(2), 138-151.

De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D. A. N., Asai, I., . . . Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*(1), 52-77.

Druss, B. G. (2007). Improving medical care for persons with serious mental illness: challenges and solutions. *J Clin Psychiatry, 68 Suppl 4*, 40-44.

Druss, B. G., Rosenheck, R. A., Desai, M. M., & Perlin, J. B. (2002). Quality of preventive medical care for patients with mental disorders. *Med Care, 40*(2), 129-136.

Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010). The Primary Care Access Referral, and Evaluation (PCARE) Study: A Randomized Trial of Medical Care Management for Community Mental Health Settings. *Am J Psychiatry, 167*(2), 151-159. doi: 10.1176/appi.ajp.2009.09050691

Druss, B. G., von Esenwein, S. A., Compton, M. T., Zhao, L., & Leslie, D. L. (2011). Budget impact and sustainability of medical care management for persons with serious mental illnesses. *Am J Psychiatry, 168*(11), 1171-1178. doi: 10.1176/appi.ajp.2011.11010071

Emory University School of Medicine. (n.d.). Grady Memorial Hospital. Retrieved March 20, 2016, from http://www.emory.edu/grady/

Federal Register Volume 58 No. 96 published Thursday May 20, pages 29422-29425,. Retrieved from http://www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf.

Frandsen, B. R., Joynt, K. E., Rebitzer, J. B., & Jha, A. K. (2015). Care fragmentation, quality, and costs among chronically ill patients. *Am J Manag Care, 21*(5), 355-362.

Galanter, W. L., Applebaum, A., Boddipalli, V., Kho, A., Lin, M., Meltzer, D., . . . Lambert, B. L. (2013). Migration of Patients Between Five Urban Teaching Hospitals in Chicago. *Journal of Medical Systems, 37*(2), 1-8. doi: 10.1007/s10916-013-9930-y

Gault, C. (2011). SAMHSA Substance Abuse and Mental Health Services Administration Primary and Behavioral health Care Integration Grant Application.

Glanz, K., & Rimer, B. (2005). Theory at a Glance: A Guide for Health Promotion Practice (pp. 4-33). Washington, DC: National Cancer Institute, National Institutes of Health, US Department of Health and Human Services.

Grady Health Systems. (n.d.). Billing and Insurance Information. Retrieved March 27, 2016, from http://www.gradyhealth.org/billing-and-insurance

Guest, G., MacQueen, K., & Namey, E. (2016). *Applied Thematic Analysis*. Los Angeles, CA: Sage Publications.

Hackman, A. L., Goldberg, R. W., Brown, C. H., Fang, L. J., Dickerson, F. B., Wohlheiter, K., . . . Dixon, L. (2006). Use of emergency department services for somatic reasons by people with serious mental illness. *Psychiatr Serv, 57*(4), 563-566. doi: 10.1176/ps.2006.57.4.563

Happell, B., Scott, D., & Platania-Phung, C. (2012). Provision of preventive services for cancer and infectious diseases among individuals with serious mental illness. *Arch Psychiatr Nurs, 26*(3), 192-201. doi: 10.1016/j.apnu.2011.09.002

Hennink, M. M., Hutter, I., & Bailey, A.,. (2011). *Qualitative research methods*. London: SAGE.

Hughes, E., Bassi, S., Gilbody, S., Bland, M., & Martin, F. (2015). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness: a systematic review and meta-analysis. *Lancet Psychiatry*. doi: 10.1016/s2215-0366(15)00357-0

Hughes, E., Bassi, S., Gilbody, S., Bland, M., & Martin, F. (2016). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness: a systematic review and meta-analysis. *The Lancet. Psychiatry, 3*(1), 40-48. doi: 10.1016/S2215-0366(15)00357-0

Lambert, T. J., Velakoulis, D., & Pantelis, C. (2003). Medical comorbidity in schizophrenia. *Med J Aust, 178 Suppl*, S67-70.

Lawrence, D., & Kisely, S. (2010). Inequalities in healthcare provision for people with severe mental illness. *Journal of Psychopharmacology (Oxford, England), 24*(4_supplement), 61-68. doi: 10.1177/1359786810382058

Maj, M. (2009). Physical health care in persons with severe mental illness: a public health and ethical priority. *World Psychiatry, 8*(1), 1-2.

Maragakis, A., Siddharthan, R., RachBeisel, J., & Snipes, C. (2015). Creating a 'reverse' integrated primary and mental healthcare clinic for those with serious mental illness. *Prim Health Care Res Dev*, 1-7. doi: 10.1017/s1463423615000523

Marshall, M. N. (1996). Sampling for qualitative research. *Fam Pract, 13*(6), 522-525.

Matevosyan, N. R. (2009). Reproductive Health in Women with Serious Mental Illnesses: A Review. *Sexuality and Disability, 27*(2), 109-118. doi: 10.1007/s11195-009-9114-3

McKinnon, K., Cournos, F., & Herman, R. (2002). HIV among people with chronic mental illness. *Psychiatr Q, 73*(1), 17-31.

McKinnon, K., Cournos, F., Sugden, R., Guido, J. R., & Herman, R. (1996). The relative contributions of psychiatric symptoms and AIDS knowledge to HIV risk behaviors among people with severe mental illness. *J Clin Psychiatry, 57*(11), 506-513.

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Educ Q, 15*(4), 351-377.

Meade, C. S., & Sikkema, K. J. (2005). HIV risk behavior among adults with severe mental illness: A systematic review. *Clinical Psychology Review, 25*(4), 433-457. doi: http://dx.doi.org/10.1016/j.cpr.2005.02.001

Meade, C. S., & Sikkema, K. J. (2007). Psychiatric and Psychosocial Correlates of Sexual Risk Behavior among Adults with Severe Mental Illness. *Community Mental Health Journal, 43*(2), 153-169. doi: 10. 1007/s10597-006-9071-6

Millar, H. (2008). Management of physical health in schizophrenia: a stepping stone to treatment success. *Eur Neuropsychopharmacol, 18 Suppl 2*, S121-128. doi: 10.1016/j.euroneuro.2008.02.002

Miller, A. (2012). Grady revamps outpatient mental health services. Retrieved March 20, 2016, from http://www.georgiahealthnews.com/2012/05/grady-consolidating-outpatient-mental-health-services/

National Institute of Mental Health. (n.d.). Serious Mental Illness (SMI) Among U.S. Adults. Retrieved March 24, 2016, from http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml

Ostrow, L., Manderscheid, R., & Mojtabai, R. (2014). Stigma and difficulty accessing medical care in a sample of adults with serious mental illness. *J Health Care Poor Underserved, 25*(4), 1956-1965. doi: 10.1353/hpu.2014.0185

Parks J, S. D., Singer P et al (eds). Morbidity and mortality in people with serious mental illness. Alexandria: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 2006,. (2006). Morbidity and mortality in people with serious mental illness. Alexandria: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

Quinn, C., Happell, B., & Browne, G. (2011). Sexuality and consumers of mental health services: the impact of gender and boundary issues. *Issues Ment Health Nurs, 32*(3), 170-176. doi: 10.3109/01612840.2010.531518

Randolph, M., Pinkerton, S., Somlai, A., Kelly, J., McAuliffe, T., Gibson, R., & Hackl, K. (2007). Severely Mentally Ill Women's HIV Risk: The Influence of Social Support, Substance Use, and Contextual Risk Factors. *Community Mental Health Journal, 43*(1), 33-47. doi: 10.1007/s10597-006-9069-0

Robson, D., & Gray, R. (2007). Serious mental illness and physical health problems: a discussion paper. *Int J Nurs Stud, 44*(3), 457-466. doi: 10.1016/j.ijnurstu.2006.07.013

Rosenberg, S. D., Goodman, L. A., Osher, F. C., Swartz, M. S., Essock, S. M., Butterfield, M. I., . . . Salyers, M. P. (2001). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. *American Journal of Public Health, 91*(1), 31-37.

Rothbard, A. B., Blank, M. B., Staab, J. P., TenHave, T., Young, D. S., Berry, S. D., & Eachus, S. (2009). Previously undetected metabolic syndromes and infectious diseases among psychiatric inpatients. *Psychiatr Serv, 60*(4), 534-537. doi: 10.1176/appi.ps.60.4.534

Senn, T. E., & Carey, M. P. (2009). HIV testing among individuals with a severe mental illness: review, suggestions for research, and clinical implications. *Psychol Med, 39*(3), 355-363. doi: 10.1017/s0033291708003930

Stevenson, R. W. (2004). Sexual medicine: why psychiatrists must talk to their patients about sex. *Can J Psychiatry, 49*(10), 673-677.

Stulberg, D. B., Dahlquist, I., Jarosch, C., & Lindau, S. T. (2016). Fragmentation of Care in Ectopic Pregnancy. *Maternal and Child Health Journal*, 1-7. doi: 10.1007/s10995-016-1979-z

US Department of Health and Human Services and Centers for Disease Control and Prevention. (n.d.). A Guide to Taking a Sexual History.

von Esenwein, S. (2016). [Personal communication, February 25, 2016].

von Esenwein, S., & Cook, S. (2016, October/November). *Establishing the need for sexual and reproductive health services among women with serious mental illness. Abstract submitted to 2016 American Public Health Association Conference, Denver, Colorado.*

Ward, M. (2013). *Improving General Health for Mental Health Consumers.* Paper presented at the Mental Health America Annual Conference, Washington, DC.

World Health Organization. (n.d.). Sexual and Reproductive Health: Global estimates shed light on toll of sexually transmitted infections. Retrieved March 31, 2016, from http://www.who.int/reproductivehealth/news/stis-estimates-2015/en/

Zieman, M., Hatcher, R., & Allen, A. Z. (2015). *Managing Contraception 2015-2016*. Tiger, GA: Bridging the Gap Foundation.

7 Appendix A: Recruitment E-mail

Dear Grady Psychiatrists:

We are contacting you because you are a psychiatrist working at the Grady Outpatient Behavioral Health Center. We are a group of graduate student researchers from the Rollins School of Public Health, collaborating with Dr. Martha Ward to better understand the facilitators and barriers to providing sexual and reproductive health services to your female patients of reproductive age. For our research, we would like to conduct 30-45 minute one-on-one interviews with you.

Your participation in this study is completely voluntary and confidential. If you choose to participate, information collected from your interview will be used to help improve patient care at this clinic.

Members of the research team are flexible and able to travel to your workplace to conduct the interview. If you are willing to participate, please respond to Zoe Philip at zoe.philip@emory.edu or call 781-820-0431 with three available times. We understand your time constraints In addition, participants will receive a $20.00 gift card for their participation.

Thank you for your time!

Sincerely,
Zoe Philip,
Darby Ford,
and Jesse Zatloff

8 Appendix B: IDI Guide

Survey ID: _____

Interviewer: _____

Date: _____

Start Time: _____

End Time: _____

Gender of Interviewee: _____

Year of residency, if applicable: _____

# of months/ years at center: _____

Research Question: At a psychiatric outpatient clinic where STI testing and limited STI treatments (gonorrhea, chlamydia, and syphilis) are available**,** what are the barriers and facilitators to psychiatrists incorporating these services into their practices?
Study Population: Psychiatrists working with women of reproductive age (18-40) with a severe mental illness who receive mental health services at the Grady Behavioral Outpatient Center.

Interview Guide

Introduction:

Thank you for agreeing to an interview today. My name is _____and I am a graduate student at Rollins School of Public Health at Emory University. I'm doing this interview with you for a research project on reproductive and sexual health while at Grady Outpatient Behavioral Health Center. We are looking at psychiatrists' experiences of incorporating reproductive and sexual health services into their practice. I am here today to talk to you about your *own* experiences. Your participation in this interview is completely voluntary; you can skip any questions you would like and we can end the interview at any time you wish. We will be interviewing other psychiatrists from this clinic to better understand these issues.

I would like to tape record our interview to document your answers since I cannot write as fast as we speak. Additionally, I want to make sure that I can focus on our interview instead of writing. This interview is completely confidential; no one other than the people associated with the project will hear the tape recording. Do you have any questions about this for me? Do I have permission to tape record our discussion today?

There are no right or wrong answers to these discussion topics. Our research team is interested in learning more about your personal experiences.

Do you have any questions before we begin? Are you ready to begin?

(**Sections**: Standard of care, STI testing, STI treatment, and safe sex education)

Warm-up questions:

1. How did you end up choosing psychiatry as your specialty?
2. What do you like about working in the Grady Healthcare system?
3. What does your typical day here at the Outpatient Center look like?
4. Can you describe how you incorporate sexual health and reproductive health into your workflow at the Outpatient Center, when working with your female patients of reproductive age?
5. How do you manage time during appointments?
    Probe: intake appointments; medication management appointments; gender balance; time; context, how many patients per day

Standard of Care

6. What is your current role in providing sexual and reproductive health care?
    a. Probe: comfort level
7. In your opinion, what is the role of psychiatrists in providing sexual and reproductive health services to female patients of reproductive age?
    Probe: screenings; family planning; does patient have PCP?

8. Who is responsible for the sexual and reproductive health of a female patient?
    Probe: Sub-specialties; PCP; the patient
9. How does the specific psychiatric diagnosis of your female patient affect the way you talk about sexual and reproductive health with her?

STI Testing

10. Can you describe situations in which you would discuss STI testing during appointments with your female patients of reproductive age?
    Probe: patient brings it up; taking a sexual history; risk factors; trauma; relationships
11. If you believe your patient should receive STI testing, can you describe your next steps?
    Probe: referral; prescribe; educate; motivational interviewing
12. Can you describe any barriers to providing STI testing here at the center with your female patients of reproductive age?
    Probe: time; liability; comfort level; space; equipment

13. Can you describe any facilitators to providing STI testing here at the center?
    Probe: testing on site; time

STI Treatment

14. Could you describe any ways it is easy for you to treat STIs at the center?
    Probe: medications on site; time; staff
15. Could you describe any barriers to treating STIs at this center?
    Probe: liability; confidence in prescribing; depends on STI; patient follow-up

Safe Sex Education

16. Can you describe situations in which you discuss safe sex practices with your female patients of reproductive age?
    Probe: risk factors; condoms; condom negotiation; motivational interviewing, on teratogenic medications that you are prescribing

Concluding Questions

17. Do you have any suggestions for incorporating reproductive and sexual health services into psychiatrist workflow?
18. Of the things you mentioned, what is the most feasible strategy?
19. Is there anything else we have not talked about that you would like to discuss?

Again, thank you so much for taking the time out of your day to interview with me.

Notes by interviewer