Written evidence from The University of Manchester [WRH0050]

This submission of evidence was prepared by Dr Holly Hope, Professor Kathryn Abel, and Dr Rohna Kearney, and supported by Policy@Manchester.

The focus of this submission is women of reproductive age 14 to 45 years, and women with mental illness. We outline why reproductive health and reproductive rights are inter-connected, and some of the health disparities experienced by women with mental illness.

We also address the current regional disparities in the treatment and diagnosis of gynaecological or urogynaecological conditions.

Reproductive health equals reproductive choice

Women in the UK are seen 2.5 times more often than men in primary care.[1] To demonstrate the size of this difference, if we take the UK 2020 population estimates, this amounts to an additional 44.6 million healthcare visits in 2020. We surmise that much of this excess healthcare utilisation is explained by the extra mental, sexual, and reproductive health needs of women – compared to men – simply to remain healthy.

Women's reproductive health, as defined by the World Health Organisation, means women can reproduce safely and healthily, at a time of their choosing.[2] Hence, reproductive health clearly overlaps with reproductive choice, a universal human right. Physical reasons for poor reproductive health include gynaecological diseases that stop or disrupt menstruation.

Gynaecological diseases are commonly associated with, and can be caused by, sexually transmitted infection (STI). For example, HPV infection is the commonest cause of cervical neoplasia/cancer, and repeated STIs associated with disease of the pelvis and fallopian tube (such as pelvic inflammatory disease or PID) which may lead to adhesions in the abdomen and its associated complications (obstruction of the bowel, peritonitis, and infertility).

Thus, physical, sexual, and reproductive health are closely intertwined. Gendered reasons for women's risk of poor reproductive health include sexual violence and sexual coercion; these experiences remove a woman's reproductive choice and disproportionately affect women from poor backgrounds and those with (serious) mental illness.

Access to contraception is also vital for women's choice both in controlling their reproductive lives - choosing when to become pregnant and to protect themselves from sexually transmitted infections. Women with mental illness and/or a history of domestic violence use emergency contraception at a far higher rate, indicating a lack of reproductive choice.[3]

Mental illness is the most common illness among women of reproductive age

The most common mental conditions are depression and anxiety. We estimated the prevalence of mental illness in mothers, and estimated that in the UK today, 1 in 4 children born in the UK live with a mother with mental illness; and almost 1 in 5 (20%) of women enter their pregnancy with a mental illness.[4] Furthermore, 24.2% of women enter pregnancy with two or more health conditions, and 70% of this health burden is mental illness.[5]

Women with mental illness have less reproductive choice and poorer reproductive outcomes

Our research has found that women with mental illness are less fertile, and have fewer live births, than women without mental illness. This is particularly the case for women with psychosis. For example, women diagnosed with schizophrenia are more likely to experience intranatal foetal death or stillbirth.[6]

They are also twice as likely to experience miscarriage (which is common); and 50% more likely to experience 3 or more recurrent miscarriages, a relatively rare experience and a strong indication of an underlying disease affecting fertility, such as prior undiagnosed PID or other forms of fallopian or uterine disease. In spite of this, **like all women**, women with mental illness are more likely to have children than to not have children, and if so, they are more likely to have more than one child.[7]

Women with mental illness are more likely to experience sexually transmitted infections, gynaecological diseases, and reproductive health cancers (e.g. breast, ovarian, cervical, vulva), all of which may affect fertility and pregnancy outcomes.

Women who smoke are more susceptible to the infections that cause gynaecological cancers; our review of GP records revealed that 17% of women currently smoked, with this number doubling to 36% for women with a diagnosis of depression or anxiety, 43% for women with psychosis, and 67% for women with an addiction disorder.[7]

Polycystic ovarian syndrome (PCOS) is consistently associated with all types of mental ill health, independent of their use of medications such as sodium valproate (known to cause PCOS). This might indicate a role for common, androgen-mediated mechanisms for linking serious mental illness and PCOS.[8] The association between mental illness and gynaecological disease, is likely, at least partly, to be mediated by the increased risk of sexually transmitted diseases.

Despite these additional health needs, women with mental illness are less likely to access primary preventive health care than well women, including lifesaving cervical screening; while their risk of receiving emergency, as opposed to prophylactic, contraception is double that of women in the general population.

Barriers to women with mental illness receiving diagnosis and treatment

The sexual and reproductive health needs of women with mental illness are not addressed by clinicians in primary or secondary care, nor do current mental health plans consider the sexual and reproductive health needs of women with mental illness. Family planning is frequently neglected in clinical practice, even though 43% of pregnancies are not planned.[9] This is particularly worrying for the woman who is taking psychotropic medication that has teratogenic potential. Two studies have shown that when women of childbearing potential are prescribed ongoing or newly initiated medication with valproate, carbamazepine or lithium, basic childbearing aspects are addressed in less than half of all cases.[10,11]

Research by Dr Hope and Professor Abel, published last year, found that:

"There remains a pressing need to develop broader clinical awareness and create opportunities to engage with women with mental illness about these aspects of their health. Conversations about sexual choice, safety, preferred method of contraception and family planning are needed as part of routine care, as well as checking cervical screening or HPV vaccination uptake. General practitioners and mental health clinicians require training in the skills to talk to women about their sexual and

reproductive health and to support women to make choices that protect this alongside their mental health needs."[12]

Service and policy implications

Changes in both policy and practice are needed so that sexual and reproductive health of clients is recognised as part of mental health practitioners' core work. Without such acceptance, these topics will remain hard to deal with for women and services alike. Accepting that a patient's sexuality and reproductive health are integral to their mental healthcare requires good working links with other clinicians in gynaecology, obstetrics, genitourinary medicine, as well as with primary care practitioners.[13]

Clinicians should discuss family planning issues with all women of childbearing potential who have a new, pre-existing, or past mental health problem.[14,15] This should include how pregnancy and childbirth might affect a mental health problem, and how a mental health problem and its treatment might affect the woman, the foetus and the baby.[16]

Midwife-led continuity of carer systems for women with mental illness that begins pre-conception would provide women with a named person who understands the context they live in and their specific sexual and reproductive health needs, and might be one route to overcome some of the barriers women face.[17]

If the woman is not planning to become pregnant, her reproductive health and contraceptive status should be discussed and optimised, which may require consultation with her general practitioner or referral to a family planning clinic. This area urgently requires improvement in clinical practice. A recent Department of Health and Social Care initiative with The University of Manchester and University of Greenwich has developed online resources to support mental health professionals to address the particular reproductive and sexual health needs of their clients – as has the charity Tommy's – but to what extent these are implemented is unclear.

For a more detailed description of how to diagnose and mange reproductive and mental health across from menarche to menopause please see Professor Abel's insightful review.

Regional disparities in the treatment and diagnosis of gynaecological or urogynaecological conditions

The Royal College of Obstetricians and Gynaecologists released a report in 2022 *Left for too long: understanding the scale and impact of gynaecology waiting lists*. This report demonstrated that gynaecology waiting lists were growing too quickly before the pandemic hit and this has deteriorated further following the pandemic with the growth in gynaecology wating lists exceeding all other specialties. There is often a lack of understanding of the impact on non-cancerous gynaecological conditions on women's personal and professional lives.

The North West region has the longest wating list, accounting for 8 of the 10 Clinical Commissioning Groups (CCGs) with the highest waiting lists by population. Delays in treatment result in progression of disease and worsening impact for women. One of the commonest concerns identified in this research is the progression of urogynaecology conditions untreated such as urinary incontinence, pelvic organ prolapse, and mesh complications. Lack of suitable trained workforce and the impact of needing to maintain maternity services with a shared workforce are other identified barriers to timely care. This report made 5 recommendations to address the findings:

1. Prioritisation of care as part of NHS recovery must look beyond clinical need to also consider the wider impacts on patients waiting for care.
2. There needs to be a shift in the way gynaecology is prioritised as a specialty across the health service, including action to move away from using the term 'benign' to describe gynaecological conditions.
3. Elective recovery must address the unequal growth of gynaecology waiting lists compared to other specialties.
4. Elective recovery in gynaecology must focus on reducing the disparities between different regions and CCGs, ending the postcode lottery for gynaecology care.
5. Governments across all four nations must put in place fully-funded, long-term plans for the NHS workforce to ensure that staffing does not continue to be a barrier to reducing waiting lists.

Models of care that empower women to look after their reproductive health are important. Dr Kearney has co-authored a multicentred, randomised control trial of self-management versus clinic-based care for women using vaginal pessaries to manage pelvic organ prolapse symptoms. This study found that self-management offered equivalent quality of life to clinic-based care, is an acceptable intervention, and reduces pessary related complications. Self-management is cost effective and reduces the cost to health services compared with clinic or hospital care.[18] Further research is exploring the barriers and facilitators of self-management.[19]

Authors

Dr Holly Hope is an academic research fellow at the Centre for Women's Mental Health, The University of Manchester. Dr Hope uses electronic health record data to research women's health. Electronic heath data are information routinely collected by doctors, nurses and other health professionals when providing care in GP, specialist clinic and hospital settings. Because these datasets are large, Dr Hope can explore the relationship between women's mental and physical health, including reproductive and sexual health, for common and rare outcomes.

Professor Kathryn Abel is Founder & Director of the Centre for Women's Mental Health, NIHR National Lead for Mental Health, and co-Chair of the UK Govt Mental Health Mission. The focus of her research is improving the lives of vulnerable women and their children, and she acts as supervisor and mentor to Dr Hope. Prof Abel has worked closely with government on the Board of the Gender & Equalities Commission (Chair Dr Sian Rees), both Women's Mental Health Taskforces, the recent APPG on the COVID generation, and is a current member with Dr Hope of the Perinatal Intelligence Network. She is author of the SCIE (2011) learning resource on sexual, reproductive and mental health; of the recent BMA special edition *Addressing unmet needs in women's health*; and of several book chapters. She is editor of Comprehensive Women's Mental Health, covering the overlap between the reproductive lives of women and their mental health experiences.

Dr Rohna Kearney is a Consultant Urogynaecologist and Deputy Medical Director at Saint Mary's Hospital, Manchester University NHST trust, and Honorary Senior Lecturer at The University of Manchester. Her research focuses on the management of pelvic organ prolapse, pelvic floor health after childbirth and management of mesh complications. She is a member of the RCOG Scientific Advisory group and NHS England Clinical Reference Group for Women's Specialised services.

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